DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

January 17, 2025

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

Dear Director Flannery:

New Mexico submitted a draft of its Reentry Demonstration Initiative Implementation Plan (IP) on November 26, 2024, and an updated draft on January 17, 2025, in accordance with the special terms and conditions (STCs), specifically STC 9.10. The Centers for Medicare & Medicaid Services (CMS) is approving the IP as an attachment to the STCs for New Mexico's section 1115 demonstration project entitled, New Mexico Turquoise Care section 1115(a) demonstration (Project Number 11-W00285/6), effective through December 31, 2029. A copy of the approved attachment is enclosed and will also be incorporated into the STCs as Attachment K. This approval is conditioned upon compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project.

We look forward to our continued partnership on the New Mexico Turquoise Care section 1115(a) demonstration. If you have any questions, please contact your project officer, Sandra Phelps at Sandra.Phelps@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2025.01.17 13:26:30 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

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

Attachment K

Reentry Demonstration Initiative Implementation Plan
January 2025

Background

The implementation plan documents the state's approach to implementing a section 1115 Reentry demonstration and helps establish what information the state will report in its monitoring reports by describing whether and how the state will phase in implementation. The state must also submit a monitoring protocol that details its plans to conduct monitoring reporting. The implementation plan does not supersede or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments. For states covering the CAA population under the 1115 demonstration, the CAA-required operational protocol is satisfied by the reentry implementation plan only for the population and services in which there is an overlap.

The implementation plan outlines key information on the overall demonstration design, as well as actions related to the five milestones included in the State Medicaid Director Letter (SMDL) "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated"[1].

Reentry demonstration reporting topics
Implementation Settings
SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
SMDL Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community
SMDL Milestone 3: Promoting continuity of care
SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
SMDL Milestone 5: Ensuring cross-system collaboration
Reducing Health Disparities
Reinvestment plan
Consolidated Appropriations Act Population
Appendix: Implementation Phase-In Approach (if applicable)

[1] This SMDL (#23-003) is available in full here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

Implementation Settings

1. In the table below, report the total number of facilities anticipated for each facility type once the reentry demonstration is fully implemented. If the demonstration includes another facility type/s not listed in the table, add a column/s for the other facility type/s.
   - Does the state intend to phase in facilities? ☒ Yes ☐ No
     - ➢ If yes, provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented, and estimate the number of facilities to be phased-in by demonstration year (DY).
     - ➢ If no, only provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented.

	State Prisons	County/Local Jails	Youth Correctional Facilities
Total	10	25	6
DY 13	2–3*	0	2 CYFD facilities**
DY 14	7	10	1 (county correctional facility)
DY 15		15	3
DY 16			
DY 17			

*New Mexico Corrections Department (NMCD) facilities incarcerate post-adjudicated youth ages 18–21 and former foster care youth up to age 26; CAA section 5121 compliance anticipated 7/1/25.
**Two New Mexico Children, Youth and Families Department (CYFD) facilities handle most post-adjudicated youth and will ensure compliance with CAA section 5121 in 2025.

2. Describe the state's plan for determining that participating facilities are ready to provide pre-release services to eligible beneficiaries. The description should address how the facilities will facilitate access into the correctional facilities for community health care providers (either in person or via telehealth). *(The information being requested here aligns with information required under Milestone 5.)*

   HCA will first focus on planning, readiness, and successful implementation for state facilities, including the 10 state facilities that are overseen by NMCD and the two facilities overseen by CYFD, Juvenile Justice Services Division. Recognizing the differences among counties, including provider capacity, carceral health care contractors, health care provider access in rural areas, systems capacity, and the universal challenges associated with short stays and unknown release dates, HCA will take additional time to implement pre-release services in county jails. This implementation plan reflects HCA's focus on implementation through state facilities and acknowledges the work needed before county jails are implemented in DY 14–DY 15.

In collaboration with state partners, HCA will establish a readiness process to ensure facilities, carceral health care vendors, providers, and managed care organizations (MCOs) are ready to offer pre-release services under the Reentry 1115 demonstration initiative. This process will consider the phasing in of different facilities per the timeline in Milestone 1 Response #1, as well as the service level structure required to ensure facilities are providing the three minimum mandatory services in Service Level 1. The readiness process will assess at a minimum:

- Medicaid suspension and eligibility support.
- Provider enrollment and billing.
- Community provider and MCO Justice Liaison access to facilities.
- Minimum service readiness.
- Additional service (optional) readiness.
- Release date and reentry coordination.
- Staffing, monitoring, and reporting.
- Managed care reenrollment.

HCA will implement a flexible model to encourage facility participation in the implementation of pre-release services while also adhering to a supportive readiness approach that ensures facilities are able to provide services before go-live. This flexible approach to service implementation will allow facilities to offer, at minimum, the mandatory services. Facilities will be encouraged to offer the full scope of pre-release services over time and as state budgets allow, and the state will determine and communicate priority services. HCA and state partners are currently defining which services will be included in service levels 2 and 3, with service level detail to be defined for the readiness process. The readiness assessment process will include guidance pertaining to service level phase-in and corresponding readiness determination.

SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

3. Does the state currently suspend eligibility and benefits during incarceration? ☒ Yes ☐ No
   - If no, describe how the state will either effectuate a suspension strategy within two years from approval of the expenditure authority or implement an alternate plan that will ensure only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release.

4. Opportunity to enroll in Medicaid:
   ☒ The state attests that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR 435.906 and 435.908, and anticipates using the following methods described at 42 CFR 435.907 to ensure enrollment:
      ☒ Online application
      ☒ by telephone
      ☒ in person
      ☒ via mail
      ☒ common electronic means
   ☒ The state attests that all individuals who are incarcerated at a participating facility will be allowed to access and complete a Medicaid application and will be assisted in this process, including by providing information about where to complete the Medicaid application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

   ☒ The state attests that all individuals enrolled in Medicaid during their incarceration will be provided with a Medicaid and/or managed care plan card or some other Medicaid and/or managed care enrollment documentation upon release, along with information on how to use their coverage.

5. Describe any challenges not already described in the milestone 1 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Challenge #1: **Agreements and Capabilities for Information Exchange**

- Not all facilities have standing General Services Agreement (GSA) or Memorandum of Agreement (MOA) contracts that ensure necessary data is exchanged to support Medicaid eligibility and enrollment determinations. Processes and capabilities to support Medicaid applications vary across carceral facilities.
    - **Mitigation Strategy**: Subject to state budget availability, HCA will make Planning and Implementation (provider capacity building) funds available to support facilities with establishing GSA or MOA agreements and train carceral facility staff on program expectations and processes for information exchange.
    - **Mitigation Strategy:** State program staff will offer technical assistance to help carceral facilities consider best practices and implement appropriate processes. This support will be provided as state staff establish an MOA or GSA contract with each carceral facility.
    - **Estimated Timeline:** By end of calendar year (CY) 2026.

Challenge #2: **Short Stays and Unknown Release Dates**

- Incarceration length and release dates are not always known, especially in county jails. Currently there can be a 48–72-hour delay from the point an individual is suspended and re-enrolled back onto managed care at release. This delay can impede coverage between the point of release to the point managed care enrollment is effective, leaving individuals without coverage for a short, but critical, time period.
    - **Mitigation Strategy**: HCA will initiate reenrollment into managed care no less than 30 days prior to release. HCA will retrospectively reconcile MCO payment to the actual release date. The objective of this approach is to minimize gaps in coverage, and ensure members have access to full benefits and continuity of care as they transition back into the community upon release.
    - **Estimated Timeline:** At implementation of county facilities based on phase-in schedule.
- Jails and detention facilities largely serve individuals for short stays and may not have an identified release date. Approximately 75% of incarcerated individuals are released from county facilities within the first 30 days of incarceration. Approximately 90% of incarcerated individuals are released from county facilities in the first 60 days of incarceration. Most of these members do not have a known release date with enough advance notice to initiate effective pre-release services.
- These facilities report challenges regarding individuals with unknown release dates. Facilities are expected to cover services with the anticipation of Medicaid reimbursement for the period up to 90-days pre-release under the demonstration, but may not be able to bill for services without an appropriate policy to address retroactive reimbursement for services covered during the 90-days prior to release when a release date was not identified in advance.
    - **Mitigation Strategy:** HCA is planning to implement a suspension strategy in jails where only authorized pre-release services and Short-term Medicaid for Incarcerated Individuals will be available for up to 90 days in anticipation of short-term stays. Coverage will continue for up to 90 days from entry for individuals likely subject to a short-term stay but will be suspended once a later release date is known or if 90 days is exceeded. This strategy will help address challenges related to short term stays and unknown release dates, ensuring continuity of care for this disenfranchised population.
    - **Estimated Timeline**: At implementation of county facilities based on phase-in schedule.
- Individuals incarcerated for short stays or when the release date is unknown may not receive a Medicaid ID card upon release.
    - **Mitigation Strategy**: HCA will implement a process to have correctional facility staff verify Medicaid eligibility at booking and help current Medicaid members log into their Yes New Mexico account or MCO member services website to print their Member card. HCA will create educational materials to help members find their managed care enrollment information.

- **Estimated Timeline**: At implementation of state and county facilities based on phase-in schedule.

Challenge #3: **Expanding Capacity for Medicaid's Presumptive Eligibility Determiners (PEDs), including New Medicaid Support for the Role of Certified Peer Educators (CPEs)**

- Staffing and capacity to support PEDs varies across carceral facilities. In jails and prisons, PEDs do much of the work to help individuals apply for Medicaid programs anytime during their incarceration period. PEDs can also help the individuals apply for additional programs *at or following release* (i.e., SNAP benefits, cash assistance, energy assistance and or housing), as individuals cannot apply for SNAP or cash benefits during their incarceration period.
- During short term stays, an inmate may not have an opportunity to work with a PED prior to release and consequently misses the chance to apply for, or re-enroll in, Medicaid and other benefits. Outreach and education to this disenfranchised population can reduce unnecessary visits to HCA Income Support Division field offices to apply for Medicaid and other benefits.
    - **Mitigation Strategy:** HCA is exploring ways to expand the availability and role of PEDs in carceral facilities. The New Mexico Peer Education Program trains inmates as health promoters and encourages them to become CPEs while inside carceral facilities. HCA sees an opportunity to provide more robust training and materials to help peer educators provide Medicaid, SNAP, and TANF enrollment assistance during the pre-release period. Once carceral facilities are enrolled Medicaid providers they too can become certified PEDs and address the Medicaid enrollment needs of short-term inmates.
    - As we develop approaches to expanding PED availability, we will examine capacity support needs.

      Subject to state budget availability, HCA will use Planning and Implementation (provider capacity building) funds to provide Medicaid, community resource training and implementation support.
    - **Estimated Timeline:** At implementation of state and county facilities based on phase-in schedule.

Challenge #4: **Managed Care Enrollment**

- When incarcerated individuals apply for Medicaid during their suspension period and choose an MCO, an enrollment file is not automatically sent to alert the MCO of a new incarcerated member. This can result in delays in starting the transition of care process to provide the member with needed pre-release services.
    - **Mitigation Strategy:** HCA will update the system to automatically report enrollment notification to MCOs of a new member during their incarceration. Additionally, system and process updates will allow for member choice of MCO. Upon release,

members will have an opportunity to disenroll without cause. These policy changes will align with the suspension strategy outlined under Milestone 1, including reconciliation to account for pre-release coverage while ensuring capitation is reinstated prior to release.

- **Estimated Timeline**: By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

SMDL Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.

6. Describe how, within two years from approval of the expenditure authority, the state will effectuate a policy to identify Medicaid and CHIP eligible individuals, or individuals who would be eligible for CHIP, except for their incarceration status. Include in the description how the state will implement a screening process to identify individuals who qualify for pre-release services in line with the qualifying criteria outlined in the state's STCs. *(The information being requested here aligns with information required under Milestone 1.)*

   Except for limited benefit populations such as family planning and Emergency Services for Non-citizen, all Medicaid and CHIP eligible beneficiaries will be covered regardless of Medicaid condition. This means HCA will not implement a pre-release eligibility screening process. Facilities will identify individuals as eligible for pre-release services based on Medicaid category of eligibility and enrollment status or new eligibility determinations.

7. Minimum pre-release benefit package:

   ☒ The state attests that Medicaid-eligible individuals who are identified as demonstration participants will have access to the minimum short-term pre-release benefit package, which, at a minimum, includes the services listed below. (Provide the Medicaid benefit category or authority for each service in the space provided.)

   - Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN) (if applicable): Expenditure authority
   - Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: Medicaid State Plan, except coverage of methadone, which is optional based on facility capacity
   - 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: Medicaid State Plan, Prescription Drug Benefit (1905(a))(12), 42 CFR 440.120(a), and 42 CFR 441.25)

8. Additional pre-release services:
   - Does the state intend that Medicaid-eligible individuals who are identified as demonstration participants will have access to any pre-release services that are in addition to the minimum benefit services addressed in question 7? ☒ Yes ☐ No
     - ➢ If yes, list the additional pre-release services in the table below, along with the Medicaid benefit category or authority for each service:

Pre-release service	Medicaid Benefit Category or Authority
All optional pre-release services are subject to state budget availability and facility readiness	
Physical and Behavioral Health Clinical Consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support prerelease case managers' development of a post-release treatment plan and discharge planning.	As defined in the State Plan, primarily: • Case management • Primary care case management • Other diagnostic, screening, preventive, and rehabilitative services (1905(a)(13), 42 CFR 440.130) • Physician Services (1905(a)(5), 42 CFR 440.50) • Pharmacy Services • Laboratory and X-Ray Services • Clinic Services (1905(a)(9), 42 CFR 440.90) As defined in the State Plan, excluding: • Inpatient services • Rural health clinic services • Federally Qualified Health Clinics • Nursing facility services • Midwifery services • Home health services • Dental services • Vision services • Any other State Plan service that is not appropriate to provide in a carceral setting For the purpose of CAA section 5121 alignment, clinical consultation services will include necessary Early and Periodic Screening, Diagnostic and Treatment screenings for individuals under age 21.

Diagnostic services, including Laboratory and radiology services	State Plan – Other diagnostic, screening, preventive, and rehabilitative services (1905(a)(13), 42 CFR 440.130)
Medications and medication administration during the pre-release period	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Medical equipment and supplies provided upon release	State Plan – Medical Equipment and Supplies 1905(a)(7), 42 CFR 440.70(b)(3)
Family planning and supplies	State Plan – Family planning services (1905(a)(4)(C), 42 CFR 441.20)
Services provided by Community Health Workers	State Plan – Preventive Service (42 CFR 440.60)
Certified Peer Support Services and Family Peer Support Services	State Plan – SPA approval 23-0006
Treatment for Hepatitis C Virus (HCV), including dispensing and administering medications	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)

➢ If no, skip down to question 9.

- If yes, does the state intend to phase-in the additional pre-release services? ☒ Yes ☐ No
  ➢ If yes, complete the information in the Appendix A table template regarding participating facilities' Service Level selections and implementation timelines.

9. Describe any challenges not already described in the milestone 2 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Challenge #1: **County and Facility Variation**

- County facilities have varying degrees of capabilities and infrastructure, including different contracts with different health care vendors. One challenge identified by numerous facilities and stakeholders is the ability to provide the 30-day supply of medications in-hand upon release in jails. Facilities have noted this is a priority to avoid disruptions in medication adherence and management, but it remains a significant gap due to the lack of capacity to dispense medications on-site. Many facilities are only able to provide a prescription in-hand or sent to a local pharmacy upon release. This is potentially the greatest implementation challenge with the mandatory benefit package.
  - **Mitigation Strategy**: HCA will work with counties to establish new processes for providing medications upon release, including issuing guidance and best practices to support readiness as facilities establish on-site pharmacies or alternative models in partnership with community-based pharmacies. After additional discussions

with facilities, HCA may determine a statewide approach is necessary to provide these medications or allow individual facilities or agencies to determine what works best for their facilities. For example, an on-site pharmacy may be a better solution for a facility with a larger number of inmates. Subject to state budget availability, HCA will prioritize this area for Planning and Implementation (provider capacity building) funding.

    - **Estimated Timeline**: By end of CY 2025, to enable planning and readiness for the implementation of the first county facilities in 2026.

- County facilities and health care vendors also have varying degrees of capacity and readiness to implement the full scope of pre-release services authorized under this demonstration. The state seeks to mitigate capacity challenges and promote consistent implementation of the mandatory benefits (at a minimum).
    - **Mitigation Strategy:** The state will not require implementation of required service levels beyond the mandatory benefits. The mandatory benefits will represent the first and only required service level. Beyond the mandatory services, HCA is in the process of determining which optional services will be included in service levels 2 and 3. Readiness assessments will be conducted as outlined in Appendix A and will account for
facility-specific service levels and phase-in plans.
    - **Estimated Timeline**: By July 1, 2025 for state facilities, at implementation of county facilities based on phase-in schedule.

Challenge #2: Pre-Release Service Refusal

- Individuals may refuse services, even when they are needed. Facilities will be unable to provide the mandatory and optional services necessary to support successful transitions if an individual refuses services.
    - **Mitigation Strategy**: HCA will work on member educational materials and engagement to promote participation for this population, including peer support workers, pre-release case management, and transition planning resources. In the event an individual refuses one or more services, the refusal will be documented to note that services were offered, and the lack of service delivery was due to individual refusal.

SMDL Milestone 3: Promoting continuity of care.

10. Person-centered care plan:
    - Describe the state's plan to ensure that, prior to release, individuals who are incarcerated will receive a person-centered care plan that addresses any physical and behavioral health needs, as well as HRSN (if applicable) and consideration for Long Term Services and Supports (LTSS) needs that should be coordinated post release. Include any existing requirements related to care plan content for reentering individuals.

Over the life of the 1115 waiver, HCA intends to develop a network of community providers who are engaged to provide in-reach pre-release services, coordinate with the carceral health providers, coordinate transitions with MCO Justice Liaisons and support the member through a post-release community transition.

Initially, HCA will build upon the current JUST Health program in order to strengthen the pre-release process and ensure every individual exiting incarceration has a Transition of Care (TOC) assessment and plan to establish appointments, referrals, 30 days of medications in hand as well as future pharmacy access for refills, transportation, social needs and continuity of care. The JUST Health program also strengthens MCO contract requirements regarding after-hour transitions to address spontaneous or unplanned discharge from custody/detention, and this language would be reviewed and revised to ensure more robust documentation to ensure smoother transitions for individuals entering the community.

The JUST Health liaison will continue to act as a single point of contact to connect the MCOs to members transitioning from incarceration, and further clarify their role to focus on administrative and
coverage-related tasks to ensure a smooth transition. This includes pre-authorization for services, ensuring network provider lists are accurate, supporting members in accessing appropriate value-added benefits, and other supportive tasks. HCA will explore an outcomes-based arrangement with MCOs to reinforce the TOC expectations and promote pre-release planning and coordination of needed HRSN services and health care access immediately post-release.

In later phases of implementation, or earlier if state budget allows for coverage of optional services, community providers will be engaged to provide in-reach services, establish provider relationships with members who will require physical and behavioral health services post-release, and help members prepare for reentry. This involvement could be related to assessment or service provision in physical health, behavioral health, HRSN services, or LTSS services as well as care coordination. Additionally, NMCD may explore options to incorporate more social workers or similar licensed providers as NMCD staff. This professional staff augmentation would allow for coordinated care through interdisciplinary care planning and coordination to ensure appropriate support and processes for reentry.

Fee-for-service (FFS) supports will be designed through ongoing Tribe, Nation, and Pueblo engagement and consultation to inform interest in participation and parameters for service delivery, including appropriate models for TOC assessment and planning.

Evaluation criteria to track and trend health outcomes for justice-involved individuals who are actively participating in care coordination will be expanded to better understand how services are working and determine areas for improvement.

Person centered care plans will align with the Targeted Case Management requirements in Section 5121 of the CAA for eligible juveniles.

11. Case manager process and policies:
    ☒ The state attests to having processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

    ☒ The state attests to having processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar. *(This attestation additionally aligns with requirements under Milestone 2.)*

    ☒ The state attests to having policies to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community. *(This attestation additionally aligns with requirements under Milestone 4.)*

12. Describe the state's policies to provide or to facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the person-centered care plan. The description should include how the policies will account for access across all implementation settings and for individuals with short-term sentences.

    New Mexico carceral facilities will provide 30 days of medication in hand upon release, as is required per the three minimum services provided through the demonstration. Through the TOC process and pre-release care coordination services, justice-involved individuals are prioritized for post release care coordination through the MCOs (which may include community health workers, peer supports, and other MCO network providers in addition to MCO staff).

    The care management process described above will also be put in place to ensure appropriate assessment and connection to services upon release. Wherever possible, continuity of care will be prioritized to ensure smooth transition and warm handoffs. Minimum standards will be developed for pre-release appointments, orders, and timeframes for follow-up post-release.

As the demonstration is implemented, HCA will ensure the TOC form is updated to encompass the federal definition of targeted case management (for CAA section 5121 juveniles) as well as including new criteria for processes to be developed and implemented under the 1115 demonstration.

Additionally, HCA and other state agencies will develop processes to ensure warm hand offs are taking place in the community upon release, and as community providers begin to participate in the in-reach process (e.g., coming into the facility up to 90 days pre-release to make connections with individuals to prepare for their exit, or connecting with individuals via telehealth if physical presence of these community providers is not an option), these connections will become more robust. HCA, in partnership with carceral facilities, will focus on the development of local networks of community providers that offer physical health, behavioral health, and social needs supports for individuals entering into the community. MCO participation will also be crucial to ensure these networks can be appropriately compensated and are adequate to provide community-based services.

HCA will develop a set of minimum requirements for pre-and post-release care coordinators to ensure information is appropriately shared with the individuals, follow-up care is scheduled and not just referred, and that a hand-off meeting between the pre-and post-release care coordinator (if different) takes place before or upon release.

13. If the state is implementing the demonstration through managed care, please attest to the item below. If not, skip down to question 14.
    ☒ The state attests that the managed care plan contracts reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

14. Describe any challenges not already described in the milestone 3 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Challenge #1: Short Stays and Unknown Release Dates

- It is challenging to develop a TOC plan for individuals incarcerated in county facilities who serve short-term stays without known release dates. Warm hand-offs may be difficult when an individual is released earlier than expected or during very short stays.
    - **Mitigation Strategy:** As described in Milestone 1, individuals in jails serving shorter term stays without a known release date will have pre-release services available upon the start of their incarceration, under the assumption that they will be released within 90 days. For individuals in county facilities, HCA will align

the TOC process to begin as soon as possible upon incarceration, so individuals can be involved early on in the process of determining their clinical and social needs upon exit. Here telehealth may also be used for the care coordination if it is not possible to arrange in-person appointments in a short amount of time.

Additionally, the readiness process for these facilities will be developed to ensure there is a process for tracking and assessing individuals while they are incarcerated and ensuring they receive appropriate services either within the facility or after release.

- **Estimated Timeline:** At implementation of county facilities based on phase-in schedule.

Challenge #2: Pre-Release Provider Network Capacity

- Based on stakeholder feedback, HCA anticipates potential challenges to implementing a uniform plan for community providers to provide in-reach services to individuals prior to release and determining the most appropriate role for these providers in developing the TOC plan.
  - **Mitigation Strategy:** HCA will work to engage community providers ahead of implementation, to help them determine the best role in this process, including how they will interface with carceral facilities and managed care plans.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.
- Based on experience, HCA acknowledges that community providers and MCO staff may also face challenges obtaining access to enter facilities to provide in-reach services due to facility security constraints.
  - **Mitigation Strategy:** Facilities will be encouraged to develop processes to allow in-reach services by community providers in a safe manner, including processes for appropriate security clearance, leveraging telehealth where possible, and using capacity building funds to invest in additional planning and process development. MOUs may also need to be developed so agreed-upon processes are in place to support both carceral facilities and providers in this arrangement and resolve any disputes.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #3: Pre-Release Services Awareness Among Incarcerated Individuals

- While peer educators already provide services in carceral facilities, they may not all have broad Medicaid application and enrollment knowledge, nor be able to help suspended members navigate the Medicaid delivery system.
  - **Mitigation Strategy:** Provide training opportunities and materials for peers and other supports already present in jails and prisons to teach suspended members how to navigate the Medicaid system.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #4: Information Exchange

- System upgrades and new ways of collaborating will be required across state, carceral, and managed care systems to ensure information is being shared appropriately across entities.
  - **Mitigation Strategy:** Clearly stipulate requirements in MCO contracts and Policy manuals for information sharing processes that promote continuity of care between MCOs and HCA, as well as other entities participating in the reentry transition process.
- Individual SUD information must be protected in accordance with 42 CFR Part 2. Information must be appropriately transferred across entities with proper consent documentation. This may present barriers to these enhancements in MCO accountability for health information exchange.
  - **Mitigation Strategy:** HCA and state partners will ensure updates to contract and policy language and HIPAA training materials stipulate guardrails for appropriate confidentiality of SUD information in alignment with 42 CFR part 2, while also including any best practices for sharing information appropriately and not encumbering an individual's continuity of care.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #5: Standardized Screening, Referral and Warm Hand-Off to Community Providers

- HCA and state partners recognize the need to develop a uniform or aligned process to ensure appropriate screening, referral, and warm hand-off to community providers upon release. Currently, this can be difficult given the state of individual facility referral patterns and local processes.
  - **Mitigation Strategy:** HCA will develop a standardized process for warm hand-offs into the community. To ensure resources are up-to-date and taking full advantage of available referrals, HCA will use current New Mexico Department of Health directories (NMHealth) at pathwaysnm.org, NMHealth helpline for warm hand-offs, Dose of Reality webpage listings of community MOUD providers, HIV/STI/HCV

services listed on NMHIVGuide.org, trainings and technical assistance to county health councils, and Bamboo Health for closed-loop referral (phasing in the new statewide closed-loop system, Find Help, once implemented) and, for managed care members, care coordination from MCO justice liaisons. HCA will also explore facility enrollment in the Synchronys Health Information Exchange and Find Help, the new statewide closed loop referral system in development.

Additionally, HCA will ensure that local variation is permitted to continue, for example where there is a supportive program or referral that is not included in other directories. Telehealth will also be leveraged if a community has less options for in-person supports.

- **Estimated Timeline**: By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #6: MCO Training and Support

- HCA recognizes that MCO Justice Liaisons will need additional training regarding the pre-release services, the providers of those services, and the warm handoff transition to MCO enrollment upon release.
  - **Mitigation Strategy:** HCA will provide training, technical assistance, and monitoring mechanisms to MCO Justice Liaisons and facilities to educate them about pre-release service needs and the transition process between carceral providers and MCOs upon release. Additional MCO justice liaison reporting requirements will be added to align with the pre-release service activities and support the seamless transition to care outside of the carceral facility.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.
- While Turquoise Care MCOs are currently required to reach out to justice-involved members and complete a TOC assessment and plan, recovery from the Public Health Emergency and lifting of carceral visiting restrictions, and variations in approaches, timeframes, and facility participation have created inconsistencies across carceral settings.
  - **Mitigation Strategy:** Leveraging CAA grant funds or capacity building funds, HCA will provide greater administrative oversight, justice liaison training and support, updated MCO contract and reporting requirements, and coordination to support and improve the process. With additional capacity and infrastructure funding, facilities may also be able to provide greater administrative oversight.
  - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

15. Describe the state's plan for monitoring that contact between the reentering individuals and the case managers occurs within an appropriate timeframe. Include in the description the state's plan for ensuring ongoing case management.

    New Mexico will develop a monitoring process that leverages current technology tools (e.g., Find Help, the upcoming statewide Closed Loop Referral system, and Synchronys Health Information Exchange) in order to support reentering individuals. After release, MCOs are required to ensure member care follows minimum standards for pre-release appointments, orders, and timeframes for follow-up. MCO justice liaisons are currently required to follow the TOC process according to their contract. Additional monitoring requirements will also be developed.

    HCA will develop a plan for post-release care coordination and ongoing case management that leverages community providers to conduct these services and adhere to the minimum standards described above.

    Estimated Timeline: HCA will pilot an approach to monitoring the effectiveness of pre-release care coordination through community transition, beginning in July 2025 with the implementation of the first state facilities. The approach will be refined as additional state and county facilities are implemented.

16. Describe any challenges not already described in the milestone 4 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Challenge #1: Short Stays and Unknown Release Dates

- Individuals serving short term stays and those without known release dates have historically been difficult to reach post-release.
    - **Mitigation Strategy:** HCA will provide operational guidance to facilities, MCOs, and providers on how to support transitions in different situations, including short term stays.
    - **Estimated Timeline:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #2*:* Information Exchange

- Currently, information exchange between carceral systems and health systems (MCOs and providers) is limited. Focused efforts will be important to ensure adequate information exchange between these entities so that MCOs and providers have access to carceral health information, as well as additional information needed to ensure coordinated care in the community upon release.

  - **Mitigation Strategy:** HCA will develop operational processes and best practices to ensure all parties have access to accurate information to support individuals after release. Because system upgrades and investments will be needed to facilitate information exchange and ongoing monitoring, this area will be prioritized for capacity building funds.
  - **Estimated Timelines:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #3: Post-Release Member Contact

- Providers or MCO representatives who perform care coordination functions after release may have difficulty contacting individuals because they lack reliable means of communicating (e.g., a cell phone or reliable internet connection) or are unstably housed.
  - **Mitigation Strategy:** Pre-release care coordination will include thorough documentation of an individual's contact information and any additional contact information for people in their support network. The NMCD Probation and Parole division (for adults) and CYFD (for youth) can also help to facilitate a connection to the individual upon release for the purpose of continuity of care and monitoring.
  - **Estimated Timelines:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #4: Post-Release Provider Network Capacity

- It will be challenging to develop adequate provider resources in rural communities, particularly for medication management and behavioral health resources, in order to connect to services that meet the needs of the reentering population.
  - **Mitigation Strategy:** HCA will look to MCOs and other nontraditional providers (e.g., new Certified Community Behavioral Health Clinics) to provide support in rural areas where resources are more sparse.
  - **Estimated Timelines:** By July 1, 2025 for state facilities; at implementation of county facilities based on phase-in schedule.
- In some regions of the state, there may not be enough provider capacity or programs to meet the HRSN of individuals exiting incarceration.
  - **Mitigation Strategy:** HCA will enhance state monitoring systems and processes to better understand the care needs and referral patterns of individuals after release. New information learned from these systems and processes can provide gap analysis to see where process and system improvements can be made.

Through monitoring systems and processes, HCA will gather information about where social care and LTSS gaps exist and work with MCOs and community partners to bolster local networks. HCA can also look to recent 1115 waiver renewal programs (for example, the expanded Linkages Housing Program) to make connections for individuals exiting incarceration.

- **Estimated Timelines:** Through the term of the approved Turquoise Care 1115 Waiver.

Challenge #5: The Need to Develop a Robust and Effective Monitoring Processes

- This monitoring process needs to be built in order to support the level of change this demonstration will require. Not only do state systems need to be developed, but managed care contracts, provider agreements, and policy manuals also need to be updated.
    - **Mitigation Strategy:** As described in Milestone 5, HCA will need to engage all departments within the agency to ensure cross-functional alignment for system changes, contract revisions, and other documentation that needs to occur.
    - **Estimated Timelines:** Through the first two to three years of the approved Turquoise Care 1115 waiver.

SMDL Milestone 5: Ensuring cross-system collaboration.

17. Describe the system/s the state Medicaid agency and participating facilities will employ (for example, a data exchange, with requisite data-sharing agreements) to allow the state Medicaid agency to monitor individuals' access to and receipt of needed health care and HRSN (if applicable), both pre- and post-release. Include in the description any anticipated data challenges and potential solutions, as well as details of the data-sharing agreements.

    HCA will develop a monitoring protocol to map out what, where, and how data will need to be exchanged and transferred, and whether the current systems support these future needs. Capacity building funds may be used to invest in facilities who need additional infrastructure to be able to participate effectively in sharing data and executing necessary agreements to share and protect health information and other data. Once implemented, Find Help, New Mexico's Closed Loop Referral system, will be leveraged to support individual monitoring and ensure health and social needs of individuals are met.

18. Engagement of key entities:
    - Specify the types of key entities (e.g., correctional systems, community supervision entities, health care providers, managed care organizations, supported employment and supported housing agencies, etc.) the state intends to include in existing and future engagement for this demonstration.

HCA began the coordination process across key entities in September 2024 by establishing the Justice Involved Core Workgroup (JI Core Group) with representation from HCA, CYFD, NMCD, Department of Health, county representatives, and carceral health vendors as appropriate. Additional connections to key implementation partners will continue to be developed, including with managed care entities, providers, and other health and advocacy organizations.

As mentioned under Milestone 3, the state will conduct ongoing Tribe, Nation, and Pueblo engagement and consultation to inform participation and service delivery for FFS members.

- Describe the plan for the organizational level engagement, coordination, and communication between the state and the entities listed above.

  The JI Core Group has begun to design the 1115 demonstration project and will continue to develop the facility readiness process. Additionally, this group will ensure cross agency and cross departmental collaboration and issues resolution across systems. Additional communication pathways will be developed with broader stakeholder groups who do not currently participate in the JI Core Group.

19. Describe the state's strategies for improving awareness about, and providing education on, Medicaid coverage and health care access among various stakeholders (e.g., individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, etc.).

    HCA will continue to provide education and stakeholder engagement on Medicaid coverage and health care access for justice-involved populations, as well as populations who are at risk of becoming justice involved. Multiple modes of stakeholder engagement will be used, including quarterly public forums; frequent agenda items for the Medicaid Advisory Committee and
    to-be-developed Beneficiary Advisory Council; dedicated webpages, webinars and presentations; and ongoing support and technical assistance to carceral facilities and their stakeholders to ensure smooth implementation and ongoing program operations. These methods will serve as important feedback tools to help HCA work to continuously improve services for justice-involved members.
    Additionally, HCA will work with MCOs and community providers to make educational materials available to members and ensure partners understand the program, its requirements, and benefits.

20. Describe any challenges not already described in the milestone 5 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

Challenge #1: Trust-Building

- HCA and our state partners recognize the need to build trust between facilities and the incarcerated population to increase engagement in services offered.
    - **Mitigation Strategy:** In order to build trust and increase service utilization, HCA will work with state partners to create robust roles for peers, community health workers, and other trusted partners to provide services during the in-reach period as well as in the community upon release. Ongoing conversations with stakeholders, including people with lived experience in incarceration settings will also be needed to understand how to improve the program once implementation begins.
    - **Estimated Timeline:** Over the Turquoise Care waiver approval period.

Challenge #2: Developing the Readiness Review Tools and Process

- Development and implementation of the readiness process will be complex and require staff time and other resources necessary to be successful. Readiness review will include facility site visits, development and distribution of training and educational materials, and Medicaid billing training, and ongoing communications to ensure the facilities are ready to provide pre-release services.
    - **Mitigation Strategy:** The successful HCA Turquoise Care readiness process that took place in early 2024 will be used as a template for the readiness process for reentry services. HCA is also pursuing CAA grant funding to assist with readiness reviews.
    - **Estimated Timeline:** By early 2025, in anticipation of July 1, 2025 implementation.

Challenge #3: Billing and Information Systems

- State carceral systems have neither the staff capacity nor knowledge to bill Medicaid for pre-release services.
    - **Mitigation Strategy:** Use the JI Core Group to make decisions and map out processes to ensure Medicaid can be billed appropriately for services delivered under the 1115 reentry demonstration program. Additionally, HCA will develop a process for the release of capacity building funds to help facilities invest in the tools, systems, and staff needed to bill Medicaid and become Medicaid providers where appropriate.
    - **Estimated Timeline:** By July 1, 2026 for state facilities; at implementation of county facilities based on phase-in schedule.
- Implementation of this demonstration will be complex and include many entities and stakeholders who may not have access to real-time information.

- **Mitigation Strategy:** HCA will consider subcommittees or other groups connected to the JI Core Group to support information dissemination from the core group to implementation partners across the state.

- The automated data exchanged between CYFD and HCA will need to be upgraded and enhanced to re-established primary data sets for the 1115 re-entry JI initiative and CAA requirements.
  - **Mitigation Strategy:** Determine where system upgrades are necessary to support the Justice-Involved demonstration program, as well as the Medicaid program as a whole, and prioritize these upgrades as budgets allow.
- It may be difficult to find common performance measures and definitions that can be used across systems.
  - **Mitigation Strategy:** HCA will consider developing sub workgroups to help with planning for these more technical process flows and opportunities for sharing information in a way that can be used and understood across systems.
  - **Estimated Timeline**: By July 1, 2026 for state facilities; at implementation of county facilities based on phase-in schedule.

Challenge #4: State Budget Funding

- Funding positions for implementation and long-term monitoring and engagement for this program may be difficult.
  - **Mitigation Strategy:** Maximize funding opportunities and keep the legislature involved with ongoing and emerging needs, especially longer term. HCA will also look for federal, state, or local grants and additional 1115 funding where available.

Reducing Health Disparities

21. Describe the state's strategies to drive positive changes in health care quality for all beneficiaries through the reentry demonstration, thereby reducing health disparities, and address how the strategies will be integrated and how the state will meaningfully involve the population of focus into the demonstration implementation and the approach for monitoring and evaluation.

    A foundational element of Turquoise Care is the third of three overarching goals: *"Identify groups that have been historically or intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives."*

    Justice-involved individuals were one of five populations selected as target populations for Turquoise Care to support this goal, given their experiences with societal inequities, disproportionately high demand for health supports and services, and disparities they have experienced within the state of New Mexico. New Mexico has an incarceration rate of 733 per 100,000 people, exceeding the national average of 664 per 100,000 people. Additionally, New Mexico's justice-involved population is made up of a disproportionately higher percentage of people of color relative to the general population, whereas white individuals are comparatively underrepresented.

The reentry demonstration proposal, submitted as part of the Turquoise Care package, laid out the strategies that the state is currently working to develop and implement since initiative approval. These strategies are consistent with the milestones laid out in the federal requirements of this initiative and will be implemented through the key activities detailed in this implementation plan.

New Mexico plans to involve people with lived experience in the implementation of this demonstration. In the early phases of implementation, peer educators with lived experience will have a role in helping incarcerated individuals apply for coverage and navigate the benefits they are entitled to. These peer educators will undergo Medicaid system training which will position them to speak to improvements that can be made as services are delivered and key demonstration strategies are implemented. Once preliminary implementation and phase-in is complete, HCA will use key forums and stakeholder group meetings to gather feedback on how ongoing service provision is going, and what improvements can be made to support better utilization of services and better health outcomes upon exit from incarceration. HCA will also consider developing an advisory group of people with lived experience in the criminal justice system to inform ongoing program operations.

HCA will detail additional monitoring and evaluation information in the forthcoming Monitoring Protocol. Additionally, a draft evaluation design will be submitted to CMS by January 21, 2025. Systems and processes at the state level that provide ongoing monitoring of individuals being served by the justice-involved reentry demonstration, as well as reports on service utilization and care gaps are yet to be developed, but will be important system upgrades to track and monitor who is incarcerated, whether they are eligible for Medicaid, when they are eligible for reentry services under the demonstration, and whether they are receiving needed services.

Reinvestment Plan

22. Describe the state's plan for reinvesting the total amount of federal matching funds received under the demonstration for any existing carceral health care services that are currently funded with state and/or local dollars. If the state already submitted this plan separately, please indicate this below.

HCA is currently developing a Reinvestment Plan that details how the state will reinvest the federal funds for existing services now covered with state and local funding into activities that will increase access to or improve the quality of health care services as well as address the health-related social needs of individuals who are incarcerated, released, or who may be at a higher risk of criminal justice involvement — particularly due to untreated behavioral health conditions. HCA is assessing the current state of services provided in carceral settings, to determine what is new and existing for the Reinvestment Plan. Refer to Attachment L of the Turquoise Care 1115 STCs, which will be submitted to CMS by January 25, 2025.

Consolidated Appropriations Act Population

23. ☒ The state attests to complying with all requirements outlined in section 5121 of the CAA by including the population in the section 1115 demonstration.

    - If the state plans to partially cover the required population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here:

24. ☒ The state attests to covering all or a portion of the optional CAA population outlined in section 5122 of the CAA by including the population in the section 1115 demonstration.
    - If the state plans to partially cover the optional population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here: New Mexico is exploring state budget availability to cover the optional section 5122 population. If determined possible to cover this group, we attest to covering all of the optional section 5122 population in the Turquoise Care demonstration.

Appendix A: Reentry Implementation Phase-in Approach Template

If a state is intending to phase-in additional pre-release services, provide the information below regarding the services in each Service Level, the number of facilities anticipated to provide each Service Level, the associated timeline for implementation, and any challenges and/or barriers that facilities may experience in providing a service/s or Service Level/s.

Service Level Description

1. In Table 1 below, provide the services included in each Service Level. Add more rows as necessary.

Table 1: Services in each service level.

Service Level	Services included in the Service Level
1 (Minimum benefit package)	• Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN): Medicaid benefit/category • Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: Medicaid benefit/category • 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: Medicaid benefit/category
2 and 3 (Additional services as defined by facilities and subject to state budget availability)	• Refer to STC 9.9d. Facilities will be encouraged to offer the full scope of pre-release services. In order for a facility to move beyond Service Level 1, a facility must meet readiness according to HCA standards for services included in a second or third service level from the approved list of optional services.

2. Describe any anticipated challenges and/or barriers experienced by state prisons in providing a service/s or service level/s.

   Anticipated challenges for state prisons include:

   - Transitioning to Medicaid billing from the current per diem billing arrangement between NMCD and its carceral health care vendor.
   - Developing a network of community-based case management (care coordination) providers who can come into state prisons and facilitate effective transitions through pre-and post-release services. This role does not exist today within the NMCD state prison system and will need to be coordinated with the MCO Justice Liaisons.

- Developing an effective team, comprised of prison health care staff, community health care providers, and MCOs to ensure incarcerated individuals receive needed care without duplication or gaps.
- Sharing electronic health records between correctional facility providers and community providers.

Service Level Information by Facility Type

3. In Table 2 below, provide the requested information regarding the number of facilities anticipated to provide each service level, by facility type and demonstration year. Indicate the demonstration year (DY) for implementation, as well as the DYs following implementation, in the table, adding service level columns and types of facility rows as needed.

4. Describe any anticipated challenges and/or barriers experienced by facilities in providing a service/s or service level/s.

   State and county facilities and health care vendors have varying degrees of capacity and readiness to implement the full scope of pre-release services authorized under this demonstration. The state seeks to mitigate capacity challenges and promote consistent implementation of the mandatory benefits (at a minimum). Beyond the mandatory services, HCA is in the process of determining which optional services will be included in service levels 2 and 3. Readiness assessments will be conducted and will account for facility-specific service levels and phase-in plans.

Table 2: By service level, total number of facilities, number of facilities anticipated to offer service level/s at implementation, and number of facilities anticipated to implement service level/s by DY.

		Service Level 1 (Minimum Benefit Package)	Service Level 2	Service Level 3	Service Level 4
State Prisons	Planned number of facilities offering each service level	*10*			
	Number of facilities anticipated to offer service level at implementation (during DY13)	2–3			
	Number of facilities anticipated to implement service level, by DY				
	DY13	2–3	Upon Readiness*	Upon Readiness*	*N/A*
	DY14	7–8	Upon Readiness*	Upon Readiness*	*N/A*
	DY15	0	Upon Readiness*	Upon Readiness*	*N/A*
	DY16	0	Upon Readiness*	Upon Readiness*	*N/A*
County/Local Jails	Planned number of facilities offering each service level	25			
	Number of facilities anticipated to offer service level at implementation	10	Upon Readiness*	Upon Readiness*	*N/A*
	Number of facilities anticipated to implement service level, by DY				
	DY13	-	-	-	-

		Service Level 1 (Minimum Benefit Package)	Service Level 2	Service Level 3	Service Level 4
	DY14	10	Upon Readiness*	Upon Readiness*	*N/A*
	DY15	15	Upon Readiness*	Upon Readiness*	*N/A*
	DY16		Upon Readiness*	Upon Readiness*	*N/A*
Youth Correctional Facilities	Planned number of facilities offering each service level	6			
	Number of facilities anticipated to offer service level at implementation	2			
	Number of facilities anticipated to implement service level, by DY				
	DY13	2	Upon Readiness*	Upon Readiness*	*N/A*
	DY14	1	Upon Readiness*	Upon Readiness*	*N/A*
	DY15	3	Upon Readiness*	Upon Readiness*	*N/A*
	DY16	-	-	-	-

* Beyond the mandatory services, HCA is in the process of determining which optional services will be included in service levels 2 and 3. Readiness assessments will be conducted and will account for facility-specific service levels and phase-in plans.