**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-01-16**
**Baltimore, Maryland 21244-1850**

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**Children and Adults Health Programs Group**

November 18, 2014

Ms. Julie Weinberg
Director
Medical Assistance Division
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, NM 87504

Dear Ms. Weinberg:

The Centers for Medicare & Medicaid Services (CMS) is approving New Mexico's attachments for the Section 1115 Demonstration titled "Centennial Care" (Project Number 11-W-00285/6) in accordance with the STCs. We have revised the STCs to reflect all attachments where there were previously placeholders for the following:

- Attachment F: Uncompensated Care (UC) Payment Application Template (STC 82)
- Attachment H: HQII Payment Methodology (STC 83)
- Attachment I: Independent Consumer Supports System Plan (STC 56)

In addition, we have reflected the adoption of the medically fragile into the Centennial Care waiver as of January 1, 2016.

Your project officer for this demonstration is Mrs. Vanessa Sammy. She is available to answer any questions concerning your section 1115 demonstration. Mrs. Sammy's contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-02-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2613
E-mail: Vanessa.Sammy@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Bill Brooks, Associate Regional Administrator for the Division of Medicaid and Children's Health in the Dallas Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children Health Operations
1301 Young St., Ste. 833

Dallas, TX 75202

We look forward to continuing to partner with you and your staff on the New Mexico "Centennial Care" demonstration.

Sincerely,

/s/

Manning Pellanda, Director
Division of State Demonstrations and Waivers

Enclosures

cc: Bill Brooks, ARA, Region VI
Angela D. Garner, CMCS
Vanessa Sammy, CMCS
Paul Boben, CMCS

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER: 11W 00285/6**

**TITLE: New Mexico Centennial Care**

**AWARDEE: New Mexico Human Service Department**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Mexico's "Centennial Care" section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the New Mexico Human Services Department (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 (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, 2014 and expire December 31, 2018. Implementation of the demonstration may begin January 1, 2014 unless otherwise specified. This demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:


I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Beneficiaries Served Through the Demonstration
V. Native American Participation and Protection
VI. Centennial Care Benefits
VII. Beneficiary Rewards
VIII. Centennial Care Enrollment
IX. Delivery System
X. Home and Community Based Services (HCBS) Service Delivery and Reporting Requirements
XI. Program Implementation and Beneficiary Protections
XII. Safety Net Care Pool
XIII. General Financial Requirements
XIV. Monitoring Budget Neutrality for the Demonstration
XV. General Reporting Requirements
XVI. Evaluation of the Demonstration
XVII. Schedule of State Deliverables During the Demonstration

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

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| Attachment A. | Quarterly Report Content and Format |
| Attachment B. | Centennial Care HCBS and Behavioral Health Service Definitions |
| Attachment C. | HCBS Participant Safeguards |
| Attachment D. | Level of Care Criteria |
| Attachment E. | List of Hospitals Eligible for the Safety Net Care Pool Initial Allocation of Uncompensated Care (UC) Funding for UC pool |
| Attachment F. | Uncompensated Care (UC) Payment Application Template |
| Attachment G. | HQII Outcome Measures |
| Attachment H. | HQII Allocation and Payment Methodology |
| Attachment I. | Independent Consumer Support System Plan |

## II. PROGRAM DESCRIPTION AND OBJECTIVES

Centennial Care seeks to modernize the New Mexico Medicaid program to assure that the state is providing the most effective, efficient health care possible for its most vulnerable and needy citizens and to create a sustainable program for the future. This new demonstration creates a comprehensive service delivery system for the New Mexico Medicaid program that is as unique as the State and designed to provide beneficiaries the right care, delivered at the right time, in the right setting. The state seeks to develop and implement a service delivery system that not only integrates care now but ensures that the State can afford to continue the program in future years.

The demonstration will enroll most New Mexico Medicaid beneficiaries and New Mexico Medicaid expansion Children's Health Insurance Program (CHIP) beneficiaries in managed care for a full range of services, including physical health, behavioral health and long term services and supports (home and community based services and institutional care). The demonstration consolidates the following, existing delivery system waivers into a single comprehensive managed care product:[1]

- Salud! 1915(b) waiver: Acute managed care for children and parents;
- CoLTS 1915(b)(c) waiver: Managed long term services and supports for dual eligible and individuals with a nursing facility level of care;
- Behavioral health 1915(b) waiver: Managed behavioral health services through a statewide behavioral health organization;
- Mi Via-Nursing Facility 1915(c) waiver: Self-directed home and community based services;
- AIDS 1915(c) waiver: Home and community based services for people living with HIV/AIDS; and
- Medically Fragile 1915(c) waiver: Home and community based services for individuals who are determined to be medically fragile.[2]

[1] Note: The state's Mi-via/ICF/IID 1915(c) waiver is not being consolidated into this 1115 demonstration.
[2] Note: Initial Centennial Care implementation will provide acute care services only to participants in the Medically Fragile 1915(c) waiver. As described in STC 18, the Medically Fragile 1915(c) waiver services will be phased in effective January 1, 2016, with a six month transition period beginning January 2016.

In addition, this demonstration expands access to long term services and supports by creating a comprehensive Community Benefit (CB) that includes both the personal care and HCBS benefits and that will be accessible without the need for a slot to beneficiaries who are otherwise Medicaid eligible, meet nursing facility (NF) level of care (LOC), and have a plan of care in place. Individuals who are not otherwise Medicaid eligible and meet the criteria for the 217-like group will be able to access the Community Benefit if a slot is available.

Other features of Centennial Care include expanded care coordination for all beneficiaries and a beneficiary reward program, offered through managed care, to provide incentives for beneficiaries to pursue healthy behaviors.

This demonstration does not expand mandatory enrollment into managed care for Native American beneficiaries, but it includes several service delivery protections for the Native American population. Specifically, Native Americans will be able to continue to see tribal providers regardless of whether those providers contract with the managed care organization, and tribal providers will be reimbursed at the OMB rate. In addition, ongoing input by the Native American Advisory Committee and the Native American Technical Advisory Committee is required in the demonstration. As is the case today under CoLTS, managed care enrollment is required for beneficiaries who meet nursing facility level of care or who are dually eligible in managed care.

The state's goals in implementing the demonstration are to:

- Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, cost effectively in the right setting;

- Ensure that the expenditures for care and services being provided are measured in terms of its' quality and not solely by its quantity;

- Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility or reducing provider rates; and

- Streamline and modernize the Medicaid program in the State.

## 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, and the Age Discrimination Act of 1975.

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.

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 as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

   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.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. 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 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 15 to reach a decision regarding the requested amendment;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall 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, including a conforming title XIX and/or title XXI state plan amendment, if necessary; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**
    a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.

    b. <u>Compliance with Transparency Requirements at 42 CFR §431.412:</u>

As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15, as well as include the following supporting documentation:

i. Demonstration Summary and Objectives: The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of the External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided or corrective action taken under the demonstration.

v. Compliance with the Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state has maintained and will maintain budget neutrality for the requested period of the extension. CMS will work with the state to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current President's budget and historical trend rates at the time of the extension.

vi. Interim Evaluation Report: The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

vii. Demonstration of Public Notice 42 CFR §431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 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 the revised phase-out plan.

b. 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 days after CMS approval of the phase-out plan.

c. 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.

d. 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 the October 1, 2010, State Health Official Letter #10-008.

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

**10. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration 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.

b. Expiration 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.

c. Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of 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 Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers 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. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the state.

    In states with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In states with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR.§431.408(b)(3)).

    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.

16. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 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 can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 117, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 118.

17. **FFP.** No Federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. BENEFICIARIES SERVED THROUGH THE DEMONSTRATION

Centennial Care provides Medicaid benefits through a comprehensive managed care delivery system to beneficiaries eligible under the state plan and to additional individuals who were otherwise Medicaid eligible under section 1902(a)(10)(A)(ii)(VI) and 42 CFR §435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) under the following 1915(c) waivers that are being transitioned into Centennial Care in accordance with STC 59:

- AIDS Waiver, NM 0161;
- Coordinated Long-Term Services (CoLTS), NM 0479;
- Mi Via NF Waiver, NM 0449; and
- Medically Fragile, NM 0223 (HCBS transitioned in 2016).

Individuals eligible for both Medicare and Medicaid (dual eligibles) are also covered under this demonstration for Medicaid services.

**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 beneficiaries 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. Table 2 describes the optional State Plan populations included in Centennial Care. Table 3, below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

In each table, Column A describes the consolidated Medicaid eligibility group for the population in accordance with the Medicaid eligibility regulations that take effect January 1, 2014, 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 the current income and resource standards and methodologies for each Medicaid eligibility group described in the state plan. Column D describes whether there are any limits on inclusion in Centennial Care for each Medicaid eligibility group (as described further in STC 19). Column E describes the budget neutrality Medicaid Eligiblity Group (MEG) under which expenditures for the population will be reported (as described further in STC 88).

The populations described in Table 1 and 2 below derived 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 technical corrections to the tables below. The effective date of any corresponding technical corrections to the table below will align with the approved state plan.

Those beneficiary 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 not applicable expenditure authorities for this demonstration.

Table 1: Mandatory State Plan populations

| A. Mandatory Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Parents/ caretaker relatives 42 CFR 435.110 | Low Income Families (1931) 42 CFR 435.110 | Income Test: TANF standards and methods<br><br>Resource test: No | No | TANF and Related |
| | Transitional Medical Assistance (12-month extension due to earnings or 4 month extension due to increased child support/ spousal support)<br>• 408(a)(11)(A) and (B)<br>• 1931(c)(1) and (2)<br>• 1925<br>• 1902(a)(52) | Income test: No<br><br>Resource test: No | No | TANF and Related |
| Consolidated group for pregnant women 42 CFR 435.116 | Low Income Families (1931) 42 CFR 435.110 | Income Test: TANF standards and methods<br><br>Resource test: No | No | TANF and Related |
| | Qualified pregnant women<br>• 1902(a)(10)(A)(i)(III)<br>• 1905(n)(1) | Income test: AFDC payment standard<br><br>Resource test: AFDC | No | TANF and Related |
| | Mandatory poverty-level related pregnant women section<br>• 1902(a)(10)(A)(i)(IV)<br>1902(l)(1)(A) | Income test:<br><br>Up to 133% FPL<br><br>Resource Test: No | No | TANF and Related |

| A. Mandatory Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Consolidated group for pregnant women 42 CFR 435.116 (continued) | Poverty level pregnant women optional eligible 1902(a)(10)(A)(ii)(IX) 1902(l)(1)(A) | Income test: 133% to 235% FPL Resource Test: No | No | TANF and Related |
| Consolidated group for children under age 19 435.118 | Low Income Families (1931) 42 CFR 435.110 | Income Test: TANF standards and methods Resource test: No | No | TANF and Related |
| | Poverty level related infants • 1902(a)(10)(A)(i)(IV) • 1902(l)(1)(B) | Income Test: Up to 133% FPL Resource Test: No | No | TANF and Related |
| | Poverty level related children under ages 1-5 • 1902(a)(10)(A)(i)(VI) • 1902(l)(1)(C) | Income Test: Up to 185% FPL Resource Test: No | No | TANF and Related |
| | Poverty level related children age 6-18 • 1902(a)(10)(A)(i)(VII) • 1902(l)(1)(D) | Income Test: Up to 185% FPL Resource Test: No | No | TANF and Related |
| | Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay • 1902(e)(7) | Income Test: Up to 185% FPL Resource Test: No | No | TANF and Related |
| | Newborns deemed eligible for one year 1902(e)(4) 42 CFR 435.117 | Income test: No Resource Test: No | No | TANF and Related |
| Adoption assistance and foster care children | Children receiving IV-E foster care payments or with IV-E adoption assistance agreements • 1902(a)(10)(i)(I) 473(b)(3) 42 CFR 435.145 | Income test: No Resource Test: No | No | TANF and Related |
| | Former foster care children 1902(a)(10)(A)(i)(IX) | Income test: No Resource Test: No | No | TANF and Related |

| A. Mandatory Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Individuals Age 19 Through 65 | Adult group<br>1902(a)(10)(A)(i)(VIII)<br>42 CFR 435.119[3] | Income test: Up to 133% MAGI<br><br>Resource test: No | No | VIII Group |
| Aged, Blind, and Disabled | Individuals receiving SSI cash benefits--§1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability--§1901(a) (10)(A)(i)(II)(aa) | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>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) | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Disabled individual whose earning exceed SSI substantial gainful activity level -1902(a)(10)(A)(i)(II)§1619(a) | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Individuals receiving mandatory state supplements<br>SSI 42 CFR 435.130 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

[3] Note: Although this group is included in section 1902(a)(10)(A)(i) of the Social Security Act, the state has the authority to decide whether to include this group.

| A. Mandatory Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Aged, Blind, and Disabled (continued) | Institutionalized individuals continuously eligible for SSI in December 1973<br>42 CFR 435.132<br>Blind and disabled individuals eligible for SSI in December 1973<br>42 CFR 435.133 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>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 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Individuals ineligible for SSI because of requirements prohibited by Medicaid<br>42 CFR 435.122 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Disabled widows and widowers 1634(b)<br>Early widows/widowers 1634(b)<br>42 CFR 435.138 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>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<br>42 CFR 435.135 | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

| A. Mandatory Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Aged, Blind, and Disabled (continued) | 1939(a)(5)(E) Disabled adult children<br>1634(c) | Income test: SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Disabled individuals whose earnings are too high to receive SSI cash<br>§1619(b) | Earned income is less than the threshold amount as defined by Social Security<br>Unearned income is the SSI amount<br>Resource standard is SSI | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard<br>1902(a)(10)(A)(ii)(V)<br>42 CFR 435.236<br>1905(a) | Income test:<br>300% of Federal Benefit Rate with Nursing Facility Level of Care (NF LOC) or PACE / ICFMR eligible<br><br>Resource test: $2000 | NF LOC: Included<br><br>PACE: Excluded<br><br>ICFMR: Excluded | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

Table 2. Optional State Plan Populations

| A. Optional Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Infants and children under age 19 | Poverty level infants not mandatorily eligible<br>• 1902(a)(10)(A)(ii)(IX)<br>• 1902(l)(2) | Income test:<br>133% up to 185% FPL<br><br>Resource Test:<br>No | No | TANF and Related |
| | Optional Targeted Low income children under 19<br>• 1902(a)(10)(a)(ii)(XIV)<br><br>Note: If sufficient Title XXI allotment is available as described under STC 99, uninsured individuals in this eligibility group are funded through the Title XXI allotment.<br><br>Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 100, then all individuals in this eligibility group are funded through Title XIX. | Income test:<br>185% up to 235% FPL<br><br>Resource test:<br>No | No | If Title XIX: TANF and Related<br><br>If Title XXI: MCHIP Children |
| Adoption assistance and foster care children<br><br>MEG:<br>TANF and Related | Independent foster care adolescents under age 21 who were in foster care on their 18th birthday<br>• 1902(a)(10)(A)(ii)(XVII) | Income test:<br>No<br><br>Resource Test:<br>No | No | TANF and Related |
| Aged, Blind, and Disabled | Working disabled Individuals §1902(A)(10)(A)(ii)(XIII) | Income test:<br>250% FPL, meet SSI non-income standards Utilize SSI Methodologies<br><br>Resource test:<br>The state uses 1902(r)(2) disregards in determining eligibility for this group. | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

| A. Optional Medicaid Eligibility Group in State Plan | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| | Individuals who would be eligible for SSI cash if not in an institution<br>42 CFR 435.211<br>1902(a)(10)(A)(ii)(IV)<br>1905(a) | Income test:<br>SSI standards and methodologies | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| Breast and Cervical Cancer Program | Individuals under 65 screened for breast or cervical cancer<br>1902(a)(10)(A)(ii)(XVIII) | Screened by NM Department Of Health/CDC provider | No | TANF and Related |
| Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group) | Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the State's 1915(c) Developmentally Disabled waiver | Income test:<br>300% of Federal Benefit Rate with an ICF/MR Level of Care determination.<br><br>Resource test:<br>$2000 | Only in Centennial Care for Acute Care | SSI Medicaid only (if not eligible for Medicare)<br><br>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<br><br>Through June 30, 2015 | Income test:<br>300% of Federal Benefit Rate with an ICF/MR Level of Care determination.<br><br>Resource test:<br>$2000 | Only in Centennial Care for Acute Care<br><br>(Through June 30, 2015) | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

## Demonstration Expansion Populations

| A. Expansion Medicaid Eligibility Group | B. Statutory/ Regulatory Citations | C. Standards and Methodologies | D. Limitations on inclusion in Centennial Care? | E. MEG for Budget Neutrality |
|---|---|---|---|---|
| Home and Community Based 1915(c) Waivers that are being 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.<br><br>Resource test: $2000 | No | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |
| | Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act, if the state had not eliminated its 1915(c) Medically Fragile Waiver<br><br>From January 1, 2016 forward | Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination.<br><br>Resource test: $2000 | Will only receive acute care services initially through Centennial Care and will receive HCBS services through fee-for-service. Will receive HCBS services through Centennial Care beginning January 1, 2016 | SSI Medicaid only (if not eligible for Medicare)<br><br>SSI Dual (if eligible for Medicare) |

**19. Populations Excluded from Centennial Care.** The following populations, who are otherwise eligible under the criteria described above, are excluded from the Centennial Care 1115 demonstration:

a. Qualified Medicare Beneficiaries (QMBs) – 1902(a)(10)(E)(i); 1905(p)
b. Service Limited 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 (described further in footnote 4 below)
i. Medically fragile waiver participants for HCBS (described further in footnote 5 below)

**20. Eligibility and Post Eligibility Treatment of Income for Centennial Care Beneficiaries who are Institutionalized.** Except as specified in STC 18 above, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All beneficiaries 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 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 home and community based services 1915(c) waivers.

[4] Acute care and behavioral health services will be received through Centennial Care

[5] Acute care services will be received through Centennial Care by medically fragile waiver participants. However, the medically fragile waiver long term services and supports will be folded into Centennial Care effectiveJanuary 1, 2016.

## V. NATIVE AMERICAN PARTICIPATION AND PROTECTIONS

**22. General.** Recognizing the federal government's historic and unique relationship with Indian tribes as well as the special protections and provisions that Indian tribes are entitled to under federal law, this section describes additional protections for Native Americans enrolled in Centennial Care.

**23. Native American Advisory Bodies.** The state will solicit advice and guidance from two advisory bodies to ensure that AI/ANs receive quality care and access to services: the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC). The New Mexico Tribes will appoint representatives to serve as members on these advisory bodies.

a. NAAB. The NAAB means a board of tribal membership that meets quarterly with, and provides feedback to, all Centennial Care MCOs on issues related to program service delivery and operations. The MCOs will solicit advice and guidance from the (NAAB) regarding Centennial Care implementation and ongoing programmatic issues. The state will monitor the MCOs' work with the Board and report on the Board's and MCO's activities in its quarterly reports.

b. NATAC. The State will work directly with the NATAC, a subcommittee to New Mexico's Medicaid Advisory Committee that will directly advise 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 will report on the NATAC activities in its quarterly reports.

**24. Maintenance of opt-in for AI/AN beneficiaries.** AI/AN beneficiaries shall maintain a choice to opt-in to Centennial Care or to access care through a fee-for-service delivery system. AI/AN beneficiaries who are dual eligible or who have a nursing facility level of care, however, will continue to be required to enroll in managed care.

**25. Requirements for Modification of AI/AN Opt-In Provision.** After thorough evaluation of the experience AI/AN beneficiaries who opt-in to Centennial Care and consultation with tribes and soliciting advice from I/T/Us in accordance with the requirements in STC 15, the state may propose to modify STC 24 to include an opt-out of Centennial Care for AI/AN beneficiaries without submitting an amendment pursuant to STC 7 if it can demonstrate to CMS' satisfaction that it has met the below conditions and the results of the evaluation indicate that AI/AN beneficiaries will receive improved quality of care under Centennial Care.

a. Outreach and Education Strategy. The state will develop for CMS review and approval a beneficiary outreach and education strategy for AI/ANs that will include culturally appropriate notices and program materials that are accessible to individuals with limited English proficiency;

b. Care Coordination**.** The state will develop for CMS's review and approval a care

coordination strategy that encourages the use of AI/AN care coordinators and limits duplication of services between I/T/U and non-I/T/U providers;

c. Model Indian Health Care Provider Contract Addendum. The state will develop for CMS's review and approval a standard I/T/U contract addendum for all MCOs to assure that MCOs comply with key federal laws that apply when contracting with I/T/U providers, minimize potential disputes, and lower the perceived barriers to contracting with I/T/Us. This model should be similar to the model QHP contract addendum for Indian Health Care Providers published by CMS on April 3, 2013;

d. Timely Claims Payment. The state will submit for CMS review and approval a plan for paying claims in a timely manner that reduces administrative burdens on tribal health programs either operated by the IHS or operated under the authority of P.L. 93-638; and

e. Network Adequacy. The state will submit for CMS review and approval documentation establishing that there are sufficient Indian Health Care Providers in the network to ensure timely access to services available under the contract for AI/AN enrollees who are eligible to receive services from such providers, consistent with 1932(h)(2)(A)(i) of the Act.

**26. Requirements for Modification of Section V.** After consultation with tribes and soliciting advice from I/T/Us in accordance with the requirements in STC 15, the state may propose changes to other requirements of Section V without submitting an amendment pursuant to STC 7 if it can demonstrate to CMS' satisfaction that the change is supported by the results of the ongoing evaluation and continuous improvement set forth in STC 28.

**27. Minimum Managed Care Guarantees.** Each MCO must, at a minimum provide the following contractual delivery service protections for AI/ANs:

a. MCOs will have to offer contracts to all Indian Health Service (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 I/T/Us. I/T/Us will not be required to contract with the plans, and all of the I/T/Us, contracted or not with an MCO, will be reimbursed, at a minimum, at the OMB rates (in accordance with 1932(h) of the Act); and as applicable up to three (3) encounters per day or the number of encounters approved in the Medicaid state plan;

b. Services provided within I/T/Us are not subject to prior authorization requirements and MCOs will provide education and training to I/T/Us on steps needed to ensure appropriate referrals to non-IHS providers in and outside of the MCO network;

c. MCOs will be required 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 LTC providers;

d. Native Americans will be permitted to select an I/T/U to be their primary care physician (PCP) and/or to access care at an I/T/U whether or not that facility is contracted with the member's MCO.

e. MCOs will be required to offer technical assistance to Tribes that seek to become certified and accredited Patient-Centered Medical Homes and/or Health Home providers; and

f. MCOs will be required to work directly with I/T/Us on billing and provider issues.

**28. Ongoing evaluation and continuous improvement.** The state shall closely monitor and evaluate the experience of AI/AN who are enrolled in Centennial Care as part of the demonstration evaluation and demonstration annual reports, described in STCs 117 and 118.

## VI. CENTENNIAL CARE BENEFITS

**29. Centennial Care Benefits.** Individuals affected by, or eligible under, the demonstration will receive comprehensive benefits that are at least equal in amount, duration and scope as those described in the State Plan.

**30. Home and Community-Based Services.** Under Centennial Care, enrollees who meet the nursing facility level of care criteria described in Attachment D will be eligible for the Community Benefit in Centennial Care. Enrollees who are otherwise Medicaid eligible (i.e. described as a mandatory or optional state plan population in paragraph 18) will be able to access the Community Benefit without the need for slots. Enrollees who are made eligible for the demonstration as a result of their nursing facility level of care (the 217-like group) will be subject to the enrollment limits described in STC 65.

The Community Benefit service categories are listed below and further defined in Attachment B. The table also indicates which services are available through either the agency-based benefit or the self-direction benefit and which services are available in both.

| Community Benefit Services Included Under Centennial Care | | |
|---|---|---|
| | **Agency-Based Benefit** | **Self-Direction Benefit** |
| Adult Day Health | X | |
| Assisted Living | X | |
| Behavior Support Consultation | X | X |
| Community Transition Services | X | |
| Customized Community Supports | | X |
| Emergency Response | X | X |
| Employment Supports | X | X |
| Environmental Modifications | X | X |
| Home Health Aide | X | X |
| Homemaker/ Personal Care | | X |
| Nutrition Counseling | | X |
| Personal Care Services* | X | |
| Private Duty Nursing for Adults | X | X |
| Related Goods | | X |
| Respite | X | X |
| Skilled Maintenance Therapy Services | X | X |
| Specialized Therapies | | X |
| Transportation (non-medical) | | X |

* Note: Personal care services may be self-directed, as specified in the state plan.

**31. Community Interveners.** Certain individuals enrolled in Centennial Care who are deaf and blind 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. Services for Community Interveners may be covered by Centennial Care MCOs and the costs associated with the Community Interveners may be included in capitation payments from the State to the Centennial Care MCO.

## VII. BENEFICIARY REWARDS PROGRAM

**32. Beneficiary Rewards Program Defined.** The Beneficiary Rewards Program provides incentives through the managed care organization to Centennial Care enrollees for participating in State defined activities that promote healthy behaviors. An individual who participates in a State defined activity that promotes healthy behaviors earns credits that are applied to an individual's account, which will be managed by the managed care organization. Earned credits may be used for health related expenditures as approved under the Beneficiary Rewards Program.

**33. Administration Overview.** The state will maintain a list of activities that generate contributions to the account. A menu of benefits or programs will be provided as will the individual value of each item on the menu. The amount available to individuals from their Beneficiary Rewards account will depend on the activities in which they participate up to a maximum amount. Once an enrollee completes an approved activity, the enrollee will be considered an active participant. The MCO will post earned credits into an account for use by the enrollee. Additional credits may be earned as the enrollee participates in additional activities. In no instance will the individual receive cash.

Programs administered by plans 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). Plans are encouraged to seek an advisory opinion from OIG once the specifics of their healthy behavior rewards programs are determined.

**34. Participants Earning Beneficiary Rewards Defined.** All enrollees in a Centennial Care plan will be eligible to participate in activities to earn Beneficiary Rewards for the duration of their enrollment.

**35. Beneficiary Access to Credits.** Under Centennial Care, the MCO will provide access to an individual's earned credits in an enhanced benefit account, as follows:

a. Individuals who are enrolled in Centennial Care who have participated in a state defined activity that promotes healthy behavior and thus have a positive balance;

b. Individuals who no longer are enrolled in Centennial Care (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate) but who have a positive balance in their account;

c. Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual may retain access to any earned funds in the beneficiary rewards program for a maximum of one year, except in the instance of termination of the demonstration or the beneficiary rewards program; and,

d. If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the Beneficiary Rewards Program and earn additional credits.

## VIII. CENTENNIAL CARE ENROLLMENT

**36. Mandatory Enrollment.** With the exception of AI/AN beneficiaries described in STC 24, the state may mandatorily enroll beneficiaries served through this demonstration in managed care organizations (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 certain readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, as required by 42 CFR §438 and must be approved by CMS.

**37. Choice of MCO.** The state must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of two (2) MCOs meeting all Federal regulatory requirements from which to choose**.**

**38. MCO Selection/Enrollment Process.** Individuals newly determined eligible for Medicaid. 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, as well any individuals receiving benefits under fee-for-service will have 60 days to enroll in a Centennial Care MCO.

b. AI/AN beneficiaries. Consistent with STC 24, AI/AN beneficiaries may not be required to enroll in a Centennial Care MCO but, at their option, may elect to enroll.

c. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating Centennial Care MCO. The State should develop an auto-assignment algorithm which is compliant with 42 CFR §438.50(f). The State shall report the number of health plan change requests made by beneficiaries that were auto-assigned during the first quarter of Centennial Care.

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 MCOs, and have an existing care plan, each Salud! MCO as well as the Behavioral Health plan (collectively the 'sending' plan) will send the care plan to the new Centennial Care MCO (collectively the 'receiving' plan). The sending MCO will also send a report to each of the receiving plans for each enrollee who is expected to be using inpatient care at the time of initial transition as well as each enrollee who is receiving prenatal care. Additionally, where

applicable, each CoLTS MCO must send the name of the NF that each assignee is in, or expected to be in, as well as service plan information for all enrollees using HCBS at the time of initial transition to the receiving plan. These care/service plans will be shared with the Centennial Care MCOs no less than 20 days prior to enrollment to allow sufficient time for transition planning.

**39. Notice Requirement for a Change in 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 other changes impacting proposed network adequacy. The state may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR §438.206.

**40. MCO Disenrollment.** Beneficiaries should be informed of opportunities no less than annually for disenrollment and ongoing MCO choice opportunities regularly in a manner consistent with 42 CFR §438.

**41. For Cause Disenrollment.** In addition to the for cause reasons for disenrollment in 42 CFR 438.56, and any other state specific reasons for disenrollment, enrollees will have the following reasons for disenrolling from an MCO and will be able to choose a different MCO:

a. Residential or employment supports provider leaves the MCO. Where an individual's residential or employment supports provider is leaving a participant's MCO, the state must allow the impacted participants the opportunity to change MCOs at any time within 90 days from the date of notice of provider departure from the MCO. If a requested transfer cannot be arranged within 90 days, there must be an extension of coverage provided to permit the individual to remain in his/her current residence until an appropriate transfer arrangement can be made. If the residential or employment supports provider goes out of business or no longer meets provider requirements, the plan must assist the participant in locating a new provider or, if necessary, the participant may change MCOs.

## IX. DELIVERY SYSTEM

Centennial Care will 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.

**42. Managed Care Requirements.** The state and its MCO contractors 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 §438.6. The certification must identify historical utilization of State Plan and HCBS services used in the rate development process.

**43. Managed Care Benefit Package.** Individuals enrolled in Centennial Care MCOs must receive from the managed care program the benefits as identified in Section VI of the STCs.

Covered benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical, behavioral, acute and long-term services and supports. Care coordination and management is a core expectation for these services. MCOs will refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a fee-for–service (FFS) delivery system (e.g. IEP required school based services or services for individuals with intellectual disabilities).

**44. Centennial Care Capitation Rates for 2014.**

a. Rate certification materials will include documented base benefit cost data, trend and adjustment factors, and non-benefit components, and include the rate ranges as well as information about the components that create the rate range difference from the midpoint. Rate ranges will not exceed 5% on each side of the midpoint of the range, unless historical experience documents the need for a larger range for a specific rate cohort;

b. The State shall evaluate potential changes in the rate cohort structure in effort to reduce variation among the current rate cohorts.

c. The State agrees to the following related to capitated payment rates to managed care organizations:
   i. CMS recognizes the State has the flexibility to make individual payment choices to each MCO within the actuarially sound rate ranges;
   ii. The State will provide CMS with supporting information about the payment rate determined within the rate range for each cohort;
   iii. The State will notify CMS if modifications to payment rates are required during the certification period and will provide justification and data supporting the proposed rate modification, and receive CMS approval for the change(s); and
   iv. CMS agrees to complete its review and evaluation of proposed rate modifications that occur during the rate period no more than 30 calendar days from the date that CMS receives the data from the State necessary to make a determination.

d. To the extent that Centennial Care MCOs will be capitated to deliver benefits to the new population beginning January 1, 2014, the State will work with CMS to address unique considerations for MCO rates including but not limited to, population cost assumptions, the need for separate rate cells for segments of this population, uniform non-benefit rate components across all MCO product lines, and risk-sharing arrangements.

**45. 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 shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 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.

**46. Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall 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).

**47. Care Coordination under Centennial Care.** MCO contracts will require MCOs to provide comprehensive care coordination at a level appropriate to each beneficiary's needs and risk stratification, in compliance with 42 CFR § 438.208. Such comprehensive care coordination will be continuous and will include at least the following:

a. Assessing each beneficiary's comprehensive physical, behavioral, functional, psychosocial, and long term care needs;

b. Identifying the medical, behavioral and long term care services and other social support services and assistance (e.g., housing, transportation or income assistance) necessary to meet identified needs;

c. Ensuring beneficiaries receive services and supports that address their needs and preferences as identified through a comprehensive needs assessment;

d. Ensuring timely access to, and provision, ongoing coordination and monitoring of services needed, in accordance with the person-centered service plan, to help each beneficiary 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 beneficiary's health, safety and welfare;

e. Ensuring adequate support for participants who choose to self-direct the Community Benefit;

f. Developing and facilitating transition plans for participants who are candidates to transition from an institutional facility to the community; and

g. Ensuring beneficiaries receive integrated behavioral health, physical health and long-term care services.

**48. Network Requirements.** The state must ensure the delivery of all covered benefits. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services for all of its members. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:

a. Special Health Care Needs. Enrollees with special health care needs must have direct

access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR. §438.208(c)(4).

b. Out of Network Requirements. Each MCO must allow beneficiaries access to non-network providers without additional cost sharing obligations when services cannot be provided consistent with the timeliness standards required by the state.

**49. Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, behavioral health, specialty, and HCBS services for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
   i. The number and types of providers available to provide covered services to the demonstration population;
   ii. The number of network providers accepting the new demonstration population; and
   iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

b. The state must submit the documentation required in subparagraphs i – iv above to CMS at an agreed upon time prior to program implementation, as well as with each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO's operation, including service area reduction and/or population expansion.

**50. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

**51. Required Components of a Comprehensive State Quality Strategy.** The Quality Strategy shall meet all the requirements of 42 CFR §438 Subpart D. The state shall adopt and implement a comprehensive and holistic, continuous Quality Improvement Strategy that focuses on all aspects of quality improvement in Centennial Care including acute, primary, behavioral and long term services and supports. The Quality Strategy must address the following: administrative authority, level of care determinations, service plans, health and welfare, and qualified providers. The Quality Strategy must include State Medicaid Agency and MCO responsibilities, with the State Medicaid Agency retaining ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. Additionally, it must also include information on how the State will monitor and evaluate each MCO's compliance with the contract requirements specific to the Centennial Care program as outlined in these STCs, including level of care evaluations, service plans, qualified providers as well as how the health and welfare of enrollees will be assessed and monitored. Pursuant to STC 118, the state must also provide CMS with annual reports on the

implementation and effectiveness of their comprehensive Quality Strategy as it impacts the demonstration.

**52. Revisions to the State Quality Strategy.** The State must update its Quality Strategy to reflect the new Centennial Care program and submit to CMS for approval. The State must obtain the input of beneficiaries and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. Any revised performance measures should focus on outcomes, quality of life, effective processes, as well as community integration for those individuals receiving HCBS. The comprehensive Quality Strategy must be submitted to CMS for final approval within 90 days from the approval date of the demonstration. In the interim time period, the State will maintain its existing quality strategies for each HCBS program. The State must revise the strategy whenever significant changes are made, including changes through this demonstration and consistent with STC 7.

**53. Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The State's EQRO process shall meet all the requirements of 42 CFR §438 Subpart E. In addition to routine encounter data validation processes that take place at the MCO and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs at a minimum of once every three years. In addition, the State, or its EQRO having sufficient experience and expertise and oversight by the SMA, shall monitor and annually evaluate the MCOs' and/or contracting providers performance on the HCBS requirements under Centennial Care. These include but are not limited to the following:

a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with the Community Benefit have been assessed to meet the required level of care for those services.

b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.

c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.

d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

**54. State Advisory Committee.** The State must maintain for the duration of the demonstration a public managed care advisory group comprised of individuals, interested parties, and 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 eligibility groups. The state's Medicaid advisory committee, or a subcommittee thereof, may perform this function in lieu of a newly created advisory group. The state shall 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 116.

**55. MCO Participant Advisory Committees.** The state shall 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.

**56. Independent Consumer Supports.** To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall create and maintain a permanent system of independent consumer supports to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

a. Core Elements of the Independent Consumer Support System.

i. *Organizational Structure*. The Independent Consumer Supports System shall operate independently from any Centennial Care MCO. Additionally, to the extent possible, the system shall also operate independently of the Medical Assistance Division of the Human Services Department. The organizational structure of the support system shall facilitate transparent and collaborative operation with beneficiaries, MCOs, and state government.

ii. *Accessibility*. The services of the Independent Consumer Supports System are available to all Medicaid beneficiaries enrolled in Centennial Care receiving long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

iii. *Functions*. The Independent Consumer Supports system assists beneficiaries to navigate and access covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity.

1. The system shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
2. The system shall service as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
3. The system shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.
4. The system shall conduct trainings with Centennial Care MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.

iv. *Staffing and training*. The Independent Consumer Supports system must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The system ultimately developed by the State may draw upon existing staff within the chosen organizational structure and provide substantive training to ensure core competencies and a consistent consumer experience.

v. *Data Collection and Reporting*. The Independent Consumer Supports System shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

b. Independent Consumer Supports System Plan. The state shall submit a plan to CMS describing the structure and operation of the Independent Consumer Supports system that aligns with the core elements provided in STC 56(a) no later than 60 days after approval of the demonstration.

**57. Reporting and Evaluation under the Demonstration.** The state will report on the activities of the Independent Consumer Support System in the quarterly and annual reports per STCs 117 and 118. The approved Independent Consumer Support System Plan required under STC 56 shall become Attachment I. Changes to Attachment I must be submitted to CMS for review and approval subject to STC **7**. The State will evaluate the impact of the Independent Consumer Support Program in the Demonstration Evaluation per Section XVI of these STCs.

**58. Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR

438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

a. Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

b. Encounter Data (State Responsibilities) - The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

d. Submission of Encounter Data to CMS - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with Federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

## X. HCBS SERVICE DELIVERY AND REPORTING REQUIREMENTS

**59. Transition of Existing 1915(c) Waiver Programs into the Demonstration.** Prior to this demonstration, the State provided HCBS through multiple section 1915(c) waivers. The following 1915(c) waivers will be transitioned into this demonstration to include Centennial Care through a mandatory managed care delivery system upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- AIDS Waiver, NM 0161;
- Coordinated Long-Term Services (CoLTS), NM 0479; and
- Mi Via NF Waiver, NM 0449
- Medically Fragile Waiver, NM 0223[6]

The State must execute the following as part of the transition of existing section 1915(c) waivers into Centennial Care prior to implementation:

a. Provide notice to participants in the 1915(c) waivers that the authority for such services is transferring to the demonstration and their need to select a MCO or be automatically assigned to ensure there is no disruption to services. Such notice must be provided to beneficiaries thirty (30) days prior to the transfer of waiver authorities from section 1915(c) to section 1115 demonstration.

b. The transition plan for this population must be submitted to CMS as part of the Readiness Review as specified in STC 71 and with the "intent to terminate 1915(c) waivers" letter that must be sent to CMS Regional Office at least thirty (30) days prior to waiver termination.

**60. Transition of Care Period.** Each enrollee who is receiving HCBS services under a section 1915(c) waiver referenced in STC 59 that has transitioned to Centennial Care who continues to meet the NF/hospital LOC criteria in place at the time of initial Centennial Care implementation must continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the MCO, whichever is later. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404. For the first six months of Centennial Care, the State must review and approve a valid representative sample of all proposed reductions in service plans prior to the change. If the number of service plan reductions is insufficient to produce a valid sample size, the state will review all proposed service plan reductions. For the remainder of the waiver period, the

[6] Note: As described in STC 18, the Medically Fragile 1915(c) waiver will be phased in effective January 1, 2016, with a six month transition period beginning January 2016. STC 59 and 60 will apply equally to the phase-in period planned for 2015.

state, or its external quality review organization acting on the state's behalf, will review a valid representative sample of service plan reductions at least annually.

**61. Community Benefit Service Planning Transition.** The MCOs, through their contracts, will be permitted to complete all service assessments within 90 days of implementation to ensure a person-centered approach to the service planning process. Until such time that the service plan is completed and either agreed upon by the enrollee or resolved through the fair hearing process, and implemented, the MCO must ensure that service level and providers used on the existing service plan are available to the member. The MCOs must, through contract requirements, prioritize the service planning process to those individuals whose service plans expire in the first 90 days or whose needs change and necessitate a new service plan. For individuals who have a service plan expiring without a new service plan implemented, the MCOs will need to extend their existing service plan (in scope of services and providers) until such time that the new service plan is implemented.

**62. Level of Care (LOC) Assessment for LTC Beneficiaries.** The following procedures and policies shall be applied to enrollees receiving Centennial Care's long term care benefit:

a. An evaluation for nursing facility level of care must be given to all applicants for whom there is a reasonable indication that services may be needed in the future either by the State, or as a contractual requirement, by the MCO. An MCO may only conduct the LOC assessment for individuals who are already enrolled in or have selected that health plan for enrollment. If an individual contacts the MCO directly before filing an application for Medicaid eligibility, the MCO must direct the individual to the appropriate State office to first complete a Medicaid application and elect that health plan for enrollment prior to the MCO conducting the LOC assessment.

b. The LOC process and instruments will be implemented as specified by the State, either the State's own processes, or as a contractual requirement, by the MCO. MCOs will be expected to use common elements within their tools that are based on the Minimum Data Set (MDS). The State will approve the evaluation tool used by each MCO for this LOC determination and the MCO will be responsible for informing HSD of the member's eligibility and enrollment status.

c. All Centennial Care enrollees must be reevaluated at least annually or as otherwise specified either by the State, or as a contractual requirement, by the MCO.

d. The state shall assure MCOs provide objective LOC determinations as follows:
    i. MCOs will be required to use LOC determination criteria developed by the state;
    ii. The state's EQRO will regularly review a valid representative sample of each MCO's LOC determinations to assure that LOC criteria are being appropriately applied;
    iii. The state's Quality Bureau shall sample MCO LOC determinations to assure that LOC criteria are being appropriately applied by the MCOs;

iv. The state will create a benchmark measure of LOC determinations based on the prior performance of its third party assessor and use it to measure performance of Centennial Care MCOs and identify and investigate discrepancies;

v. The MCOs will report monthly on the LOC determinations/redeterminations they conduct, with the reports capturing information including, but not limited to, the number of LOC determinations completed, number completed within required timeframes, and the number of assessments where the LOC criteria was not met;

vi. Beneficiaries shall have the opportunity to appeal determinations through the MCO grievance and appeals process and the state's fair hearing process;

vii. The state will apply directed corrective action plans and other disciplinary actions, as needed, to MCOs that demonstrate a pattern of failure to correctly and objectively apply LOC determination criteria, and closely monitor MCO performance; and shall have an independent entity reassess affected beneficiaries; and

viii. The MCOs' LOC assessment function will be administratively separate from service plan provision and monitoring functions, unless specifically approved by the state.

**63. Freedom of Choice.** The MCO care coordinators must be required to inform each participant or member of any alternatives available, including the choice of institutional care versus HCBS during the assessment process. Documentation of choice must be incorporated into the service plan.

**64. Community Benefit Cost of Care.** Each MCO will conduct a comprehensive needs assessment that will be used to determine an eligible participant's service plan for the Community Benefit (see STC 62). The maximum allowable cost of care for the Community Benefit will be tied to the state's cost of care for persons served in a private nursing facility. However, the maximum allowable cost of care is not an entitlement. A participant's actual cost of care for the Community Benefit will be determined by the comprehensive needs assessment.

The State, on an annual basis and prior to the annual waiver period, will determine the average annual cost of being served in a private nursing facility in New Mexico. The average annual cost will be determined utilizing the Medicaid nursing facility fee schedule for low level of care in effect at the time of annual determination. The State, at its discretion, may adjust the maximum allowable cost of care to reflect any modifications to the Medicaid fee schedule for private nursing facilities. The State will communicate the maximum allowable cost of care to contracted Centennial Care MCO's for use prior to each annual contract period.

**65. Enrollment Limit.** Over the course of the life of the waiver, the state will work to expand access to the Community Benefit; however, the state will impose enrollment limits for persons who are not otherwise Medicaid eligible and who have been determined to meet nursing facility level of care in order to manage the growth of the program. The state increased its current 1915(c) waiver cap from 3,989 to 4,289 to accommodate additional persons not otherwise Medicaid eligible who meet nursing facility level of care criteria. The

state will continue to prioritize the use of these slots for persons transitioning from nursing facilities and persons determined to be at high risk of entering a nursing facility. For future years, the state will draw upon its experience in providing services to persons who are otherwise Medicaid eligible and management of the Central Registry that tracks the waitlist for the Community Benefit to guide decisions regarding additional participants.

**66. Central Registry.** The state will implement a process to manage the Central Registry that tracks the waitlist for the Community Benefit. The process will be based on objective criteria applied consistently across all regions of the state. The state will provide a plan to CMS one year following approval of the demonstration.

**67. Integration of Section 1915(c) Waiver Assurances and Program Requirements into Centennial Care.** CMS expects the State to implement Centennial Care in such a way that the waiver assurances and other program requirements currently part of its 1915(c) waiver programs are met, either by the State or by the MCOs through specific contract provisions until a comprehensive and integrated quality plan is approved by CMS and implemented as defined in STC 51:

a. Person-Centered Planning and Individual Service Plans.

i. The state shall require the use of a person-centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee as well as to identify an enrollee's long term care needs and the resources available to meet these needs, and to provide access to additional care options as specified by the contract. Person-Centered Planning includes consideration of current and unique psycho-social and medical needs, history of the enrollee, and the person's functional level and support systems. The person-centered plan is developed by the participant with the assistance of the team and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs to live in the community.

ii. The state shall require that meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited team members.

iii. The state shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals.

iv. The state shall 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 MCO contract shall require that all HCBS service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.

v. The state shall require 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.

vi. The state shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.

vii. The state shall require that enrollees receiving HCBS services have a choice of provider within the MCO's network, and that enrollees will have access to non-participating providers or the option to change MCOs when the appropriate provider type is not in the current MCO's network.

viii. The state shall require policies and procedures for the MCO to monitor appropriate implementation of the individual service plans.

ix. The state shall specify the minimum guidelines in the approved MCO contracts regarding:

1. The individuals who develop the person-centered service plan (and their requisite qualifications);
2. The individuals who are expected to participate in the plan development process;
3. Types of assessments that are conducted as part of the service plan development process; and
4. How participants are informed of the services available to them;

b. Qualified Providers.

i. The MCO provider credentialing requirement in 42 CFR 438.214 shall apply to all CB providers. If the state wishes to change provider qualification standards from those that exist under waivers #0161, 0449, 0479, and 0223 the State must reach agreement with CMS to do so and ensure that the new standards preserve health and welfare. The State is required to report any changes in provider qualification standards as a part of the quarterly monitoring calls and quarterly reports pursuant to STCs 116 and 117.

ii. To the extent that the MCO's credentialing policies and procedures do not address non-licensed non-certified providers, the MCO shall create alternative mechanisms to ensure the health and safety of enrollees.

c. Health and Welfare of Enrollees. The State, or the MCO for CB enrolled individuals, through an MCO contract, shall 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

d. Critical Incident Management System. The State Medicaid Agency must operate a critical incident management system according to the State Medicaid Agency's established policies, procedures and regulations. On an ongoing basis the State Medicaid Agency ensures that all entities, including the MCOs, 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.

MCOs, providers and participants are educated about this system initially at the start or at hire, and at least annually thereafter. MCO and provider obligations include specific action steps that MCOs and providers must take in the event of suspected or substantiated abuse, neglect or exploitation, including risk mitigation. If the State Medicaid Agency delegates the responsibility for the critical incident management systems to the participating MCOs, the State Medicaid Agency 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.

e. Demonstration Participant Protections. The State will assure 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.

The State/MCOs will 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.

**68. Service Planning Firewalls.** The State Medicaid Agency ensures: a) there are clear conflict-free guidelines 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 plan; and c) each participant has freedom of choice between alternative home and community-based services and settings.

**69. Option for Participant Direction of certain HCBS**. Centennial Care participants who elect the self-direction opportunity must have the option to self-direct the HCBS. Participant direction must afford Centennial Care participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

a. The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for purchasing these needed services.

b. Information and Assistance in Support of Participant Direction. The State or MCO contract shall 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 shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall 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 Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage.

c. Participant Direction by Representative. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.

d. Independent Advocacy. Each enrollee shall 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. The plans will provide participants with information regarding independent advocacy supports.

e. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.

    i. *Participant/Common Law Employer*. The participant (or the participant's representative) is the common law employer of workers who provide personal care 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. Supports are available to assist the participant in conducting employer-related functions.

    ii. *Decision Making Authorities*. The participant exercises the following decision making authorities: 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.

f. Disenrollment from Participant-Direction. A participant may voluntarily disenroll from the self-directed option 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 also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or 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 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 the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

g. Appeals. The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):

i. A reduction in services;

ii. A denial of a requested adjustment to the budget; or

iii. A reduction in amount of the budget.

Participants may use the State fair hearing process after they have exhausted the MCO appeal process to request reconsideration of these adverse actions.

**70. Home and Community Characteristics.** Residential settings located in the community will provide members with the following:

- Private or semi-private bedrooms including decisions associated with sharing a bedroom.
- Full access to typical facilities in a home such as a kitchen with cooking, facilities, small dining areas.
- All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
- Private or semi-private bathrooms that include provisions for privacy.
- Common living areas and shared common space for interaction between participants, their guests, and other residents.
- Enrollees must have access to a food storage or food pantry area at all times.
- Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
- Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

In provider owned or controlled residential settings, the following additional conditions will be provided to members:

- Privacy in sleeping or living unit.
- Units have lockable entrance doors, with appropriate staff having keys to doors.
- Enrollees share units only at the enrollee's choice.
- Enrollees have freedom to furnish and decorate sleeping or living units.
- The setting is physically accessible to the enrollee.

CB services are not provided in institution-like settings except when such settings are employed

to furnish short-term respite to individuals.

## XI. PROGRAM IMPLEMENTATION AND BENEFICIARY PROTECTIONS

**71. Readiness Review Requirements for Centennial Care.** The state shall conduct a final readiness review of each MCO at least sixty (60) days prior to program implementation.

Readiness reviews shall address each MCO's capacity to serve the Centennial Care enrollees, including, but not limited to, adequate network capacity, operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program for personal care services.

Prior to the state's planned implementation date for the Centennial Care, the state must submit the following to CMS for review, according to the milestones specified below:

a. A list of deliverables and submissions the state will request from health plans to establish their readiness, with a description of the state's approach to analysis and verification;
b. Plans for ongoing monitoring and oversight of MCO contract compliance;
c. A contingency plan for addressing insufficient network issues;
d. A plan for the transition from the section 1915(c) waiver program to Centennial Care as described in STC 59;
e. Proposed managed care contracts or contract amendments, as needed, to implement Centennial Care.

CMS reserves the right to request additional documentation and impose additional milestones on Centennial Care in light of findings from the readiness review activities.

**72. Attempts To Gain an Accurate Beneficiary Address.** The state will complete return mail tracking after first enrollment notification mailing and throughout the first 90 days of implementation. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address. For CB enrollees, the state must deliver such notices to CB enrollees through their CB provider or residential provider in any case where mailings have been returned to the state.

**73. Verification of Beneficiary's MCO Enrollment.** The state shall implement a CMS approved process for an MCO, network and non-network providers, or the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider.

**74. Call Center Availability.** The state must require the existing MCOs not included in Centennial Care to have a "final message" for members calling into the MCO's call center for the first 30 days of implementation that directs individuals to alternative sources of information. The state must require the existing MCOs not included in Centennial Care to continue to process claims for services rendered prior to January 1, 2014 and continue to offer effective provider support for these claims.

**75. Sample Notification Letters.** The state must send sample beneficiary notification letters to the existing Medicaid providers, either through direct mailing, posted on the Centennial Care website, or other widely distributed method, so providers are informed of what is being told to the beneficiaries regarding their transition to Centennial Care.

**76. Educational Activities for Beneficiaries and Providers**. The state will conduct a series of educational events for beneficiaries and providers throughout the State during the five months prior to the implementation of Centennial Care.

a. Beneficiary educational events will consist of state and MCO staff traveling to locations throughout the state to provide enrollees and potential enrollees with information about Centennial Care and the MCOs. Events will be focused on the various demonstration populations including the elderly, HCBS participants, Native Americans, and families. The educational events will educate beneficiaries on their MCO enrollment options, rights and responsibilities, and other important program elements. This effort will include, at a minimum, participation of ombudsman, presumptive eligibility determiners, school-based health center staff and any other relevant group providing enrollment support for beneficiaries. All informational materials will include contact numbers for the State Call Center and other contracted entities (e.g., fiscal intermediary, ADRCs) that can provide beneficiaries with enrollment support.

b. Provider education events will be conducted primarily by the MCOs with the state in attendance. Events will occur throughout the state at times and places that will allow providers and their administrative staff, as appropriate, to attend. MCOs and the state will educate providers about the goals of Centennial Care and the MCOs will train providers and their administrative staff on basic processes and procedures.

**77. 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. 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.

**78. Call Center Response Statistics.** During the first 30 days of implementation the state must review all call center response statistics daily to ensure all contracted entities are meeting requirements in their contracts. If deficiencies are found, the state and the entity must determine how they will remedy the deficiency as soon as possible. After the first 30 days, if all entities are consistently meeting requirements, the state can lessen the review of call center statistics, but must still review all statistics at least weekly for the first 180 days of implementation. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

**79. Implementation Calls with the MCOs.** During the initial implementation of Centennial Care, the state must hold regular calls with the MCOs to discuss any issues that arise.. The calls should cover all MCO operations and determine plans for correcting any issues as

quickly as possible. The must maintain weekly calls for the first 90 days and bi-weekly calls for the next 90 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs.

**80. State Review of Beneficiary Complaints, Grievances, and Appeals.** During the first six months of Centennial Care, the state must review complaint, grievance, and appeal logs for each MCO and data from the state or MCO operated incident management system on a monthly basis, to understand what issues beneficiaries and providers are having with each of the MCOs. This review should be particularly focused on issues raised by populations that were transitioned from a 1915(c) waiver into Centennial Care. The state will use this information to implement any immediate corrective actions necessary. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 117. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

## XII. SAFETY NET CARE POOL

The terms and conditions in Section XI apply to the operation of the state's safety net care pools (SNCP), as authorized by Expenditure Authorities 3 and 4.

### 81. 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 subparagraph 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 117, 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. On or before March 31, 2014, the state must submit Medicaid state plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its state plan, with an effective date of January 1, 2014. The state may not subsequently amend its Medicaid state plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.

d. The state will 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.

e. Each quarter the state makes a pools payment for either pool described in STC 82 and 83 below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may 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 will also identify all other funds transferred to such fund making the payment.

**82. Uncompensated Care (UC) Pool.** The UC Pool is available in DYs 1 through 5 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. Expenditures must be claimed in accordance with the methodology described in STC 82(c) below.

a. Eligible hospitals. Eligibility for UC pool payments is limited to sole community provider (SCP) hospitals and the state teaching hospital that were eligible to receive SCP and Upper Payment Limit (UPL) supplemental payments at the time of the demonstration approval. A full list of eligible hospitals and their number of beds is included in Attachment E.

   Eligible hospitals shall be divided into groups based on their size, as defined by the number of hospital beds. Total available funding from the UC pool shall 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 any DY may be allocated to the Hospital Quality Improvement Incentive Pool (HQII) in the next DY.

| Demonstration Year | UC Pool (total computable) |
|---|---|
| DY1 | $68,889,323 |
| DY2 | $68,889,323 |
| DY3 | $68,889,323 |
| DY4 | $68,889,323 |
| DY5 | $68,889,323 |

c. UC Payment Methodology

   i. All UC payments 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 disproportionate share hospital (DSH) payments received in that fiscal year. Nothing in this paragraph shall require that a hospital not receiving a DSH payment be subject to a DSH audit of its cost report.

   ii. If the total allocation to any hospital group, as described in paragraph 81(a) and further defined in attachment H, 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 STC 84(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 UC Payment Application template must be submitted to CMS for review by March 31, 2014. 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.

   i. After CMS has approved the UC Payment Application template, the state may begin accepting applications from hospitals for UC payments in DY 1. For subsequent DYs, starting with DY 2, 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.

   ii. Cost and payment data included on the application must be based on the Medicare 2552.96 cost report. The state may 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 3 application will be used to determine the actual uncompensated care for DY 1 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 may 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 shall return the associated FFP to CMS. .

   iii. The state may 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 shall return the associated FFP to CMS.

f. Annual 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 demonstration year. The reporting requirements are as follows:

i. By March 31st of each demonstration year, beginning in DY 2, the state shall provide the following information to CMS:

1. The UC payment applications submitted by eligible providers; and

2. A chart of estimated UC Payments to each provider for a DY.

3. In DY 1, all UC Payment Applications must be submitted to CMS within 90 days of approval of the UC Payment Application template in order to qualify for DY 1 UC Payments.

ii. Within ninety (90) days after the end of each demonstration year, the state shall provide the following information to CMS:

1. The UC Payment applications submitted by eligible providers; and

2. A chart of actual UC payments to each provider for the previous DY.

g. <u>UC Pool Timeline</u>

i. DY 1:

1. By March 31, 2014, the state must submit to CMS the UC Payment Application template for review and approval. CMS shall review and approve the template within 60 days of submission.

2. Following CMS approval of the UC Payment Application template, hospitals may begin to submit the template for DY 1.

3. Within 90 days of CMS approval of the UC Payment Application, the state must submit all completed UC Payment Applications in order to qualify for DY 1 UC Payments.

4. By December 31st, hospitals must submit the UC Payment Application for DY 2 in order to qualify to DY 2 UC Payments

ii. DY 2 through 4:

1. By December 31st of each year, hospitals must submit to the state the UC Payment Application for the DY beginning January 1.

iii. DY 2 through 5:

1. By March 31st of each year, the state must submit to CMS the UC Payment Applications and a chart of the estimated UC Payments to each provider for the DY.

2. Within 90 days of the end of the previous DY, the state must submit to CMS:

    a. The UC Applications submitted by eligible providers; and

    b. A chart of actual UC Payments for the previous DY.

**83. Hospital Quality Improvement Incentive (HQII) Pool.** The HQII Pool is available in DY 2 through 5 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 any harm whatsoever to individuals, families or communities).

The requirements for the HQII pool are outlined below and additional information is provided in Attachment E (List of Eligible Hospitals), Attachment G (HQII Outcome Measures), and Attachment H (HQII Allocation and Payment Methodology).

a. Eligible hospitals. Eligibility for HQII pool payments is limited to sole community provider (SCP) hospitals and the state teaching hospital that were eligible to receive SCP and UPL supplemental hospital payments at the time of the demonstration approval. A full list of eligible hospitals is included in Attachment E.

b. Outcome measures: The outcome measures for HQQI must be nationally validated measures of patients' clinical events or health status that reflect areas of high need for the New Mexico 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:

    i. *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.
    ii. *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 will be directed towards outcome measures in domain 1 and incentive payments from any reallocation of unused HQII funding (as described in paragraph (d)(i) below) will be directed towards outcomes measures in domain 2.

c. Performance levels. By no later than April 1, 2014, the state will identify high performance levels (HPL) and minimum performance levels (MPL) for each outcome measure, which will be used by hospitals to help set targets for improvement. HPLs and MPLs should be based on state and national benchmarks according to a methodology agreed to by the state and CMS. In general, HPLs should be set to the 90th percentile of the state or national performance and MPLs should be set to the 25th percentile of state or national aggregate performance.

On or before April 1, 2014, the state may 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 New Mexico 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, 2014, the state will 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 will become attachment H of the STCs.

i. *Allocations.* The HQII funds available for allocation to providers is the sum of the initial pool amount (described in STC 84) plus any additional UC funds made available as described in STC 83(b) above. The APM document will describe a methodology to distribute the initial allocation for each provider opting to participate in the HQII pool. The allocation methodology shall 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 will be given one opportunity in DY 1 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 may 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.

ii. *Improvement targets*. For each outcome measure, improvement targets must be set in DY 3, 4, and 5 that progressively close the gap between the provider's current performance and the high performance level (as defined in paragraph (c) above). Targets for DY 4 and 5 must be no lower than the minimum performance level set by the state.

The state will 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.

iii. *Incentive payment amount*. The total amount of funding over DY 2-5 for each outcome measure should be described in the APM document and should 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 demonstration years in the same proportion as the initial HQII allocation.

iv. *Payment oversight.* The APM document will 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 will 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.

v. *Annual reporting template.* The state will 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 can be used for oversight by CMS and shared learning among all hospitals.

e. HQII Mid-Course Review. Prior to the start of DY 4, 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 3 is found to exceed the high performance level (as described in paragraph (c) above, CMS or the state may require the hospital to report on an additional outcome measure for DY 4 and achieve improvements on that measure in DY 5. The additional outcome measures should be nationally validated, in accordance with the requirements of paragraph (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.

**84. Limits on Pool Payments.** The state may claim FFP for the Safety Net Care Pool in each DY up to the limits on total computable listed in the table below.

| | DY 1 (CY 2014) | DY 2 (CY 2015) | DY 3 (CY 2016) | DY 4 (CY 2017) | DY 5 (CY 2018) | Total |
|---|---|---|---|---|---|---|
| UC Pool | $68,889,323 | $68,889,323 | $68,889,323 | $68,889,323 | $68,889,323 | $344,446,615 |
| HQII Pool | - | $2,824,462 | $5,764,727 | $8,825,544 | $12,011,853 | $29,426,586 |
| % UC Pool | 100% | 96% | 92% | 89% | 85% | 92% |
| % HQII | n/a | 4% | 8% | 11% | 15% | 8% |
| Total | $68,889,323 | $71,713,785 | $74,654,050 | $77,714,867 | $80,901,176 | $373,873,201 |

**85. Assurance of Budget Neutrality.**

a. By October 1 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 Medicaid Eligibility Group (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 will be incorporated through an amendment to the demonstration.

**86. 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.

## XIII. 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

**87. 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 XIV of the STCs

The state shall provide quarterly Title XXI expenditure reports using the Form CMS-21 to report total Title XXI expenditures for services provided under the approved CHIP plan and those provided through Centennial Care under the section 1115 authority. CMS will provide Federal financial participation (FFP) only for allowable New Mexico Title XXI demonstration expenditures that do not exceed the state's available title XXI funding.

**88. 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 will 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 Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in Section XV.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the

demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should 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) should 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 will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on 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 shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (described in Section XIV 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":

i. MEG 1 – "TANF and Related"
ii. MEG 2 – "SSI Medicaid Only"
iii. MEG 3 – "SSI Dual"
iv. MEG 4 – "217-like Medicaid"
v. MEG 5 – "217-like group Dual" MEG 6 – "VIII Group"
vi. "UC"
vii. "HQII"

f. Use of Waiver Forms for CHIP.

i. 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 Social Security 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.

ii. Title XIX funds for these uninsured children meeting the definition specified in section 2110(b)(1) of the Social Security Act are available under this

demonstration if the state exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.

iii. 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:

1) The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population;

2) The state shall 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 shall 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.

iv. If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, the expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under STC 70, using the per member per month (PMPM) amounts for TANF Children described in STC 83(a)(ii), and will be considered expenditures subject to the budget neutrality cap as defined in STC 104, so that the state is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. Mandated Increase in Physician Payment Rates in 2013 and 2014**.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides an increased Federal medical assistance of 100 percent for the amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

h. The Demonstration Years (DY) for this demonstration are defined as follows:

| | | |
|---|---|---|
| Demonstration Year 1 (DY1) | January 1, 2014 to December 31, 2014 | 12 months |
| Demonstration Year 2 (DY2) | January 1, 2015 to December 31, 2015 | 12 months |
| Demonstration Year 3 (DY3) | January 1, 2016 to December 31, 2016 | 12 months |
| Demonstration Year 4 (DY4) | January 1, 2017 to December 31, 2017 | 12 months |
| Demonstration Year 5 (DY5) | January 1, 2018 to December 1, 2018 | 12 months |

**89. Administrative Costs.** Administrative costs will 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".

**90. Payment for Home and Community Based Services or Managed Long Term Services and Supports.** The State will 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 managed care organization/entity for these services.

**91. 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.

**92. 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 quarterly report required under STC 117, the actual number of eligible member months for the Demonstration Populations defined in STC 18. 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.

**93. 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.

**94. Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. New Mexico must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the state shall 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.

**95. 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 XIV 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.

**96. 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 shall 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 shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall 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.

**97. 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, may 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) may 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.

**98. Post Cap Reconciliation Process.** For any given month the state does not receive Community Benefit encounter data from an MCO for each member assessed to need the Community Benefit, the state will adjust the MCO's PMPM accordingly.

**99. Title XXI Limits.** New Mexico will 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.

**100. 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, may be claimed as title XIX expenditures as approved in the Medicaid State plan. The State shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with paragraph 36**.**

**101. 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 beneficiaries unless specific waiver and expenditure authorities are granted through this Demonstration.

## XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**102. Limit on Title XIX Funding.** The state shall 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, with an aggregate adjustment. Budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. 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.

**103. 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.

**104. Calculation of the Budget Neutrality Limit:** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 105below. 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 will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The Federal share of this limit will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 109 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 Supplemental Tests described in STCs 107 and 108.

**105. Requirement to increase FFS rates.** On or before March 31, 2014 the state will submit Medicaid state plan amendments to CMS to increase the FFS rates with an effective date of January 1, 2014. The state must comply with the requirements for public notice described in 42 C.F.R. §447.205 and the requirements for public process described in section 1902(a)(13)(A) of the Act.

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.

**106. 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 STC xx. 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 1 - PMPM | DY 2 – PMPM | DY3 – PMPM | DY4 – PMPM | –DY5 – PMPM |
|---|---|---|---|---|---|---|
| **TANF and Related** | 3.88% | $385.80 | $400.77 | $416.32 | $432.47 | $449.25 |
| **SSI and Related – Medicaid Only** | 4.30% | $1,763.90 | $1,842.83 | $1,925.21 | $2,008.00 | $2,094.34 |
| **SSI and Related — Dual** | 4.30% | $1,780.77 | $1,857.34 | $1,937.21 | $2,020.51 | $2,107.39 |

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 1 – Total | DY 2 – Total | DY3 – Total | DY4 – Total | –DY5 – Total |
|---|---|---|---|---|---|---|
| **UPL Payments** | 4.1% | $68,889,323 | $71,713,785 | $74,654,050 | $77,714,867 | $80,901,176 |

**107. Supplemental Budget Neutrality 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 Supplemental Budget Neutrality Test 1.

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

| MEG | TREND | DY 1 – PMPM | DY 2 – PMPM | DY3 – PMPM | DY4 – PMPM | –DY5 – PMPM |
|---|---|---|---|---|---|---|
| **217-like Medicaid** | 3.11% | $4,936.92 | $5,090.46 | $5,248.77 | $5,412.01 | $5,580.32 |
| **217-like Group-Dual** | 4.30% | $1,776.90 | $1,853.31 | $1,933.00 | $2,016.12 | $2,102.81 |

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. Supplemental Budget Neutrality 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 paragraph 111.

**108. Supplemental Budget Neutrality Test 2: VIII Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state will 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 Supplemental Budget Neutrality Test 2.

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

| MEG | TREND | DY 1 – PMPM | DY 2 – PMPM | DY3 – PMPM | DY4 – PMPM | –DY5 – PMPM |
|---|---|---|---|---|---|---|
| **VIII Group** | 5.1% | $577.87 | $607.34 | $638.31 | $670.87 | $705.08 |

b. If the state's experience of the take up rate for the VIII group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the VIII group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment pursuant to paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. 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 2is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.

d. Supplemental Budget Neutrality Test 2 is a comparison between the Federal share of the Supplemental Cap 2 and total FFP reported by the State for VIII Group.

e. If total FFP for VIII Group should exceed the Federal share of Supplemental Cap 2 after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC

106.

**109. Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (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 three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in STC 106; Composite Federal Share 2, based on the expenditures reported under the Waiver Names listed in STC 107(a); and Composite Federal Share 3, based on the expenditures reported under the Waiver Names listed in STC 108(a). 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.

**110. 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.

**111. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

| Year | Cumulative target definition | Percentage |
|---|---|---|
| DY 1 | Cumulative budget neutrality limit plus: | 2.0 percent |
| DY 2 | Cumulative budget neutrality limit plus: | 1.5 percent |
| DY 3 | Cumulative budget neutrality limit plus: | 1.0 percent |
| DY 4 | Cumulative budget neutrality limit plus: | 0.5 percent |
| DY 5 | Cumulative budget neutrality limit plus: | 0 percent |

**112. Exceeding Budget Neutrality**. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

## XV. GENERAL REPORTING REQUIREMENTS

**113. 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 XIV of these STCs.

**114. Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR Part §438 et. seq. except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

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

**116. Monthly Monitoring Calls.** CMS will convene monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. 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, access, 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. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

**117. Quarterly Progress Reports.** The state must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly and bi-annual reports must include the following, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

c. For the first quarterly report, the State shall report the number of beneficiary plan change requests following auto-assignment as specified in STC 38(d).

d. Adverse incidents including abuse, neglect, exploitation, mortality reviews and critical incidents that result in death;

e. A summary of any issues identified or recommendations made by the Native American Advisory Board and the Native American Technical Advisory Subcommittee;

f. Action plans for addressing any policy, administrative, or budget issues identified;

g. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

h. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned; and

i. Complaints, grievances and appeals filed during the quarter by type including access to urgent, routine, specialty and the Community Benefit.

j. Evaluation activities and interim findings. The State shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.

k. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STC 118, the State must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the Demonstration.

l. Information related to beneficiary rewards eligibility activities, respective earnings for each activity, eligible health related expenditures and access to account information.

**118. Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the Demonstration Year (DY) to CMS.

a. All items included in the quarterly report pursuant to STC 117(a)-(d) and (f)-(k) must be summarized to reflect the operation/activities throughout the DY;

b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;

d. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance. The annual report must include an analysis of service reductions that occurred as a result of the assessment within the first 90 days of the transition of 1915(c) HCBS participants into the 1115 demonstration, and must also include an analysis of service reductions that occurred through the course of the service planning process

e. Annual summary of the quality of care and health outcomes for AI/AN beneficiaries under Centennial Care

**119. Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

## XVI. EVALUATION OF THE DEMONSTRATION

**120. Submission of a Draft Evaluation Plan.** The state shall submit a draft evaluation plan to CMS no later than 120 days after the award of the Demonstration. The evaluation plan, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 121, is subject to CMS approval.

**121. Evaluation plan requirements.** The evaluation plan should be described in sufficient detail to determine that it is scientifically rigorous. The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet the standards of academic journal peer review, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and

reporting of the limitations of data and their effects on results; and the generalizability of results.

The Evaluation Plan shall include the following core components:

a. Research questions and hypothesis: This includes a comprehensive statement of the specific research questions and testable hypotheses that cover the various interventions and specific impacts on target beneficiaries, and more generally on providers, health plans, market areas and public expenditures. The research questions shall focus on the programmatic goals and objectives of the Demonstration and the potential impacts, particularly as they relate to CMS' Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs. At a minimum, the research questions shall address the following topics:

    i. *Demonstration Goal 1*: Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, cost effectively in the right setting.

    ii. *Demonstration Goal 2*: Ensure that the expenditures for care and services being provided by the program are measured in terms of its quality and not solely by its quantity.

    iii. *Demonstration Goal 3*: Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility or reducing provider rates.

    iv. *Demonstration Goal 4*: Streamline and modernize the Medicaid program in the State.

b. Study Design: This includes a description of the study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion shall include a proposed baseline; definition of control and/or comparison groups or within-subjects design, if applicable; and/or benchmarking to national standards, if applicable.

c. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion shall include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

d. Outcome Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration, particularly as it relates to the Three Part Aim. Outcomes shall be clearly stated and described, with the numerator and dominator clearly defined, if applicable. To the extent possible, the State shall incorporate comparisons to national data and/or measure sets.

e. Data Collection: This includes description of the data sources; the frequency and timing of data collection; and the method of data collection, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys.

f. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis might be at the beneficiary, provider, and aggregate program level, as appropriate, and may include population stratifications to the extent feasible, for further depth. Qualitative analysis methods shall also be described, if applicable.

g. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

h. 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, how the state will assure no conflict of interest, and a budget for evaluation activities.

**122. Interim Evaluation Report.** If the State submits a request for a renewal of the Demonstration, the State shall submit a draft Interim Evaluation Report at the time of application. The Interim Evaluation Report shall include the same core components as identified in STC 123 for the Final Evaluation Report and should be consistent with the rigor and format described in the draft evaluation design, in accordance with STC 121. In addition, the discussion of the Conclusions and Policy Implications in the Interim Evaluation Report should support the request for the Demonstration extension or renewal. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS' comments.

**123. Final Evaluation Report.** On or before April 30, 2019 (or 120 days following the original expiration date of the demonstration, should that date be later), the State shall submit a draft Final Evaluation Report to CMS. CMS will provide comments on the draft Final Evaluation Report within 60 days of draft receipt. The State should respond to comments and submit the Final Evaluation Report within 60 days of receiving comments. The Final Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to the Triple Aim and interventions implemented.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses, type of study design, impacted populations; data sources; and data collection and analysis techniques.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

**124. Public Access.** The State shall post the final approved Evaluation Plan, Quarterly and Annual Progress Reports, Interim Evaluation Report, if applicable, and Final Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

In addition, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

**125. Electronic Submission of Reports.** The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

**126. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS and its contractor. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

## XVII. 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 |
|---|---|---|
| 60 days after approval | Submit plan for Independent Consumer Support Program | STC 56 |
| 90 days after approval | Submit quality strategy | STC 52 |
| 120 days after approval | Submit draft evaluation plan | STC 120 |
| 6 months after implementation, and annually thereafter | Hold post-award forum (and publish date, time, and location 30 days before each forum) | STC 16 |
| 1 year after approval | Submit a plan for the central registry | STC 0 |
| Monthly | Monitoring calls | STC 116 |
| 60 days after the end of each quarter | Quarterly progress report | STC 117 |
| Quarterly | Quarterly financial report | STC 87 |
| Annually | Annual report | STC 118 |
| 6 months before specific authority expires | Submit an expiration plan | STC 10 |
| 12 months before the termination of the demonstration | Submit an extension request or a phase out plan and an interim evaluation report | STC 8 |
| 120 days after the termination of the demonstration | Draft final report | STC 119 |

## ATTACHMENT A. QUARTERLY REPORT CONTENT AND FORMAT

Pursuant to STC 117 *(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 Waiver Demonstration
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
*Example: Demonstration Year: 1 (1/1/2014– 12/31/2014)*
*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 beneficiary rewards program, including the number of people participating, credits earned, and credits redeemed.

Information about community interveners.

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 - Dual** | | | |
| **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 for AI/AN beneficiaries including:

1. Access to care, especially in frontier areas;
2. Status of contracting between MCOs and I/T/U providers and the use of the I/T/U contract addendum.
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 Related** | | | | |
| **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- Dual** | | | | |
| **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 65(e).

**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**

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

## ATTACHMENT B. CENTENNIAL CARE HCBS (INCLUDING SELF-DIRECTED SERVICES) AND NEW MEDICAID BEHAVIORAL HEALTH SERVICE DEFINITIONS

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

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

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

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

Core services provide assistance to the beneficiary in meeting a broad range of activities of daily living including; personal support services (homemaker, chore, attendant services, meal preparation), and companion services; medication oversight (to the extent permitted under state law), 24-hour, on-site response capability to meet scheduled or unpredictable eligible beneficiary 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. Assisted Living settings must comply with STC II.70.

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

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

Behavior Support Consultation: 1) informs and guides the eligible beneficiary's paid and unpaid caregivers with the services and supports as they relate to the eligible beneficiary's behavior and

his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the eligible beneficiary and his/her service and support providers. Based on the eligible beneficiary's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

***Community Transition Services***

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

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

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

***Customized Community Supports***

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. These services are provided at least 4 or more hours per day one or more days per week as specified in the participant's care plan.

**Limits or Exclusions:** N/A

***Emergency Response***

Emergency Response services provide an electronic device that enables an eligible beneficiary to secure help in an emergency at home and avoid institutionalization.
The eligible beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the eligible beneficiary's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing, testing and maintaining equipment; training eligible beneficiaries, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting eligible beneficiary emergencies and changes in the eligible beneficiary's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response.

**Limits or Exclusions:** Eligible beneficiary must have a landline phone.

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

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

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

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

***Environmental Modifications***
Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to an eligible beneficiary's residence that are necessary to

ensure the health, welfare, and safety of the eligible beneficiary or enhance the eligible beneficiary's level of independence.

Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

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

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

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

***Family Support Services***

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

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

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

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

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

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

***Home Health Aide***

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

***Homemaker/ Personal Care***

Homemaker/ Personal Care services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the participant to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/ Personal Care services are provided in the participant's home and in the community, depending on the participant's needs. The participant identifies the Homemaker/ Personal Care worker's training needs, and, if the participant is unable to do the training him/herself, the participant arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Homemaker/ Personal Care services are not duplicative of home health aide services. Home health aides may provide basic non-invasive

nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

Two or more participants living in the same residence, who are receiving services and supports will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on the common needs and not on individual needs, unless it has been assessed by the state or its designee that there is an individual need for the provision of the service(s) or supports.

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

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

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

***Recovery Services***
Recovery Services are peer-to-peer group instructional services that assist individuals with serious mental illness, severe emotional disturbance, and substance use disorders to develop the skills they need to maximize their potential for a successful recovery. Recovery Services empower consumers by recognizing the important insights a peer in Recovery can share with individuals facing similar challenges. Recovery Services reinforce a belief that recovery is possible and helps build the wellness skills and social supports needed for a healthy lifestyle in recovery.

Recovery Services promote recovery and resiliency through enhancing the individuals' strengths and building on their capabilities to address challenges and life barriers to life goals precipitated by mental illness, substance abuse and/or co-occurring (mental illness *and* substance use) disorders. Services are provided in a manner that embraces diversity and that is culturally sensitive. This service is embedded within an integrated multi-disciplinary approach, through the

Core Service Agency (CSA). Eligible beneficiaries receiving this service shall be able to identify additional needs and be able to link themselves to additional support as a result of this service.

Recovery Services are targeted to adults and children who have completed active treatment but have been unable to achieve functional use of natural and community support systems to effectively self-manage recovery and wellness. Recovery Services are structured group discussions provided within a supportive group setting and focus participants on developing specific wellness skills, building an awareness of good healthcare practices, and strengthening social supports. The individual will build a Recovery Plan to identify on-going needs, supports and goals that are important to their recovery. Through continued Recovery Services, individuals have a better understanding of the dimensions of wellness and a better opportunity for on-going resiliency, relapse prevention, and chronic disease management.

Recovery Services operate within the structure of a CSA that provides an array of services for individuals with serious mental illness and substance use disorders. Staff providing Recovery Services will be Certified Peer Support Workers or Certified Family Specialists, either directly employed by or contracted with Core Service Agencies. Each Recovery Service program will include trained peer specialists who have experience with mental illness and addiction. Each Recovery Service program will have an independently-licensed Clinical Supervisor. Group ratios will not exceed one worker to ten individuals in each Recovery Service Group Meeting. These services will not usually be billed in conjunction with active therapies (Multi-systemic therapies or Assertive Community Treatment or Intensive Outpatient Program), inpatient hospitalization, or residential treatment.

***Related Goods***

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

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

**Limits or Exclusions:** Experimental or prohibited treatments and goods are excluded.

***Respite***

Respite services are provided to beneficiaries unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or nursing facility or an ICF/MR meeting the qualifications for provider certification. When respite care services are provided to an eligible individual by an institution, that individual will not be considered a resident of the institution for purposes of waiver 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 beneficiary at all times.

Respite is also available to children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder as defined by the DSM IV whose primary caregivers typically are the same people day after day. The service involves the supervision and/or care of children and youth residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers and may include a range of activities to meet the social, emotional and physical needs of the person during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays. Respite may be provided on either a planned or an unplanned basis and may be provided in a variety of settings. If unplanned respite is needed, the appropriate agency personnel will assess the situation and, with the caregiver, recommend the appropriate setting for respite. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care. Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their service plan.

Respite for beneficiaries who are eligible through the medically fragile waiver is provided by licensed nurses (RN or LPN). A home health aide (HHA) may provide respite if the family designates a primary caregiver in residence who can provide the skilled care that is needed. The HHA only provides services related to the individual's ADLs. The interdisciplinary team is responsible for determining the need for respite care. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or nursing facility (NF) or an ICF/MR meeting the qualifications for provider certification. When respite care services are provided to an eligible individual by an institution, that individual will not be considered a resident of the institution for purposes of waiver eligibility. For this specialized population, respite services may also include: skilled care specific to individuals who are ventilator dependent, have tracheostomies, require assessment of their respiratory status with subsequent medications and treatments, receive TPN – total parenteral nutrition, receive I.V. therapy, peritoneal dialysis, medical interventions during and/or after seizures etc.

**Limits or Exclusions:** Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible

beneficiary's health and safety needs exceed the specified limit.

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

For beneficiaries eligible through the medically fragile waiver, respite services are limited to a maximum of 336 hours per annual individual service plan cycle.

***Skilled Maintenance Therapy Services***

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

Skilled Maintenance Therapy services specifically include:

**Physical Therapy**

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

**Occupational Therapy Services**

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

**Speech Language Therapy**

SLT services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development

of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the eligible beneficiary's environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the eligible beneficiary.

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

***Specialized Medical Equipment and Supplies***

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

**Limits or Exclusions*:*** Medical equipment and supplies that are furnished by the Medicaid State Plan are not covered in the Specialized Medical Equipment and Supplies. This service only applies to persons qualified through the medically fragile criteria. The service is limited to $1,000 per care plan year.

***Specialized Therapies***

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

Services in this category include:

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

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

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

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

**Hippotherapy**
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for eligible beneficiaries with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the eligible beneficiary use cognitive functioning, especially for sequencing and memory. Eligible beneficiaries with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise,

neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy.
The activities may also help improve respiratory function and assist with improved breathing and speech production.

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

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

**Native American Healers**
There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healers are individuals who are recognized as healers within their respective Native American communities. Native American healers deliver a wide variety of culturally-appropriate therapies that support eligible beneficiaries in their communities by addressing their physical, emotional and spiritual health. Treatments delivered by Native American healers may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects. Native American healers provide opportunities for eligible beneficiaries to remain connected with their communities. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some Tribes, Nations and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

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

## ATTACHMENT C: HCBS Participant Safeguards

### State Critical Event or Incident Reporting Requirements

The New Mexico Human Services Department (HSD) has established processes and procedures to monitor access, quality, and appropriateness of service delivery. Centennial Care (CC) Managed Care Organizations (MCO) are expected to comply with all requirements.

Reportable critical incidents may include, but are not limited to, abuse, neglect and exploitation; death; environmental hazards; law enforcement intervention; and emergency services, that encompass the full range of physical and behavioral health, other state plan services and home and community-based supports and services. For all allegations of abuse, neglect, or exploitation, the CC MCO must first and foremost ensure the safety of the person, including facilitating appropriate response and intervention for the victim and obtaining medical care and behavioral health services as appropriate.

The CC MCO must report all critical events or incidents to HSD and other state agencies as required by state statute. The CC MCO must monitor all reports and route identified issues to the appropriate internal department for appropriate resolution of the event. Issues may be identified by the care coordinator, health care provider, member services staff, member, or legal representative.

Allegations of abuse, neglect, or exploitation must be reported to the New Mexico Aging and Long Term Services Department's (ALTSD)Adult Protective Services (APS) or, if a child, the New Mexico Children, Youth and Families Department's (CYFD)Child Protective Services (CPS) immediately. An incident report must be electronically reported to the Human Services Department/Medical Assistance Division (HSD/MAD) within 24 hours of knowledge of the incident. (If the event occurs on a weekend or holiday, it should be electronically reported the next business day). If the incident involves a facility licensed by the New Mexico Department of Health (DOH), the incident reports must be faxed to DOH.

If the incident involves a criminal act, the MCO must contact the local Law Enforcement Agency.

Deaths that are suspected of being related to abuse or neglect should be immediately reported to ALTSD/APS and CYFD/CPS's. All deaths must be reported to the DOH Division of Health Improvement (DOH/DHI) and HSD/MAD within 24 hours of knowledge of the death. If the death occurred outside a medical facility, the MCO must contact the local Law Enforcement Agency.

Other reportable incidents should be reported to HSD/MAD with 24 hours of knowledge of the incident.

### Participant Training and Education

The CC MCO is responsible for informing the member or legal representative of their rights and responsibilities related to abuse, neglect, and exploitation. The CC MCO is also responsible for informing the member of critical incident reporting mechanisms and requirements. This occurs

as part of the comprehensive needs assessment and care plan development process. Information provided to members during this process includes how to recognize and report abuse, neglect and exploitation, as well as the prohibition on the use of restraints. The CC MCO will acquire a signature from the member or legal representative verifying critical event/incident information has been furnished during the comprehensive needs assessment and care plan development process. This documentation is maintained in the member's case files. The assessment, care plan development, and critical event/incident training are performed annually. The CC care coordinator is responsible for reviewing this information at least annually with the member or legal representative at time of reassessment or if there is suspicion of abuse, neglect, exploitation or abandonment.

**Use of Restraints or Seclusion**

The State prohibits the use of restraints or seclusion. Unauthorized use of restraints or seclusion is monitored by the CC MCO and ALTSD or HSD/MAD through the following five methods:
1) The CC MCO care coordinator monitors the member's health and welfare monthly through a review of the implementation of the care plan.
2) The CC MCO manages critical events/incidents and provides provider training and technical assistance for reporting procedures. The CC MCO monitors t the reporting of abuse and neglect to APS/CPS and any identified service issues.
3) The CC MCO completes quality management reviews of the member's health and safety and reports results to ALTSD or HSD/MAD.
4) The CC MCO conducts reviews of a random sample of care plans to insure that member health and safety are being monitored by the CC MCO Care coordinator. The reviews include face-to-face visits with waiver participants. Additionally, HSD/MAD will review quality management reports from the CC MCO to ensure that required procedures are followed.
5) An external quality review organization (EQRO) will conduct annual quality and performance review audits of the CC MCOs.

**Use of Restrictive Interventions**

The State prohibits the use of restrictive interventions. Unauthorized use of restrictive interventions is monitored by the CC MCO and HSD/MAD through five methods:
1) CC MCO care coordinators monitor the member's health and welfare monthly through a review of the implementation of the care plan.
2) CC MCO manages critical events/incidents and provides provider training and technical assistance for reporting procedures. The CC MCO monitors the reporting of abuse and neglect to APS/CPS and any identified service issues.
3) CC MCO completes quality management reviews of member's health and safety and reports results to HSD/MAD.
4) The CC MCO conducts reviews of a random sample of care plans to insure that participant health and safety are being monitored by the CC care coordinator. The reviews include face-to-face visits with waiver participants.
5) Additionally, HSD/MAD reviews quality management reports from the CC MCO to ensure that required procedures are followed and the health and welfare of members' are protected.

**Medication Management and Administration**

**Nursing Facilities**

When a member's medication is dispensed by the pharmacist, state law requires the pharmacist to provide necessary consultation services with regard to the use of the medication and to address any questions the participant or the agent of the participant may have. The pharmacist is responsible for detecting over- or under-utilization and potential drug interactions according to the records the pharmacy maintains.

Medication errors are reported to the Pharmacy Board. All irregularities must be recorded and reported to the director of the facility. Medication errors include: administering medication to the wrong person or at the wrong time; administering the wrong medication, the wrong dose, or wrong route; missed doses; and inaccurate documentation.

By state law, facilities must record a member's refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions. The report includes notifying the physician, notifying the director of the facility, documenting the incident, and taking any other appropriate action.

State law requires oversight of the administration of medications by a pharmacist including periodic reviews by a pharmacist and periodic reviews by facility surveyors during the facility's annual licensure process. The facility surveyors have the responsibility to assure all the procedures are followed including that medication error is documented, reported, and acted upon. Other administrative and enforcement agencies include the Pharmacy Board that separately licenses the facility and determines that medication error reporting procedures are followed.

The Pharmacy Board licenses all facilities in which medication errors can occur, including nursing facilities, hospitals, clinics and Assisted Living facilities. State law requires the facilities to have a consultant pharmacist available to the facility. The consultant pharmacist is required by state law to establish procedures and protocols for reporting adverse reactions and medication error events, including use the Pharmacy Board's "Significant Adverse Drug Event Reporting" system.

DOH/DHI surveys facilities for license renewal and specifically looks at medication management during the survey including properly documenting, reporting, and taking appropriate actions for a medication error. Whenever deficiencies are found, notice is given to the facility. If a facility is unable or unwilling to correct their procedures, the license is revoked. Other licensing bodies for each type of providers, such as the Pharmacy Board, Nursing Board, and Board of Medical Examiners have the enforcement authority for the state statutes and regulations regarding medication errors.

**Residential Community Settings**

All residential community settings will comply with STC 69 regarding characteristics of home and community based settings. The CC MCO monitors Assisted Living facilities. The CC MCO compiles monitoring results listing all citations for each agency monitored as part of their Quality Management Strategy. The list of citations is aggregated, trended, and compiled into a

report which is provided to HSD/MAD. As necessary, an Action Plan is developed and implemented to address any identified and prioritized issues. The report is reviewed by HSD/MAD. If the State identifies any issues that are inconsistent with Medicaid requirements or state statute, HSD/MAD ensures that the CC MCO corrects the problem through a directed correction action as specified by DOH Policy ADM 05:140 specified by the severity of the problem.

The HSD/MAD has entered into a joint powers agreement (JPA) with the DOH to review medication management during the annual survey process. The DOH/DHI monitoring surveys of Assisted Living facilities are reviewed and monitored by DOH/DHI in collaboration with HSD/MAD as part of the CC quality management strategy. DOH compiles monitoring results listing all citations for each provider monitored. The list is aggregated, trended and compiled into a report. The report is reviewed by DOH/DHI and HSD/MAD. Any HSD/MAD identified deficiencies or inconsistencies with Medicaid requirements, require corrective action by the MCO.

## ATTACHMENT D: Level of Care (LOC) Criteria

The State will require the Centennial Care MCOs to use state-developed level of care (LOC) criteria and a state-approved assessment tool that incorporates elements relevant from each of the current waivers for determining nursing facility (NF) LOC for all long-term care services (both NF placement and the Community Benefit).

Elements of the LOC criteria that are utilized to determine and re-determine the individual's medical eligibility include: medical risk factors, including but not limited to medical diagnoses, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), range of motion capability, need for medical treatments, clinical monitoring by RN, hospitalization in last 90 days; support and social resources, such as personal care assistance, housekeeping, home delivered meals, living arrangements, homebound status, durable medical equipment; environmental assessments, including safety and accessibility problems; nutrition, including eating issues, such as swallowing problems, tube feeding, special diet, nausea, tooth or mouth problems; communication and cognition; behaviors/mental health assessment; health and safety risks; ability to perform activities of daily living, such as ambulation, falls, bladder, bowel, toileting, bathing, dressing, hygiene; and ability to perform instrumental activities of daily living, such as making phone calls, scheduling appointments, preparing meals, shopping, transportation, and laundry.

**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 Juan | 194* |
| Sierra Vista Hospital | Sierra | 15 |
| Socorro General Hospital | Socorro | 24 |
| CHRISTUS St. Vincent Regional Med. Ctr. | 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: Uncompensated Care (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. <u>The same standard is being applied for the New Mexico UC Payment calculation.</u>

**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. **Increase to Payments:** Include the estimated impact of any expected increase to payment rates such as HSD'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.HSD intends to 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 Demonstration Year 3 application will be used to determine the actual uncompensated care for Demonstration Year 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 Demonstration Year 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 Funding | 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***
HSD 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., HSD 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 (50th 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 25th 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 90th percentile. Targets can be no lower than the MPL (25th percentile) and must increase each year until the HPL is reached.
    - Example 1: A hospital that performed at the 30th percentile must set a target that is greater than the 30th percentile (improved performance).
    - Example 2: A hospital performing at the 10th percentile would need to set a target of at least the 25th percentile (the MPL).
    - Example 3: A hospital performing at the 90th percentile could set a target that sustains performance at the 90th 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***
HSD 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. HSD 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***
HSD 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. HSD will continue to communicate programmatic policies and procedures through these channels, providing guidance, training or technical assistance, as necessary.

HSD 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. HSD may use its contracted agents, Myers & Stauffer, to assist in performing necessary monitoring activities. This may include such activities as desk and field audits.

# Independent Consumer Support System For the New Mexico State Medicaid Program Long-Term Services and Supports

**Prepared by**
**The New Mexico Human Services Department**
**Office of the Secretary**

**November 2013**

## Independent Consumer Supports System (ICSS) Plan

### Introduction to Centennial Care

As a result of years of experience with managed care, New Mexico began to evaluate its "lessons learned" and to move its Medicaid program to a new and more sophisticated level that focuses on a comprehensive service delivery system, aggressive care coordination and administrative simplicity. Based on its analysis and after months of statewide stakeholder meetings, the State submitted a Section 1115 waiver for federal approval; the waiver was approved on July 12, 2013. Under the new program, Centennial Care, enrollees will choose among four competing MCOs, each providing a comprehensive array of services, including behavioral health and community-based long term care as well as institutional long term care services.

As with all federal waivers, the approval for Centennial Care was accompanied by a series of Special Terms and Conditions (STCs), which articulate the details of the agreement between the State and its federal partner, the Centers for Medicare and Medicaid (CMS). One of those STCs requires the State to establish an "Independent Consumer Support System".

This document describes the State's plan for implementing that system.

### Background - Choice Counseling and Advocacy in New Mexico

Centennial Care is the next generation of Medicaid managed care in New Mexico. Before implementing Centennial Care , the State had been delivering managed care health services to Medicaid members for over 15 years. The State had an acute services managed care program (SALUD) since 1997, a managed care behavioral health program since 2005 and a managed long term services and supports (LTSS) program, Coordination of Long Term Services (CoLTS), since 2008. As a result of these early efforts, and to better serve the needs of beneficiaries, HSD built strong interagency partnerships and collaborations with the New Mexico Aging and Long Term Services Department (ALSTD) and its Aging and Disability Resource Center (ADRC), the LTC Ombudsman, the New Mexico Department of Health (DOH), and the New Mexico Behavioral Health Collaborative.

HSD and its sister agencies offered a variety of services to individuals enrolled in the state's previous managed care plans, as they will to members enrolled in Centennial Care. The LTC Ombudsman program and ADRC worked with the CoLTS MCOs and with the state's contract management and quality staff advocating for the disabled, for people receiving services in the community, and for those who wanting to receive services in the community. The CoLTS MCOs implemented effective nursing home diversion programs that identified members who could be at risk for nursing facility care and helped provide items and services that allowed beneficiaries to remain safely in the community. The CoLTS MCOs also operated successful programs that transitioned individuals from nursing facilities back to the community. The state expects these activities to be further improved through the enhanced and expanded care coordination and member monitoring requirements of Centennial Care.

The ADRC and LTC Ombudsman program also refer beneficiaries' issues to HSD's Medical Assistance Division's (MAD) contract management bureau and quality bureau. MAD assists all Medicaid beneficiaries, and is committed to working on a beneficiary's case with the MCO. MAD's behavioral health ombudsman responds to direct calls from beneficiaries and works independently to help resolve beneficiary issues. Additionally, the ADRC and LTC Ombudsman functions are enhanced throughout the state by independent advocacy resources for disabled and older adult Medicaid beneficiaries. New Mexico has five centers (5) Centers for Independent Living (CILs) that serve the entire state. There are six (6) Area Agencies on Aging (AAAs) with over 240 senior center providers throughout the state including the 22 tribes, nations and pueblos. The CILs and AAAs assist beneficiaries with Medicaid benefits and understanding choices in long term services.

New Mexico has pioneered the "No Wrong Door" model, a model which has been nationally recognized as an innovative single point of entry system. The ADRC "No Wrong Door" model offers access through a toll-free number, in person assistance at the ADRC, community-based partner programs throughout the State, in consumers' homes and in alternative locations convenient to the consumer. State and local agency partnerships include advocacy and community organizations where beneficiaries and family advocates also access consumer supports and services. The ADRC, after providing grievance and appeal process counseling, direct consumers to appropriate parties such as Medicaid or the MCO but also offers referrals to organizations like the Senior Citizens Law Office and the Lawyer Referral for the Elderly Program for legal services that reach beyond the scope of counseling.

It was this rich but loosely coordinated environment of Medicaid beneficiary advocacy and support entities that inspired the State to propose linking them into a system of consumer support, rather than duplicating resources already in place in New Mexico with yet another entity layered upon these existing resources. The State has solicited and received input from numerous stakeholders and advocacy groups including the Governor's Commission on Disability, the Centennial Care MCOs, the ADRC, ALTSD, CILs, Disability Rights of NM, the ARC of New Mexico and the Senior Citizens Law Center.

As part of the implementation of Centennial Care, HSD held trainings to educate the LTC Ombudsman, ADRC, and Senior Health Insurance Assistance Program (SHIP) staff and volunteers about Centennial Care and MCO services, as well as enhance education in the grievance and appeals process. These trainings will continue regionally across the state. Additionally, HSD will provide regular follow-up trainings to ICSS entities. Public education events tailored to beneficiaries and advocates are occurring statewide, drawing in local government entities and interested provider staff including the Centers for Independent Living. Provider education by the MCOs is also in place.

**CMS STC Section IX - Delivery System**

The STC the State is in the process of designing and implementing states:

*STC- #56 Independent Consumer Supports requires the State to support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care*

*environment by creating and maintaining a permanent system of independent consumer supports to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.*

The State's ICSS plan addresses STC 56's core elements of the system as listed below.

*I. Organizational Structure. The Independent Consumer Supports System shall operate independently from any Centennial Care MCO. Additionally, to the extent possible, the system shall also operate independently of the Medical Assistance Division of the Human Services Department. The organizational structure of the support system shall facilitate transparent and collaborative operation with beneficiaries, MCOs, and state government.*

*II. Accessibility. The services of the Independent Consumer Supports System are available to all Medicaid beneficiaries enrolled in Centennial Care receiving long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.*

*III. Functions. The Independent Consumer Supports system assists beneficiaries to navigate and access covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity.*

*1. The system shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.*

*2. The system shall service as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.*

*3. The system shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.*

*4. The system shall conduct trainings with Centennial Care MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.*

*IV. Staffing and training. The Independent Consumer Supports system must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The system ultimately developed by the State may draw upon existing staff within the chosen organizational structure and provide substantive training to ensure core competencies and a consistent consumer experience.*

*V. Data Collection and Reporting. The Independent Consumer Supports System shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will*

*inform the state of any provider or contractor issues and support the reporting requirements to CMS.*

**ICSS Organizational Structure**

In response to STC-#56, HSD's Office of the Secretary, contracted with an individual to organize and lead the State's effort in developing the ICSS. The State will implement the ICSS by connecting the numerous disparate consumer support entities that already exist in New Mexico. The ICSS will be independent of the Centennial Care MCOs and, to the extent possible, of the Medical Assistance Division, and will foster collaboration among the MCOs, state government, and advocacy organizations to assist Centennial Care members. HSD will link the functions of the multiple programs described above, combined with other advocacy resources in New Mexico, to meet the choice counseling and advocacy needs of Medicaid beneficiaries receiving long term services and supports.

**ICSS Accessibility:**

Through the ICSS, Medicaid beneficiaries may use several points of entry for questions related to Medicaid eligibility, Centennial Care benefits, and grievances and appeals. The Medicaid call center (operated by Xerox, an HSD contractor), HSD Income Support Division call center, ADRC, MCOs, and LTC Ombudsman all offer toll-free phone numbers. The ADRC, LTC Ombudsman, CILs, and numerous senior centers offer face-to-face consultations. HSD will use multiple tools to streamline the experience for consumers seeking information and supports. Below are the phone numbers and website URLs:

- Medicaid (Xerox) Call Center 888-997-2583
- Aging & Disability Resource Center (ADRC) 800-432-2080 TTY: 505-476-4937
- HSD has purchased several web domains for the ICSS website. The proposed website domain name is www.nmicss.com and will be hosted independently of the HSD agency website.
- Centennial Care www.CentennialCare.net

The ICSS website and ICSS brochures will inform beneficiaries, advocates and counselors how to access the ICSS and which entities can help with specific topics. The website will provide a central location of important phone numbers and a listing of ICSS entities and descriptions of their services. It will also offer printable information regarding long-term services and supports, grievances and appeals, the Centennial Care program, organizations and agencies offering additional resources and supports, and links to websites for ICSS entities and other resources.

The ICSS entities will all have access to additional standardized materials and information that will allow the entities to provide consistent and accurate information. This will ensure that enrollees and their families are accurately referred to the correct resource if the ICSS entity

cannot respond to their needs directly. Referral processes and trainings will be provided to all ICSS entities including the Medicaid and ADRC call centers. The ADRC call center already supports beneficiaries seeking assistance regarding grievances, appeals and fair hearings, and it has referral processes in place for those in need of legal support.

**ICSS Functions:**

1. The System shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.

The ICSS is still in final development stages and is only one small piece of a much larger state effort to provide clear, unbiased, helpful information to ALL beneficiaries (not just those seeking long term care services) about the opportunity to choose a health plan. The State has held over 200 outreach meetings throughout this vast state to educate members and to introduce them to the plans, direct them to plan provider directories, and, in general, help enrollees understand the benefits of the new program.

As Centennial Care continues to develop and mature, the various components of the ICSS will continue to play an important role in helping people make good choices and understand how to access long term care services and supports within each and all of the MCOs participating in the program.

HSD is providing training and information to our partner agencies, including the LTC Ombudsman Program, the ADRC Benefits Counseling hotline and SHIP Counselors about the Centennial Care Benefit Plan and MCO value added services. The LTC Ombudsman program is available to potential Medicaid beneficiaries upon admission to LTC facilities. Additionally counseling is provided to individuals transitioning from nursing facilities to home and community-based services. This includes information about the MCOs' provider networks, community support services, and other related information. The ADRC uses a "person-centered", interactive decision supported process whereby consumers are supported in deliberations to make informed long term support choices. The process may include developing action steps toward a goal or LTSS plan including assistance in accessing support options. It also includes following up with each consumer.

2. The system shall serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.

All ICSS participating entities will be trained to provide choice counseling to beneficiaries in an unbiased fashion, particularly that they are not able to recommend one plan over another. Most ICSS entities have no business relationship with the Centennial Care Managed Care Organizations (MCOs). Entities that could have potential for bias in their choice counseling will be required to sign a Memorandum of Understanding (MOU) indicating that they will only provide unbiased choice counseling in their role as an ICSS entity.

The ICSS entities will advise beneficiaries on things they should consider when choosing a health plan. Beneficiaries will be advised that all plans are responsible for assuring that their members have access to all Medicaid benefits that they need. Beneficiaries will also be advised of things to consider when selecting a plan. These include:

A. Whether the plan has the beneficiary's most important health care providers and/or home care providers in its network.

- Beneficiaries will be advised to ask their doctors or home care providers what
- Medicaid MCO networks they are associated with.
- Beneficiaries will be encouraged to contact the MCOs to find out if their doctors or home care providers are in the MCO's networks.

B. Whether the plan has health care providers conveniently located.

- Beneficiaries will be encouraged to contact the MCOs to find out about health care providers that are located nearby their work or homes.

C. What kinds of extra benefits the plan offers.

- ICSS entities will have a listing of the value-added benefits each MCO offers and they will also encourage the beneficiaries to contact the MCOs to find out about these extra benefits.

Beneficiaries will also be instructed how they can register their MCO selection and what the rules are for changing MCOs.

3. The system shall help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level and assist them through the process if needed or requested.

The LTC Ombudsman Program provides referrals to the legal services, subcontracted through ALTSD, for enrollees who need assistance in understanding their legal rights. ALTSD contracts with local governments and non-profit organizations to provide legal assistance to beneficiaries age 50 and older, caregivers and adults with disabilities. The ADRC explains the grievance and appeals process, provides information regarding the roles of each party and directs consumers to the appropriate parties, such as the Medical Assistance Division, HSD's Fair Hearings Bureau or the MCO. The LTC Ombudsman trains MCOs about resident rights in concert with state and federal regulations and provides training about advocacy services. The ADRC will train the Centennial Care MCOs on the services provided by the ADRC, such as options counseling, benefit counseling and accessing social services programs.

The State has also organized an internal workgroup to look carefully at the grievance and appeals process as well as access to the State's fair hearings process. This group will work with all of the

agencies within the ICSS to provide information and training about how the grievance and appeals process should work within the plans and how a beneficiary can access the State's fair hearing process.

The ICSS will provide standardized tools and resources for beneficiaries and their advocates seeking information and assistance with the grievance, appeal rights and fair hearings process. These tools will include materials that explain, step-by-step, how the process works, timelines, and required documentation and so on. When seeking counseling or support from an agency or organization outside of the member's MCO, beneficiaries will be directed to the ADRC for help with these important processes.

4. The system, led by HSD, shall conduct trainings with Centennial Care MCOs as well as providers on community based resources and support that can be linked with covered plan benefits.

HSD, Office of the Secretary, will work with internal and inter-agency staff to create additional educational tools and trainings, develop a web-based resource site, and work with agency and community partners to effectively enhance beneficiary understanding of available resources and processes. The State offers educational information and fact sheets in both English and Spanish. When presenting educational events in Native American Chapter Houses and government tribal buildings, Native American translation services are made available. The MCO call lines also provide translation services as part of the call center. HSD will standardize informational materials and educational trainings to assist the States' efforts in disseminating consistent and accurate information to its beneficiaries.

These activities will not only assure consistent training and messaging for state staff but will then be offered to plans as well as to all participating agencies' staff within the ICSS.

**Staffing and Training:**

The ICSS will link together an array of Medicaid beneficiary advocacy and support entities in New Mexico into a system of consumer support. The ICSS is not a separately staffed entity. Rather it will be a system of organizations that provide standardized information to beneficiaries about Centennial Care, long term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process. HSD will not set staffing standards for ICSS entities with the exception of the Medicaid Call Center operated by Xerox, which has a set of service level agreements for the Medicaid Call Center.

**ICSS Data Collection and Reporting:**

HSD is assessing the data that is collected by entities like the ADRC, LTC Ombudsman and the Xerox call center to assist in developing the data collection and reporting requirements for the ICSS. The LTC Ombudsman program collects and reports data to the state pursuant to its charter and goals established under federal and state law. HSD Medical Assistance Division receives data from the Ombudsman on a quarterly basis. The ADRC maintains an extensive data base on the use of its services. This data includes beneficiary information, counseling notes, and

the reason for an inquiry. The system also includes a feature to set up an activity to conduct a follow-up call.

HSD will develop a streamlined tracking system that will inform the ICSS and support the reporting requirements to CMS. The data collected will include such things as the total numbers of beneficiaries assisted, the number of calls received, and the type of assistance requested, such as MCO choice counseling, how to file a grievance or appeal, how to access LTSS, etc. The state is sensitive to placing an undue burden on advocacy organizations, community partners and providers for data collection but recognizes the importance of tracking the volume and nature of beneficiary contacts and resolutions. HSD expects to create simple web-based reporting tools to assist organizations with less sophisticated or no data-collection systems.

**Summary Table: ICSS Components and Functions**

**This chart reflects how each component of the ICSS does and/or will function once the system is completely operational. Most of these functions are being performed today; the difference will be the organizational structure provided to link the new system together.**

| ICSS | HSD | ADRC * | LTC Ombudsman | Medicaid Call Center | AAAs & Senior Centers | CILs | Advocacy Groups |
|---|---|---|---|---|---|---|---|
| Training of ICSS Entities | • | • | | | | | |
| MCO Choice Counseling | • | • | • | | • | • | • |
| LTC Options Counseling | | • | | | • | • | • |
| Rights and Choices Counseling (*Benefits Counseling) | | • | • | | • | | • |
| Grievance and Appeals Guidance | • | • | • | | • | | • |
| Fair Hearings Guidance | • | • | • | | • | | • |
| Legal Services Referrals | | • | • | | | | • |
| ICSS Brochure Production | • | | | | | | |

| ICSS | HSD | ADRC * | LTC Ombudsman | Medicaid Call Center | AAAs & Senior Centers | CILs | Advocacy Groups |
|---|---|---|---|---|---|---|---|
| ICSS Brochure Distribution | • | • | • | • | • | • | • |
| ICSS Web Site Development and Operation | • | | | | | | |
| Data Collection | • | • | • | • | • | • | • |
| ICSS Advisory Team | • | • | • | | • | • | • |

**The MCOs will not be members of the ICSS advisory team. The ICSS will utilize MCO participation as a training and information resource that will support the ICSS entities. HSD will require the MCOs include information about the ICSS and the ADRC in their member handbooks and provide ICSS brochures during counseling so members are informed of resources available that are independent of the MCO.**

**ICSS Implementation Plan:**

HSD has developed an implementation work plan that includes the state goals and action steps planned for meeting the ICSS Core Elements requirements outlined in CMS STC-#56. This plan itemizes the specific tools and resources HSD will create and utilize in order to effectively establish the ICSS. The ICSS Implementation Plan is included as **Attachment A**.

**Summary**

The State is confident that the functions of the multiple state-supported programs available combined with other advocacy and community based resources in New Mexico, are more than sufficient to meet the choice counseling and advocacy needs of Medicaid beneficiaries, especially disabled beneficiaries living in the community. The key to maximizing all of the programs and resources is linking them under the umbrella of the ICSS in order to effectively support Medicaid beneficiaries. The State will be the organizing force in bringing together the many resources currently in place and developing the ICSS as a centralized system for Medicaid beneficiaries enrolled in Centennial Care and receiving long-term services and supports. HSD will utilize the data collection and reporting feature required under the ICSS Core Elements to inform the ICSS and whether it is meeting its intended purpose. The State will work to enhance the beneficiary understanding of the resources and processes available and ensure access to choice counseling and supports.

HSD will continue to work with our sister agencies and advocacy organizations to add structure to this system for the benefit of Centennial Care enrollees. We recognize that this approach has not been endorsed by two NM advocacy organizations. However, we believe a more 'grass-roots' effort that links and maximizes existing resources is preferable to a state-dictated and duplicative structure.

HSD convened an advisory team to assist in the on-going development and oversight of the ICSS. This team consists of state and local government agencies, a number of advocacy organizations and community organizations that work with Medicaid beneficiaries receiving long-term services and supports. The ICSS Advisory Team (IAT) is working to add consumer representative s to the team to allow for beneficiary input.

HSD views the advisory team as a key partner in establishing an ICSS and enhancing the on-going development of the system. The advisory team has already provided valuable input and feedback on the development of the ICSS itself. The IAT will also provide input on the website, brochures and other educational materials related to LTSS. The advisory team will also assist in efforts to expanding the ICSS to include additional organizations.

We will continue to engage and work with all entities that will be a part of this system. **HSD views this system as dynamic and seeks to link resources in a manner that can be easily modified or enhanced as necessary to respond to a changing environment.**

The State also wishes to note that the ICSS is only one piece of a much larger picture and that this plan and approach do not constitute the full array of the State's efforts to assure a smooth transition to Centennial Care and efforts to assure that every enrollee has access to and receives the services that will maximize their opportunity to live as healthy a life as possible in their homes and communities.

**Independent Consumer Support System (ICSS) Implementation Plan CY13-CY14**

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| ***Organizational Structure***. *The Independent Consumer Supports System shall operate independently from any Centennial Care MCO. Additionally, to the extent possible, the system shall also operate independently of the Medical Assistance Division of the Human Services Department. The organizational structure of the support system shall facilitate transparent and collaborative operation with beneficiaries, MCOs, and state government.* | 1. Create and maintain a system independent of Centennial Care MCOs and HSD Medical Assistance Division.<br><br>2. Facilitate transparency and collaboration. | -HSD's Office of the Secretary will oversee development, implementation and operation of the ICSS.<br>-HSD's Office of the Secretary will contract with an individual to organize and lead the ICSS effort.<br>-Contractor will organize internal working group for ICSS implementation<br><br>- HSD will form an ICSS advisory team to assist in ongoing development and oversight of the ICSS. | CY13 4th Q - CY14 2nd Q (now on-going)<br><br>Completed<br><br>Completed<br><br>Completed |
| ***Accessibility.*** *The services of the Independent Consumer Supports System are available to all Medicaid beneficiaries enrolled in Centennial Care receiving long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized* | 1. Create a system that is accessible to beneficiaries receiving long term services and supports through multiple entryways. | - HSD is creating an independent website and consulting with the ICSS advisory team for design and content feedback. Webpage information in the HSD Centennial Care website will include the following information:<br>1) List all applicable 800 numbers and its purpose; | CY14 1st Q – CY14 2nd Q |

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| *representatives through various means (mail, phone, in person), as appropriate.* | | 2) Provide links to ADRC counseling and referrals;<br>3) Post and create, where needed, educational materials related to Centennial Care;<br>4) Create and post an ICSS informational brochure;<br>5) Provide links to MCOs plans and post step-by-step grievance/appeals information;<br>6) Create and post HSD Fair Hearings fact sheet;<br>7) Provide links to relevant advocacy organizations and government agencies.<br>- Establish ICSS referral process for HSD's Medicaid call center;<br>- Establish ICSS referral process for HSD Income Support Division (ISD).<br>- Require each MCO to establish an ICSS referral process. | CY14 1st Q – CY14 2nd Q<br>CY14 1st Q – CY14 2nd Q<br>CY14 1st Q – CY14 2nd Q |
| ***Functions.*** *The Independent Consumer Supports system assists* | 1. Create a system that assists beneficiaries in | - HSD will provide an ICSS choice counseling brochure at | CY14 1st Q – CY14 2nd Q |

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| *beneficiaries to navigate and access covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity.*<br>*1. The system shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.*<br>*2. The system shall service as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.*<br>*3. The system shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.* | navigating and accessing covered health care services and supports.<br>2. Enhance the system to help consumers understand the fair hearing, grievance, and appeal rights process with the MCO and at the state level. | ISD offices where Medicaid applications are received and processed;<br>- HSD will include an ICSS brochure that includes information about the ADRC, LTC Ombudsman, AAAs and CILs in all correspondence to beneficiaries;<br>- HSD will include choice counseling information in Centennial Care educational outreach events and trainings;<br>- HSD will create a Centennial Care MCOs side by side comparison;<br>- ALTSD will assist HSD with the education of over 240 senior center providers including all 23 tribes throughout the state;<br>- HSD will require MCOs provide information to community-based members and members receiving a level of care assessment about long term services choices, the MCO grievance and appeals process, including independent resources the member can access for assistance; | CY14 1st Q – 2nd Q<br>CY14 1st Q – CY14 2nd Q<br>Completed<br>CY13 4th Q – CY14 2nd Q<br>CY14 1st Q – CY14 2nd Q |

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| *4. The system shall conduct trainings with Centennial Care MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.* | | - HSD will require MCOs educate providers about Centennial Care, the ICSS and provide ICSS brochure and website information.<br><br>- HSD will develop a fair hearings educational fact sheet;<br>- HSD will post information about the ADRC, LTC Ombudsman, the CILs and AAAs along with the grievance, appeals and fair hearings process on the ICSS, state's contractors and MCOs websites. | CY14 1st Q – 2nd Q<br><br>Completed<br><br>CY13 4th Q – CY14 2nd Q |
| ***Staffing and Training.*** *The Independent Consumer Supports system must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition,* | 1. Create a system that provides subject matter experts in Centennial Care, LTSS and grievance and appeals.<br><br>2. Ensure cultural competency and accessibility to individuals with limited English proficiency. | - HSD will provide regular training to the ADRC, LTC Ombudsman, CILs and AAAs on MCO choice counseling;<br>- HSD will provide on-going training in the grievance and appeals process and the state fair hearing process;<br>- HSD will train HSD call center staff on the ICSS system and referral process; | CY13 4th Q – CY14 2nd Q (on-going)<br><br>CY14 1st Q – CY14 2nd Q (on-going)<br><br>CY13 4th Q – CY14 1st Q |

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| *disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The system ultimately developed by the State may draw upon existing staff within the chosen organizational structure and provide substantive training to ensure core competencies and a consistent consumer experience.* | | - HSD will train ISD offices on the ICSS system and referral process;<br><br>- HSD will post English and Spanish translated educational materials and fact sheets;<br>- Individuals needing counseling services in Spanish will be provided appropriate referrals to agencies with Spanish speaking counselors. | CY13 4th Q – CY 14 2nd Q<br><br>CY13 4th Q – CY 14 2nd Q<br><br>CY 13 4th Q (on-going) |
| ***Data Collection and Reporting***. *The Independent Consumer Supports System shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.* | 1. Establish an ICSS tracking system to collect data and inform the effectiveness of the ICSS and its ability to service beneficiaries. | - Develop a streamlined tracking process for the ICSS and its partners;<br>-Set-up a tracking process for the HSD call center;<br>-Request quarterly data from the ADRC and LTC Ombudsman;<br>-Work with partnering advocacy and community organizations to collect data in a simplified manner and request quarterly reports;<br>-Drawing from the broad data collection required of | CY14 2nd Q<br><br>CY14 2nd Q<br><br>CY14 2nd Q<br><br>CY14 2nd Q<br><br>CY14 2nd Q |

| ICSS Core Elements | State Goals | State Tasks | Timeline CY13 4th Quarter (Q) - CY14 2nd Q |
|---|---|---|---|
| | | Centennial Care MCOs, request quarterly data from the MCO as it relates to beneficiary counseling and supports. | |