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

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

September 25, 2026

Alanna Dancis, DNP, CNP, RN
Acting Medicaid Director
New Mexico Health Care Authority
P.O. Box 2348
Santa Fe, NM 87504-2348

Dear Acting Director Dancis:

The Centers for Medicare & Medicaid Services (CMS) is making a conforming change to align with recent changes to Medicaid and Children's Health Insurance Program (CHIP) statutes and related regulation and policy for New Mexico's "Turquoise Care" section 1115 demonstration, (Project Number 11-W-00285/6).

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related changes will affect this demonstration. Therefore, in this action, CMS is making a conforming change to the Turquoise Care section 1115 demonstration during this demonstration period.

Specifically in this action:

- We are changing the demonstration special terms and conditions (STCs) to conform with section 1903(v)(5) of the Act (added by section 71109 of the WFTC legislation) and guidance related to this section of the Act; this change is effective October 1, 2026, through December 31, 2029.

Unless renewed or amended, all authorities granted to operate this demonstration will expire on December 31, 2029.

The conforming change to the STCs is authorized under STC 3.3, titled "Changes in Medicaid and CHIP Law, Regulation, and Policy," which provides that the state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in law, regulation, or policy affecting the Medicaid program that occur during the demonstration approval period. Under STC 3.3, CMS may amend the STCs to reflect such changes without requiring the state to submit an amendment.

CMS has determined that this action for the Turquoise Care demonstration is likely to assist in promoting the objectives of the Medicaid statute by aligning this section 1115 demonstration

with new statutory requirements applicable to the Medicaid program and with how CMS has interpreted and implemented those requirements in regulations and guidance. The effective date of this action is intended to align with the implementation timeline of this new statutory requirement.

This section 1115(a) demonstration action is subject to the limitations specified in Attachment P below, which is appended to the demonstration's STCs, as changed and restated in our approval on May 27, 2026. Attachment P makes a conforming change to the demonstration's STCs as further specified therein, and governs any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The changes in Attachment P of this letter should be considered as part of the broader set of STCs that were approved on May 27, 2026, for the Turquoise Care demonstration and will be incorporated into the full STCs at a future approval action for this demonstration.

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related

health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as "emergency Medicaid"), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. New Mexico elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and pregnant women.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.[1] On August 17, 2026, CMS issued a letter to New Mexico describing CMS's determination that continuing previously approve policies in section 1115 demonstrations that authorize federal matching funds for expenditures for services furnished to individuals who will be subject to the FFP limitations in sections 1903(v)(5) and 2107(e)(1)(R) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.[2] In this action, CMS is making a conforming change to align with section 1903(v)(5) of the Act to the STCs of the demonstration. This change, which is further described below, is expected to protect program integrity, ensure accurate eligibility determinations, and ensure proper claiming of FFP.

Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide expenditure authority for expanded continuous eligibility. On July 17, 2025, CMS issued a Dear Colleague letter indicating that CMS does not anticipate approving new requests for expanded continuous eligibility or renewing existing section 1115 demonstration authority for expanded continuous eligibility, beyond what is required or available under the Medicaid and CHIP statutes, as applicable.[3] CMS has provided technical assistance to assist states as they begin upgrading eligibility systems, notifying beneficiaries, and conducting an orderly phase out of expanded continuous eligibility where it has been approved under section 1115 demonstration authority.

CMS clarified in SHO Letter #26-001 that states must apply the FFP limitations under section 1903(v)(5) of the Act for the following: 1) children in a continuous eligibility period under the state plan or section 1115 demonstrations under section 1902(e)(12) of the Act; 2) individuals

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/New_Mexico_71109_Letter_08.17.26.pdf
[3] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

covered during a period of continuous postpartum coverage under the state plan or section 1115 demonstrations under section 1902(e)(16) of the Act; and 3) individuals receiving authority for an expanded continuous eligibility period under the terms of a section 1115 demonstration. For Medicaid applicants and current Medicaid beneficiaries who are not U.S. citizens or U.S. nationals, LPRs, Cuban/Haitian entrants, or COFA migrants, and are not lawfully residing children and pregnant women eligible under the state's election of the CHIPRA 214 option, FFP remains available for emergency Medicaid coverage for such individuals in accordance with section 1903(v)(5) of the Act beginning October 1, 2026, and for the remainder of the expanded continuous eligibility period.

In this action, consistent with its August 17, 2026, letter to New Mexico, CMS is making a conforming change to reflect that populations receiving expanded continuous eligibility under section 1115(a)(2) expenditure authority in New Mexico's Turquoise Care demonstration are subject to this new requirement beginning October 1, 2026. Specifically, CMS is adding subsection (i) to STC 4.8.a to affirm that the FFP limitation under section 1903(v)(5) of the Act is applicable to New Mexico's expanded continuous eligibility authority in the Turquoise Care demonstration.

Budget Neutrality

There is no change to budget neutrality for this action.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the conforming change specified in this letter and attachment into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to implementation of the conforming change in this letter and attachment.

Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved waivers, expenditure authorities and STCs (as modified as stated in this letter and Attachment P) which set forth in detail the nature, character and extent of anticipated federal involvement in the project. In addition, this action is subject to CMS receiving written acceptance within 30 days of the date of this letter. Your project officer is Alex Desatoff, who is available to answer any questions concerning your section 1115 demonstration. Mr. Desatoff's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26

7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Alexei.Desatoff@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

[redacted]

Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

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

Attachment P
CONFORMING CHANGES TO SPECIAL TERMS AND CONDITIONS

This Attachment P makes a conforming change to the STCs that were approved on July 25, 2024, and amended and restated on May 27, 2026, as follows. Language CMS is newly adding is in red text.

Edits to STC 4.8.a: Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

STC 4.8.a.i: Expanded Continuous Eligibility for Noncitizens Ineligible for FFP. For current Medicaid beneficiaries in an expanded continuous eligibility period, beginning October 1, 2026, the state must apply the FFP limitations under section 1903(v)(5) of the Act. FFP is limited to payment for emergency Medicaid coverage during the remainder of the expanded continuous eligibility period for such Medicaid beneficiaries who are not U.S. citizens or nationals, Lawful Permanent Residents (LPRs), Cuban/Haitian entrants, or Compact of Free Association (COFA) migrants and are not eligible as a child or pregnant woman who is lawfully residing in the U.S. under the state's election of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option in accordance with section 1903(v)(4) of the Act.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITIES

NUMBER: **11-W-00285/6**

TITLE: **Turquoise Care Medicaid 1115 Demonstration**

AWARDEE: **New Mexico Health Care Authority**

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

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

A. Title XIX

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** **Section 1902(a)(84)(D)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00285/6**

TITLE: **Turquoise Care Medicaid 1115 Demonstration**

AWARDEE: **New Mexico Health Care Authority**

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

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

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

    a. Section 1903(m)(2)(H) and federal regulations at 42 CFR 438.56(g) but only insofar as to allow the state to automatically reenroll an individual who loses eligibility or whose eligibility is suspended for a period of three months or less in the same managed care plan in which the individual was previously enrolled.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Substance Use Disorder

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

Serious Mental Illness/ Serious Emotional Disturbance

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

High Fidelity Wrap Around Intensive Care Coordination

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

TITLE XIX REQUIREMENTS NOT APPLICABLE TO ALL EXPENDITURE AUTHORITIES

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

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 4

Statewide Operation — Section 1902(a)(1)

To the extent necessary to enable the state to operate on less than a statewide basis for Pre-Tenancy and Tenancy services for up to 450 beneficiaries in the Turquoise Care program with

[1] New Mexico uses the term severe emotional disturbance, in accordance with 8.321 of New Mexico Administrative Code (NMAC).

SMI/SED in geographically limited areas of the state.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITIES 4 AND 5

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

Reasonable Promptness Section 1902(a)(8)

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

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITIES 8 AND 9

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 12

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

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00285/6

TITLE: Turquoise Care Medicaid 1115 Demonstration

AWARDEE: New Mexico Health Care Authority

1. PREFACE

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

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

The STCs have been arranged into the following subject areas:

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

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

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

2. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

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

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, and increasing utilization of preventive services;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

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

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

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

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

On February 7, 2020, the demonstration was amended to incorporate the following five changes into the demonstration: 1) removal of co-payments for Centennial Care members, 2) removal of premiums requirements for beneficiaries in the Adult Expansion Group, 3) removal of the waiver

of retroactive eligibility, 4) increase the number of Community Benefit slots by 1,500 throughout the remainder of the current demonstration approval period, and 5) expansion of the Centennial Home Visiting Pilot Program by removing restrictions on the number of counties and number of individuals that may participate in the pilot program.

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

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

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

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

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

incorporate four additional evidence-based models; and 5) increase supportive housing enrollment from 180 to 450 members annually.

On July 25, 2024, the Centennial Care 2.0 demonstration was extended to December 31, 2029 and with the extension, New Mexico requested to change the demonstration name was changed to Turquoise Care at the state's and CMS approved this request with the extension approval. With this extension, the state received approval for the continuation of the demonstration program with the exception of the Uncompensated Care program which expired with the previous demonstration period. The state requested and received approval for two new programs in the demonstration extension 1) provide reentry services for eligible individuals for up to 90-days pre-release from a carceral facility, and 2) provided health related social need services for individuals meeting eligibility criteria for short-term post hospitalization housing and home delivered meals for pregnant individuals. In addition to the new programs for the demonstration extension, the state expanded its providers for the pre-tenancy/tenancy support program, and the expanded Community Benefit services to provide individuals meeting eligibility criteria up to two meals per day.

On October 15, 2024, CMS approved an amendment to provide expenditure authority for coverage of traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

3. GENERAL PROGRAM REQUIREMENTS

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

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

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the

state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

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

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

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

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

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

reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12, which must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

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

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

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

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

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

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

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

state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

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

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

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

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

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services,

continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

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

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to Medicaid or CHIP programs or procedures; or possible changes in methods or level of payment for benefits or services

under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected By the Demonstration. Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration. These state plan eligible members are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

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

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

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

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

Turquoise Care, and Column E describes the budget neutrality MEG under which expenditures for the population will be reported (as described further in STC 13.10).

Table 1: Mandatory State Plan Populations

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

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
Children under Age 19	Consolidated group for children under age 19 • §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) • §§1902(a)(10)(A)(ii)(IV) and (IX) • §1931(b) and (d) 42 CFR 435.118	No	TANF and Related
Continuous Eligibility for Hospitalized Children	Children eligible under 42 CFR 435.118 receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay §1902(e)(7) 42 CFR 435.172	No	TANF and Related
Deemed Newborns	Newborns deemed eligible for one year §1902(e)(4) 42 CFR 435.117	No	TANF and Related
Adoption Assistance and Foster Care Children	Children receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements • §1902(a)(10)(A)(i)(I) • §473(b)(3) 42 CFR 435.145	No	TANF and Related
Former Foster Care Children	Former foster care children under age 26 not eligible for another mandatory group 1902(a)(10)(A)(i)(IX) 42 CFR 435.150	No	TANF and Related

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
Adult group	Non-pregnant individuals age 19 through 64 with income at or below 133% FPL 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	No	VIII Group
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals under age 21 eligible for Medicaid in the month they apply for SSI 1902(a)(10)(A)(i)(II)(cc)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individual whose earning exceed SSI substantial gainful activity level 1902(a)(10)(A)(i)(II) 1619(a)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals receiving mandatory state supplements 42 CFR 435.130	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR 435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR 435.133	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 42 CFR 435.134	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals ineligible for SSI because of requirements inapplicable in Medicaid 42 CFR 435.122	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled widows and widowers Early widows/widowers 1634(b) 42 CFR 435.138	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Turquoise Care?	D. MEG for Budget Neutrality
	1939(a)(5)(E) Disabled adult children 1634(c)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individuals whose earnings are too high to receive SSI cash 1902(a)(10)(A)(i)(II)(bb); 1905(q) 1619(b)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 2. Optional State Plan Populations

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/Regulatory Citations	C. Limitations on Turquoise Care?	D. MEG for Budget Neutrality
Optional Targeted Low-Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR 435.226	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/Regulatory Citations	C. Limitations on Turquoise Care?	D. MEG for Budget Neutrality
Out-of-State Former Foster Care Children under the Individuals above 133% FPL under Age 65 group	Individuals under age 26 who were in foster care in a state other than New Mexico (or tribe in such other state) when they aged out of foster care, not otherwise eligible for Medicaid 1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard. 1902(a)(10)(A)(ii)(V) 1905(a) 42 CFR 435.236	NF LOC: Included PACE: Excluded ICF/IID: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Institutionalized Individuals	Individuals who would be eligible for SSI cash if not in an institution 1902(a)(10)(A)(ii)(IV) 1905(a) 42 CFR 435.211	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Uninsured individuals under 65 screened and found to need treatment for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII) 42 CFR 435.213	No	TANF and Related
Home and Community Based 1915(c) Waivers that are continuing outside the	Individuals whose eligibility is determined	1915(c) waiver services are not	SSI Medicaid only (if

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

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/Regulatory Citations	C. Limitations on Turquoise Care?	D. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that are continuing outside of the demonstration (217 group)	using institutional eligibility rules for individuals who are eligible as specified under 42 CFR 435.217 and 435.236 and section 1924 of the Act		not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 3: Demonstration Expansion Populations

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

A. Expansion Medicaid Eligibility Group	B. Description Statutory/Regulatory Citations	C. Financial Eligibility Standards	D. Limitations on inclusion in Turquoise Care?	E. MEG for Budget Neutrality
	Individuals whose eligibility is determined using institutional eligibility rules for individuals who are eligible as specified under 42 CFR 435.217 and 435.236 and section 1924 of the Act	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2,000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

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

a. Qualified Medicare Beneficiaries (QMBs) – 1902(a)(10)(E)(i); 1905(p)
b. Specified Low-Income Medicare Beneficiaries (SLMBs) – 1902(a)(10)(E)(iii)
c. Qualifying Individuals (QIs) – 1902(a)(10)(E)(iv)
d. Qualified Disabled Working Individuals (QDWIs) – 1902(a)(10)(E)(ii); 1905(s)
e. Non-citizens only eligible for emergency medical services – 1903(v)
f. Program for All-Inclusive Care for the Elderly (PACE) Participants – 1934
g. Individuals residing in ICFs/IID – 1905(a)(15)
h. Developmental Disabilities Waiver, Mi Via Waiver, and Supports Waiver participants for HCBS services only
i. Medically Fragile Waiver participants for HCBS services only
j. Except as provided in STC 4.9, individuals receiving family planning-only benefits through the Family Planning category of eligibility.

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

4.5. Regular and Post-Eligibility Treatment of Income for Turquoise Care Individuals Receiving HCBS (Specified at 42 CFR 435.726 of the Federal Regulations and 1924 of the Social Security Act). For individuals receiving 1915(c)-like services, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the

same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the federal regulations and section 1924 of the Act, if the home and community-based services were provided under a section 1915(c) waiver.

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

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

4.8. Continuous Eligibility for Children up to Age 6.

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

b. Continuous Eligibility Period. The state is authorized to provide continuous eligibility for children ages zero through the end of the month of their sixth birthday regardless of the delivery system through which these populations receive Medicaid benefits. Coverage shall be continuous for children ages 0 through 5 who qualify for continuous eligibility until the end of the month in which their 6th birthday falls. The child's continuous eligibility period begins on the effective date of the child's eligibility under 42 CFR 435.915. The state will redetermine eligibility consistent with 42 CFR 435.916 when the child turns age 6. The state will continue to redetermine eligibility during a period of continuous enrollment in limited circumstances, if appropriate.

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

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

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

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

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

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

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

4.9. Family Planning Services. The state will phase out the limitations on Family Planning eligibility by December 31, 2025 to otherwise eligible individuals age 50 and under who do

not have other health insurance coverage and individuals who are under age 65 who have only Medicare coverage that does not include family planning benefits.

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

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

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

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

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

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

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

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

into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

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

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

5. NATIVE AMERICAN PARTICIPATION AND PROTECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. DEMONSTRATION PROGRAMS AND BENEFITS

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

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

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

Table 4. Community Benefit Services Included Under Turquoise Care

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

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

6.4. Community Benefit Cost of Care. The state must require each MCO to conduct a comprehensive needs assessment (CNA) that will be used to determine an eligible participant's Comprehensive Care Plan (CCP) for the CB (see STC 6.6). The maximum allowable cost of care for the CB will continue to be tied to the state's annual cost of care

for persons served in a private NF. However, the maximum allowable cost of care is not an entitlement. A participant's actual cost of care for the CB will be determined by the CNA.

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

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

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

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

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

d. The state must require the MCOs that are conducting NF LOC assessments to provide objective LOC determinations based on criteria developed by the state. The state must

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

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

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

6.9. Quality Strategy for 1915(c)-like HCBS Service. For services that could have been authorized to individuals under a 1915(c) HCBS waiver, the state must have an approved Quality Improvement Strategy (QIS) that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302. and is required to develop performance measures to address the following assurances.

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

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

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

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

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

c. Qualified Providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iii. Person-Centered Planning and Individual Service Plans.

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

2. The state must require that a process is in place that permits participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The state, through the MCO contract, must require all HCBS service plans to be updated and/or revised annually or when warranted by changes in the enrollee's needs as required by 42 CFR 441.365(e).

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

iv. Demonstration Participant Protections.

1. The state must ensure that children, youth, and adults in CB programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and

Permanency) through all service entities, including the MCOs. The state will ensure that these linkages are in place before, during, and after the transition to the CB as applicable.

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

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

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

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

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

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

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

a. Information and Assistance in Support of Participant Direction. The state or MCO must have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets.

Participants must be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants must also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but are not limited to Financial Management Services and Support Brokerage assistance.

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

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

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

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

6.18. Decision Making Authority. The participant (or the participant's designated representative) exercises the following decision making activities: recruit staff, select staff from worker registry (if available), hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

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

b. Existing SDCB members who, at implementation of Turquoise Care, have budgets that exceed the service limits applicable under Turquoise Care for related goods and services, specialized therapies or non-medical transportation, will have their current budgets carried over until 2023. After 2023, the budgets for these members must be based upon the approved amounts consistent with the then-applicable Turquoise Care

service limits. Members newly receiving SDCB will be subject to the Turquoise Care service limitations beginning on January 1, 2019. See Attachment A for details regarding service limits.

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

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

6.19. Home and Community-Based Provider Settings. All HCBS provider settings must be assessed by the MCOs, prior to providing the CB and as part of ongoing monitoring, to ensure that they meet all applicable federal requirements for appropriate settings (42 CFR 441.301(c)(4)-(5)). Ongoing monitoring activities must be multi-faceted and include: 1) care coordinators verifying whether members are receiving services in compliant settings as part of care coordination touch point meetings as required in the MCO contract, 2) MCOs verifying that all requirements are met and continue to be met as part of credentialing and re-credentialing activities, for credentialed providers, and 3) state and MCOs responding to complaints and allegations of noncompliance. The state must ensure that services are not furnished in provider settings that are not compliant with applicable requirements until identified issues are successfully remediated. The state must hold MCOs accountable, through contractual requirements, for monitoring ongoing provider compliance and must require MCOs to regularly report to the state on provider status and monitoring activities. This STC does not include the SMI/SED pre-tenancy and tenancy referred to in STC 6.22 or short-term post hospitalization housing for members experiencing homelessness.

6.20. Community Interveners. Deaf and blind individuals enrolled in Turquoise Care may access the benefit of Community Interveners. A Community Intervener is a trained professional who meets the criteria as determined by the state. The Intervener works one-on-one with

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

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

6.22. Peer Delivered Pre-Tenancy and Tenancy Services. The aim of 1915(i)-like pre-tenancy and tenancy services is to assist members in acquiring, retaining and maintaining stable housing, making it more conducive for members to participate in ongoing treatment of their illness and improve the management of their mental and physical health issues. Pre-tenancy and tenancy services do not include tenancy assistance in the form of rent or subsidized housing; instead they expand the availability of basic housing supports provided today through comprehensive community support services (CCSS), currently authorized under the state plan as case management, habilitation, and other similar services. The pre-tenancy and tenancy services authorized under this demonstration are specified in Attachment I. The state will use its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program and/or Local Lead Agency providers associated with the Set Aside Housing Program to deliver pre-tenancy and tenancy services. Linkages providers will be expected to utilize community support workers, case managers, supportive housing coordinators, or certified peer support workers (CPSWs) who have similar lived experience, are on a solid footing in their recovery, and are employed by Linkages providers or Local Lead Agency provider for service delivery.

This approach builds upon a successful statewide supportive housing model; expands the peer workforce; and improves the engagement, service delivery and outcomes for individuals with SMI/SED.

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

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

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

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

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

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

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

6.23. Quality Strategy for 1915(i)-like HCBS Services. For services that could have been authorized to individuals under a 1915(i) HCBS state plan amendment, the state must have an approved QIS that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal requirements at 42 CFR 441.745(b) and is required to develop performance measures to address the following requirements:

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

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

ii. Are updated annually; and

iii. Document choice of services and providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	*State plan (Individual*	

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

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

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

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

c. Patient Placement. Establishment of a utilization management approach such that members have access to SUD services at the appropriate LOC and that the interventions are appropriate for the diagnosis and LOC, including an independent

process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

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

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

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

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

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

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

j. SUD Health IT Plan. Implementation of the Substance Use Disorder Health Information Technology Plan which describes technology that will support the airs of

the demonstration. Further information which describes milestones and metrics as detailed in STC 6.28 or Attachment H.

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

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

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

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

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

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

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

Components of the Health IT Plan include:

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

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

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

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

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

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

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

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

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

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

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

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

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

      A. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must

be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Earlier Identification and Engagement in Treatment and Increased Integration

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

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

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

6.31. SMI/SED Health Information Technology (Health IT) Plan. The Health IT Plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every

appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 6.30), to develop the infrastructure/capabilities of the state's health IT infrastructure.

a. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment J) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

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

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

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

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

f. Components of the Health IT Plan include:

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

    ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the

following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

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

1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

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

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

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

6.33. Maintenance of Effort (MOE). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount

of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 15.5.

6.34. Availability of FFP for the SMI/SED Services Under Expenditure Authority #10. FFP is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD to receive acute care for a primary diagnosis of SMI/SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

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

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

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

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

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

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

a. Children or youth with an SED diagnosis;

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

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

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

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

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

6.39. HFW beneficiaries receive the following benefits:

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

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

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

a. Wraparound Facilitator

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

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

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

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

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

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

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

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

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

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

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

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

   i. Complete Parent Peer Support Provider Module Trainings;

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

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

iv. Maintain CFPSW certification, including continuing education requirements;

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

vi. Have a valid Driver's License;

vii. Have a high school diploma or GED; and

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

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

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

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

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

e. Clinical Director. The Clinical Director must:

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

ii. Clinically oversee patient care;

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

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

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

6.41. Beneficiary-Reported Information and Periodic Data Checks. The state must have procedures designed to ensure that members can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information relevant to the

state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The member must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

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

b. The state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 15.5).

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

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

7. MEMBER ENGAGEMENT

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

expenditures as approved under the Member Rewards Program. Additional details regarding the rewards program not found in these STCs may be found the Member Rewards Guide.

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

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

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

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

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

8. DELIVERY SYSTEM

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

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

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

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

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

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

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

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

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

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

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

8.11 State Oversight of Medical Loss Ratio (MLR).

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.
    i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf .https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf. The state must submit its plan to operationalize STC 8.11.b. through e. no later than six months after the demonstration approval. This plan must outline key deliverables and timelines to meet the requirements of STC 8.11.b. through e.
b. Effective July 1, 2025, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
c. No later than July 1, 2026, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.
d. STC 8.11.a, 8.11.b, and 8.11.c must apply for all of the following entities:

i. Risk-based plans for which the state receives FFP for associated expenditures;
ii. Full and partially delegated plans;
iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 8.11.e.ii; and
iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 8.11.e.iii.

e. The state must work with CMS to effectuate an audit of the MLR data for all complete rating periods (i.e., MLR reporting periods) in this 1115 demonstration package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period.

9. REENTRY DEMONSTRATION INITIATIVE

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

9.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of MAT and other SUD and behavioral health treatments, as appropriate for the individual.

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

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

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

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

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

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

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

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

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

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

j. Reduce recidivism;

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

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

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

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

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

b. Be enrolled in Medicaid.

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

a. The covered pre-release services are:

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

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

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

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

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

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

vii. Family planning services and supplies;

viii. Services provided by community health workers;

ix. Peer support services;

x. Treatment for Hepatitis C; and

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

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

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

9.6. Participating Providers.

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

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

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

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

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

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

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

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

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

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

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

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

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans;

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

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

h. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable

federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

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

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

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

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

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

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

that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment L the Reentry Demonstration Initiative Reinvestment Plan) is not required to be reinvested pursuant to this STC.

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

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

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

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

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

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

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

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

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

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

9.12. Reentry Demonstration Initiative Planning and Implementation.

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

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

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

Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

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

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

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

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

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

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

The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given

demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

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

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

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

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

10. HEALTH RELATED SOCIAL NEEDS SERVICES

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

10.1. Health-Related Social Needs (HRSN) Services. The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment N and this STC, subject to the restrictions described below, including Section 11 of these STCs, and outlined in any related CMS published guidance on HRSN services[3],[4]. Expenditures are limited to expenditures for items and services not otherwise covered under title XIX but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and HRSN criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances

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

will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 10.7 (Service Delivery) and Attachment N.

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

i. Housing interventions, including:

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

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

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

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

10.3. HRSN Infrastructure.

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

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

ii. Development of business or operational practices – e.g., procurement and planning, screening and referral processes, capacity building for social service providers and network development, developing policies and workflows for

referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

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

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

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

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

	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17	Total
Total Computable Expenditures	$6,963,195	$49,737,110	$39,789,688	$2,984,227	$0	$0	$99,474,220

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

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 10.3.a. are not factored into managed care capitation payments, and that there is no duplication of funds.

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

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

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

iii. Construction costs (bricks and mortar).

iv. Capital investments.

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

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

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

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

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

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

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

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

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

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

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

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

Specifically, the protocol must include the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN Services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

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

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

updating through its Monitoring Reports on the inclusion of HRSN services in managed care programs.

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

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

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

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

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

staff offering services through Social Service Providers must be licensed when appropriate and applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.18. HRSN Implementation Plan.

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

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

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

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

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

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

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

assistance programs, relative to the number of total eligible beneficiaries in the state;

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

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

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

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

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

11. TRADITIONAL HEALTH CARE PRACTICES

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

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

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

a. Is a Medicaid beneficiary, and

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

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

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

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

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

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

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

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

ii. Room and board;

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

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

v. Capital investments; and

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

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

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

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

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

described in STC 11.1), the state may draw FFP for traditional health care practices after using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above).

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

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

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

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

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

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

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

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

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

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

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

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

ii. Room and board;

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

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

v. Capital investments; and

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

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

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

12. PROVIDER PAYMENT RATE INCREASE REQUIREMENTS

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

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

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

b. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this STC, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

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

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

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

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

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

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

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

        3. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate,

the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

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

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

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

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

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

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

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

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

h. If the state uses a managed care delivery system for any of the service categories defined in STC 12.2(b), for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 14 through DY 17 the managed care plans' provider payment rate increase for each service in the affected

category will be no lower than the highest rate in DY 17 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 12.2(b).

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

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

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

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

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

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

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

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these

service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

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

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

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

☐a. The effective date of the rate increases is the first day of DY 14 and will be at least sustained, if not higher, through DY 16.

☐b. New Mexico has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 14. New Mexico will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 16.

New Mexico [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and/or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

New Mexico [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 12.2(d)(ii). through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.2(f)(ii), I attest that necessary arrangements will be made to assure

that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
New Mexico further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 12.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide date*_____] [*Provide printed name of signator*]

13. GENERAL FINANCIAL REQUIREMENTS

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

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

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

expenditures for which it determines that the sources of non-federal share are impermissible.

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

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

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

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

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

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

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

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third

parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 9: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
TANF and Related	Main	X		X	Eligible TANF and related individuals (STC 4.2).
SSI Medicaid Only	Main	X		X	Eligible SSI Medicaid Only individuals (STC 4.2).
SSI Dual	Main	X		X	Eligible SSI Dual individuals (STC 4.2).
217-Like Medicaid	Hypo 6	X		X	Eligible 217-like Medicaid individuals (STC 4.2).
217-like group Dual	Hypo 6	X		X	Eligible 217-like group Dual eligible individuals (STC 4.2).
VIII Group	Hypo 2	X		X	Eligible VIII Group individuals (STC 4.2).
SUD/IMD	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment (STC 4.2).
CHV	Hypo 3	X		X	Months of Medicaid eligibility for the CHV program eligible (STC 6.21).
Tenancy	Hypo 3	X		X	Months of Medicaid eligibility for individuals eligible to receive tenancy supports (STC 6.22).
SMI/SED IMD Managed Care	Hypo 3	X		X	All expenditures for medical assistance provided during an SMI/SED IMD month for managed care enrollees.
SMI/SED IMD FFS	Hypo 3	X		X	All expenditures for medical assistance provided during an SMI/SED IMD month for FFS enrollees.
Continuous Eligibility Children	Hypo 7	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who

Table 9: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					would otherwise lose coverage during an eligibility determination.
Reentry Services	Hypo 8	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating correctional facilities.
Reentry Non-Services	Hypo 8		X	X	Expenditures for planning and supporting the Reentry Demonstration Initiative.
HRSN Services	Hypo 9		X	X	Expenditures for approved HRSN initiatives.
HRSN Infrastructure	Hypo 9		X	X	Infrastructure expenditures for approved HRSN initiatives.
Traditional health care practices implementation expenditures	Main			X	See Expenditure Authority 13

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

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

13.12. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as

otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

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

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

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

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

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

state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
TANF and Related	All expenditures for medical assistance provided to TANF and Related eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
SSI Medicaid Only	All expenditures for medical assistance provided to SSI Medicaid Only eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
SSI Dual	All expenditures for medical assistance provided to SSI Dual eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
217-like Medicaid	All expenditures for medical assistance provided to 217-like Medicaid eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
217-like group Dual	All expenditures for medical assistance provided to 217-like group Dual eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
VIII Group	All expenditures for medical assistance provided to VIII Group eligibles	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/14	12/31/29
SUD/IMD	All expenditures	N/A	Follow	Date of	MAP	Y	5/21/19	12/31/29

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

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

Table 10: MEG Detail for Expenditure and Member Month Reporting								
MEG	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expenditures are assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
	HRSN Infrastructure		Category of Service Definitions					
Traditional health care practices implementation expenditures	Implementation costs related to traditional health care practices	See STC 11.7d	Follow standard CMS-64.10 Category of Service Definition	Date of payment	ADM	N	10/15/24	12/31/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	ADM	N	1/1/14	12/31/29

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

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

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

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

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

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

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

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

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

changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

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

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

b. Types of Allowable Changes. Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

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

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

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

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

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

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

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

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

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

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

14. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

14.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 9, Master MEG Chart and Table 10, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for

the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

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

Table 12: Main Budget Neutrality Test

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
TANF and Related	PC	Both	4.7%	$508.85	$526.68	$551.43	$577.35	$604.49	$632.90
SSI and Related – Medicaid Only	PC	Both	5.4%	$2,630.67	$2,736.51	$2,884.28	$3,040.03	$3,204.19	$3,377.22
SSI and	PC	Both	4.8%	$1,891.75	$1,959.45	$2,053.50	$2,152.07	$2,255.37	$2,363.63

Related – Dual									
UPL Payments	Agg	WOW Only	n/a	$40,450,588	$80,901,176	$80,901,176	$80,901,176	$80,901,176	$80,901,176
Traditional health care practices implementation expenditures	Agg	WW Only	The state must have savings to offset these expenditures.						

*PC = Per Capita, Agg = Aggregate

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

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

Table 13: Hypothetical Budget Neutrality Test 1									
MEG	**PC**	**WOW**	**Trend**	**DY12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY 17**

	or Agg	Only, WW Only, or Both	Rate						
SUD/IMD MC	PC	Both	5.1%	$1,010.03	$1,048.42	$1,101.89	$1,158.09	$1,217.15	$1,279.22
SUD/IMD FFS	PC	Both	5.1%	$1,010.03	$1,048.42	$1,101.89	$1,158.09	$1,217.15	$1,279.22

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

Table 14: Hypothetical Budget Neutrality Test 2

MEG	TREND	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
VIII Group	5.2%	$748.62	$777.63	$818.07	$860.61	$905.36	$952.44

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

Table 15: Hypothetical Budget Neutrality Test 3

MEG	TREND	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
CHV	4.7%	$708.33	$741.62	$776.48	$812.97	$851.18	$891.19
Tenancy	6.4%	$450.00	$478.80	$509.44	$542.05	$576.74	$613.65

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

Table 16: Hypothetical Budget Neutrality Test 4

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

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

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

14.10. Hypothetical Test 6: Additional Hypothetical Groups: The budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Hypothetical Test 6.

Table 18: Hypothetical Budget Neutrality Test 6							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
217- like Medicaid	5.4%	$4,031.35	$4,193.54	$4,419.99	$4,658.67	$4,910.24	$5,175.39
217-like Group - Dual	4.8%	$4,161.63	$4,310.57	$4,517.48	$4,734.32	$4,961.57	$5,199.73

Hypothetical Test 7: Continuous Eligibility for Children: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 19: Hypothetical Budget Neutrality Test 7							
MEG	**TREND**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
CE Children	4.9%	$546.14	$564.88	$592.56	$621.59	$652.05	$684.00

Hypothetical Budget Neutrality Test 8: Reentry. Reentry Demonstration Initiative Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 20: Hypothetical Budget Neutrality Test 8

MEG	PC or Agg	WOW Only, WW Only, or Both	TREND	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Reentry Services	PC	Both	5.0%	$0	$1,074	$1,127	$1,184	$1,243	$1,305
Reentry Non-Services	Agg	Both	$0	$20,007,032	$60,021,097	$60,021,097	$60,021,097	$0	$0

14.11. Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 10), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll

over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

14.12. Capped Hypothetical Budget Neutrality Test: HRSN. The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 21: Capped Hypothetical Budget Neutrality Test 9

MEG	Agg	WOW only, WW Only, or Both	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HRSN Services	Agg	Both	$40,241,844	$88,532,056	$144,870,637	$160,967,374	$177,064,112	$193,160,849
HRSN Infrastructure	Agg	Both	$6,963,195	$49,737,110	$39,789,688	$2,984,277	$0	$0

14.13. **Monitoring Budget Neutrality for Traditional Health Care Practices.** As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration.

Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7. This amendment includes the addition of a "with waiver" only expenditure authority for implementation expenditures which will be paid for with demonstration savings. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

14.14. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

14.15. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 07/25/2024 to 12/31/2029. If at the end of the demonstration approval period the Main Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

14.16. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

15. MONITORING AND REPORTING REQUIREMENTS

15.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in MBES/CBES following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

iii. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

15.2. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

15.3. Submission of Post-Approval Deliverables. The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

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

i. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

ii. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

iii. Submit deliverables to the appropriate system as directed by CMS.

15.5. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment G. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

a. At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 15.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

b. The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

c. In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

d. In addition, the state must describe in the Monitoring Protocol methods and a timeline for collecting and analyzing non-Medicaid administrative data necessary to conduct comprehensive monitoring and evaluation of traditional health care practices. These sources may include but are not limited to data related to traditional health care practices provided by IHS, Tribal, or UIO facilities. Across data sources, in consultation with IHS, Tribal, and UIO facilities, the state must make efforts to collect data in ways that support subgroup analyses as appropriate.

e. For the qualitative elements (e.g., operational updates as described in STC 15.6), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

15.6. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each demonstration year (DY). The fourth quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth quarter

information) is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable.

   Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. For the traditional health care practices demonstration component, Monitoring Reports must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 11.1.

   Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will

support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 9.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities and providers providing traditional health care practices under the demonstration, the number of each type of traditional health care practice provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration. In addition, the state must provide narrative updates on activities undertaken regarding allowable traditional health care practices implementation expenditures.

For the HRSN component, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs, such as, SNAP and WIC for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

Common SUD metrics include, but are not limited to, those that measure alignment with assessment of need and qualification for SUD treatment services and the demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17- 003).[6]

Common SMI metrics include, but are not limited to, screening of beneficiaries admitted to psychiatric hospitals or residential treatment facilities, mental health services utilization (inpatient and outpatient), and average length of stay in IMDs and the demonstration's four milestones as outlines in the SMDL dated November 13, 2018 (SMDL #18—011).[7]

In consultation with CMS, proposed HFW performance metrics should pertain to, but not be limited to, intensive care coordination, treatment planning, and staff trainings completed to meet the HFW requirements for HFW intensive care coordination.

In consultation with CMS, HCBS performance metrics should continue to be tracked as before but account for the expanded HCBS (Community Benefit) enrollment.

In addition to tracking enrollment and renewal metrics, systematic monitoring of the continuous eligibility policy must support—at a minimum—understanding the trends in preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.

The state must also establish monitoring metrics to help track operational and implementation progress and performance of the demonstration's Home Visiting services. At a minimum, the metrics for these programs must capture the number of individuals eligible for these pilots, the counts of service utilization by type, and corresponding health outcomes, as applicable.

The required monitoring and performance metrics must be included in writing in the Monitoring Reports and must follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations

[6] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[7] SMDL #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD and SMI/SED Health IT. The state will include a summary of progress made in regard to SUD and SMI/SED Health IT requirements outlined in STC 6.27.

15.7. Reentry Demonstration Initiative Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

e. CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

15.8. SUD and SMI/SED Mid-Point Assessment. For the SUD and SMI/SED components, the state must contract with an independent entity to conduct an independent Mid-Point Assessment by June 30, 2026. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid- Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the relevant Implementation Plan and Monitoring Protocol for ameliorating these risks. Modifications to the Implementation, Financing Plan, and Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plans and toward meeting the targets for performance measures as approved in the Monitoring Protocol;

ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

iv. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement; and

v. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

15.9. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.10. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 16.7 and 16.8, respectively.

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

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

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 15.1.

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

a. The purpose of these calls is to discuss ongoing demonstration operations, to include but not limited to, any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

15.12. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

16. EVALUATION OF THE DEMONSTRATION

16.1. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development,

implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 15.1.

16.2. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

16.3. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with:

a. Attachment D (Developing the Evaluation Design) of these STCs, and

b. Any applicable CMS evaluation guidance and technical assistance specific to the demonstration's policy components.

16.4. The draft Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 16.7 and 16.8.

a. For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

16.5. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff,

administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

16.6. Evaluation Design Approval and Updates. The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

a. Evaluation Questions and Hypotheses. Consistent with Attachments D and F (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary individual understanding of and experience with and experience the various demonstration policy components, including but not limited to, beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of

the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

b. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

c. The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

d. The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

e. Evaluation hypotheses for the HRSN initiatives in the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the

HRSN evaluation must include an analysis of how the initiatives (e.g., short-term pre/post-hospitalization services, nutrition services, and temporary housing services) affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

f. The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

g. In addition, in accordance with the approved Evaluation Design, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

h. Evaluation hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose.

i. Hypotheses for the SMI component must map to the SMI goals of the demonstration including reducing utilization and lengths of stay in EDs, reducing preventable readmissions to acute care hospitals and residential settings, improving the

availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

j. For expanded enrollment in HCBS for PCS, hypotheses must test the impact of the programs on all relevant populations focused on beneficiaries' experience of care, access to care, provision and utilization of care, the quality, efficiency, and coordination of care centered on rebalancing and community integration, and the costs of care.

k. The state must evaluate the impact of the continuous eligibility policy program on all relevant populations appropriately tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes.

l. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

f. The state must conduct comprehensive evaluation of its pilot programs and develop robust evaluation questions and hypotheses to examine the impacts on enrollment, health outcomes, and general effectiveness of the Medicaid Home Visiting Pilot Services in serving eligible pregnant individuals, postpartum individuals, infants, children and families.

g. Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to culturally appropriate care for beneficiaries served by or through IHS, Tribal, or UIO facilities. In evaluating the effectiveness of the initiative, the state must capture the perspectives of IHS, Tribal, and UIO facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS, Tribal, and UIO facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the traditional health care practices; access to, utilization and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. The state's evaluation efforts must facilitate understanding the extent to which the traditional health care practices initiative might

support reducing existing disparities in access to and quality of care and health outcomes.

h. As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

i. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

16.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment F (Preparing the Interim and Summative Evaluation Report) of these STCs.

16.8. Summative Evaluation Report. The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment F (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

16.9. Corrective Action Plan Related to Evaluation Data. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16.10. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

16.11. Public Access. The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

16.12. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials.

CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

17. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverables	STC Reference
30 calendar days after demonstration approval	State acceptance of demonstration waiver/expenditure authorities and STCs	Approval letter
90 days after SMI/SED program approval date	SMI/SED Implementation Plan (including Health IT Plan)	STC 6.30
60 calendar days after receipt of CMS comments	Revised SMI/SED Implementation Plan (including Health IT Plan)	STC 6.30
90 days after approval of demonstration	HRSN Services and Infrastructure Protocol	STC 10.6
90 days after the approval of any amendment to the demonstration impacting HRSN Services or Infrastructure	Revised HRSN Services and Infrastructure Protocol	STC 10.6
9 months after approval of the demonstration	HRSN Implementation Plan	STC 10.14
90 days after the approval of the demonstration	HRSN MOE Information	STC 10.12
90 days after the approval of the demonstration	Provider Rate Ratio Analysis	STC 12.2
90 days after the approval of the demonstration	Provider Rate Increase Attestation Table	STC 12.2
Yearly, as part of Annual Demonstration Monitoring Report	Yearly Provider Rate Increase Attestation	STC 12.2
150 days after approval	Monitoring Protocol	STC 15.5
60 calendar days after receipt of CMS comments	Revised SMI/SED Monitoring Protocol	STC 15.5
No later than 60 calendar days after March 28, 2026	Mid-Point Assessments	STC 15.7, 15.8
60 calendar days after receipt of CMS comments	Revised Mid-Point Assessments	STC 15.7, 15.8
180 days after initial approval or amendment	Submit Draft Evaluation Design	STC 16.3
60 calendar days after receipt of CMS comments	Revised Evaluation Design	STC 16.6
One year prior to the end of the demonstration	Draft Interim Evaluation Report	STC 16.7
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 16.7

18 months prior to the end of the demonstration	Draft Summative Evaluation Report	STC 16.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 16.8
Monthly	Monitoring Calls	STC 15.10
60 after the end of each quarter	Quarterly Monitoring Report	STC 15.6
Quarterly	Quarterly Financial Report	STC 14.5
Annually	Annual Monitoring Report	STC 15.6
Six months before specific authority expires	Submit an Expiration Plan	STC 3.10
12 months before the demonstration termination	Submit an Extension Request or a Phase Out Plan and an Interim Evaluation Report	STC 3.10
120 days after the demonstration termination	Close-Out Report	STC 15.10

Attachment A
Turquoise Care Community Benefit Definitions and Limits

I. Adult Day Health (ABCB)

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

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

II. Assisted Living (ABCB)

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

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

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

III. Behavior Support Consultation (ABCB and SDCB)

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

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)

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

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

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $4,000 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a NF stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)

Customized Community Supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

VI. Emergency Response (ABCB and SDCB)

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

VII. Employment Supports (ABCB and SDCB)

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

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

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

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

VIII. Environmental Modifications (ABCB and SDCB)

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence.

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

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

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

Limits or Exclusions: Environmental Modification services are limited to six thousand dollars ($6,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Delivered Meals (ABCB and SDBC)

Services to provide and deliver home delivered meals on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Services are furnished consistent with the participant's person-centered service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

X. Home Health Aide (ABCB and SDCB)

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

XI. Non-Medical Transportation (SDCB)

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

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

XII. Nutritional Counseling (ABCB and SDCB)

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

XIII. Personal Care Services (ABCB and SDCB)

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

Agency-Based Community Benefit:

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

Self-Directed Community Benefit:

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

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

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

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

XV. Related Goods (SDCB)

Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying

condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.
The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

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

XVI. Respite (ABCB and SDCB)

Respite services are provided to members unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or NF or an ICF/IDD meeting the qualifications for provider certification. When respite care services are provided to a member by an institution, that individual will not be considered a resident of the institution for purposes of demonstration eligibility. Respite care services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder car; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and case manager, ensuring the health and safety of the member at all times.

Limits or Exclusions: Respite services are limited to a maximum of 300 hours annually per care plan year.

XVII. Skilled Maintenance Therapy Services (ABCB and SDCB)

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

Physical Therapy
Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include:

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

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

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

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

XVIII. Specialized Therapies (SDCB)

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent

the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

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

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

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

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

Hippotherapy

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

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

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

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

community-recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life. This self-directed community benefit service will phase out of the demonstration by December 31, 2025.

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

ATTACHMENT B:
MEDICAID HOME VISITING PILOT SERVICES

Table One: Description of Services

Evidence-Based Model	Description of Services
Nurse Family Partnership (NFP)	NFP is focused on first time mothers: First visit must be before mother is 28 weeks pregnant, and program ends when child is 2 years old. Prenatally, NFP is focused on preventive health and prenatal practices for the mother–helping her find appropriate prenatal care, improve her diet, and reduce her use of tobacco, alcohol, and illegal substances. Additionally, maternal and child health nurses help the mother prepare emotionally for the arrival of the baby. Post-birth, the model is focused on health and development education, including child development milestones and behaviors and teaching parents to use praise and other nonviolent techniques. They also focus on coaching the mothers and their families in planning for their future, staying in school, finding employment, and planning future pregnancies.
Parents as Teachers (PAT)	Parents as Teachers is an early childhood, parent education, and family support program serving families from pregnancy until their children enter kindergarten. Certified parent educators conduct home visits, using a curriculum with the latest neuroscience research findings to offer practical ideas on ways to enhance parenting knowledge. The educators provide age-appropriate information as the child develops. The educators also work with parents to increase the parents' skills as observers of their child. Parents also meet in groups to discuss topics such as positive discipline, sleep, sibling rivalry, and toilet learning and to promote parent–child interaction through activities such as story reading and play. During home visits, parent educators conduct periodic vision, hearing, and general developmental screenings. They also will refer parents to resources provided by their own agencies or others in the community.

Child First	Child First is a comprehensive, home-based, therapeutic intervention for high-risk families with children ages 6–36 months. The Child FIRST model includes the following two complementary core components: • Intensive care coordination: The model connects families with comprehensive, integrated, community-based services and supports through a system-of-care approach. These services are meant to stimulate growth and learning and decrease the stress experienced by the family. • Parent–child psychotherapy: A team of mental health practitioners provides parents and caregivers relationship-based psychotherapy to strengthen the learning environment and boost development. Instead of using a fixed curriculum, parents/caregivers are given guidance and parenting strategies based on their needs. The clinician and care coordinator develop a family plan of broad, integrated supports and services for all family members based on family priorities, strengths, culture, and needs. The care coordinator completes the therapeutic assessment and helps the family to become engaged in community services. While no curriculum is used, easy-to-read child development materials are often shared with the families, in English and Spanish. The clinician and parent study the child's behavior and attempt to interpret reasons (motivations and feelings) for the behavior and find ways parents might respond to their children. Play is used to promote parent–child interactions, handle challenges, and promote language development.

Healthy Families America	Families are eligible to begin between prenatally to 3 months old. Services are provided for a minimum of 3 years. Home visitors offer participating families long-term services (usually three to five years), beginning intensively (at least one visit per week), and use well-defined criteria for determining whether the intensity of service should be increased or decreased. Services are culturally sensitive. Comprehensive services support parents, parent–child interaction, and child development. Families are linked to a medical provider (for timely inoculations and well-childcare) and, if needed, financial assistance, food and housing assistance programs, school readiness programs, childcare, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

Family Connects	The Family Connects model uses a triage model of care, providing one to three home visits to every family living within a defined service area, typically when the infant is 2 to 12 weeks old, and up to 6 months old. During the initial home visit, the nurse conducts a physical health assessment of the mother and newborn, provides supportive guidance on topics that are common to all families (such as infant feeding and safe sleeping practices), and conducts a systematic assessment of family risks and needs associated with the health and well-being of mothers and infants. If an assessment reveals a risk or need, nurses directly support families or connect them to community resources, typically through additional home visits and/or telephone contacts. In cases of mild risk, nurses may provide direct support, such as feeding assistance. If a family's risk is more significant, the nurse collaborates with the family to connect them to desired community services and supports. Supports may include intensive, targeted home visiting programs, mental health services, public assistance programs, or primary health care providers. Nurses use a searchable database of local agencies, created by local program staff, in making referrals. One month after case closure, a staff member (the nurse home visitor or another staff member) calls families to determine whether they connected with the referred agency(ies), are receiving services, have any additional needs, and were satisfied with the program.

SafeCare Augmented	SafeCare Augmented is an adapted version of the SafeCare model that that incorporates additional training for providers in Motivational Interviewing. This model targets families with children from birth to five years old. SafeCare includes three modules: (1) infant and child health, (2) home safety, and (3) parent-infant/parent-child interactions (Planned Activities Training). The health module trains parents to use health reference materials, record health information, use basic health supplies (such as a thermometer), prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment. The safety module helps parents identify and eliminate safety and health hazards and teaches parents how to appropriately supervise their young children. The parent-infant/parent-child interactions (Planned Activities Training) module aims to teach parents how to provide engaging and stimulating activities, increase positive interactions, and prevent challenging child behaviors. Providers observe parents during daily routines and parent-infant/parent-child play. Providers reinforce positive behaviors with parents and address problematic ones. In addition, providers offer parents activity cards to encourage skill acquisition. The three SafeCare modules typically include a baseline assessment and observation of parents' knowledge and skills, followed by four parent training sessions, and conclude with a follow-up assessment to monitor change.

CMS Approved Models

The excerpt below provides descriptions of the of six home visiting models approved for use in New Mexico's Medicaid Home Visiting Pilot program, which all meet the criteria established by the Department of Health and Human Services (DHHS) as an "evidence based early childhood home visiting service delivery model."

The NFP program model is designed for first time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families' economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-

time mothers' health during pregnancy, care of their child, and own personal growth and development. The NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The PAT program model features: 1) comprehensive assessment on maternal (prenatal and postpartum) and child health, parent-child interactions and early literacy; 2) family goal setting; and 3) personal visits and group connection practices that home visitors partner, facilitate and reflect with families to reach their goals. Parent educators use the PAT *Foundational Curriculum* in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting and family well-being. The Program's outcomes include increased healthy pregnancies and improved birth outcomes as well as improved child health and development, prevention of child abuse and neglect, increased school readiness and increased parent involvement in children's care and education.

The goal of the Child First model is to prevent and heal adverse effects of childhood trauma, such as developmental and learning issues, emotional and behavioral disturbance, and abuse and neglect and childhood trauma, especially amongst high-risk young children and families. Outcomes target wellbeing of parents and children including: 1) decreased child abuse and neglect and improved social-emotional development; 2) language and cognitive development and executive functioning amongst children; and 1) improved various mental wellbeing measures (i.e., depression, Post-Traumatic Stress Disorder); 2) decreased parental stress; 3) improved executive functioning; and 4) increased education and employment amongst parents. The Child First model assigns each family a team of licensed master's level clinicians and a care coordinator to develop an ecological approach that best supports each family's strengths and weaknesses, culture, and priorities. The model is flexible and dependent on the needs of each family. This model will be implemented in New Mexico in 2024.

The Healthy Families of America (HFA) model intends to focus its intervention on parents experiencing challenges such as single parenthood, being of low income, having childhood history of abuse or other adverse experiences, and previous or current substance abuse, mental health issues, and/or domestic violence. All parents must complete the parent survey which is used by individual HFA sites to determine the specific population they will serve. The model 1) screens and assesses families to determine those at risk for the challenges mentioned above; 2) provides home visiting services; and 3) involves routine screening for parent-child interactions, child development, and maternal depression. By using evidence-informed curriculum, HFA aims to strengthen nurturing parent-child relationships, promote health childhood growth and development, and enhance family functioning by reducing risk and building protective factors. This model will be implemented in New Mexico in 2024.

The Family Connects model uses nurse home visits to provide families who have newborns the resources they need to support the well-being of their child. Based off an assessment in the initial home visit, the nurse home visitor will provide general parenting guidance, but also connect the

family with community resources specific to their needs. This model is primarily designed for families who have newborns between two to 12 weeks old. The model's outcomes include 1) increased connection to community resources; 2) reduced child maltreatment; 3) reduced usage of emergency medical care; 4) safer home environments; 5) increased positive parenting behaviors; 6) less parental anxiety and depression; and 7) when non-parental childcare is desired, promotion of high quality child care. This model will be implemented in New Mexico in 2024.

The SafeCare Augmented model is designed to address behaviors that could lead to child neglect and abuse. The model targets families with risk factors for child maltreatment, including families with children who have developmental, behavioral, emotional, mental health, and/or physical disabilities. SafeCare is intended to supplement intervention services a family may be receiving from a different agency. The model is structured into three sections; each section provides training on general parenting knowledge and best practices. SafeCare is intended to be delivered within 18 home visits but varies based on how quickly a parent masters each skill that is taught with a four-step approach. This model will be implemented in New Mexico in 2024.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

Home Visitor Provider Qualifications – **Nurse Family Partnership (NFP)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Nurse Home Visitors – Hired by approved NFP implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife, current licensure.	At least five years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Pilot Program Standards.

		year of the required experience.	and quality improvement analysis skills.	
Nurse Home Visitor Supervisor	RN with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife.	At least five years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR and valid AED certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Nurses must receive reflective supervision weekly to meet requirements of the evidence-based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or members LOC needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate LOC.	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Pilot Program Standards.

Home Visitor Provider Qualifications – **Parents as Teachers (PAT)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Home Visitors – Hired by approved PAT implementing agency	High School Diploma or GED	At least two years of experience working with children/families in a related field.	Certification in Family and Infant Studies; Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Pilot Program Standards.
Clinical Manager	Licensed Master Social Worker	A Master's degree in a relevant discipline, one to three years in related program oversight experience.	Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Pilot Program Standards.

Home Visitor Provider Qualifications – **Child First**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Mental Health/ Developmental Clinicians - Hired by approved Child First Affiliate Agency	Master's level or higher degree	Licensed or licensed-eligible (with approval) in a mental health specialty and three to five years of experience providing relationship-based psychotherapy with very young children. Must be culturally informed and sensitive, meet the language needs of the communities served.	All staff should be co-located at same organization to enhance relationship and team building.	Pre-service training in the form of distance learning modules which explain the fundamentals of the Child First model. Includes reading and community-based child observations. On-site, in-person Child First Learning Collaborative that is eight months and divided into four learning sessions of two to three days (Pre-service and in-service training). Also involves ongoing professional development.
Care Coordinator	Bachelor's degree	Knowledge about community resources and experience working in ethnically diverse young children and families.	Same as above	Same as above

Clinical Director/ Supervisor	Master's level or higher degree in Mental Health Training	Experience and training in mental health and child development, including at least five years in relationship-based psychotherapy for young children and families and knowledge of adult psychotherapy. Experience in providing clinical supervision. Experience working with ethnically diverse, low-income, high-risk families.	Same as above	In addition to the training listed above, must participate in biweekly, clinical, and reflective consultation with Child First state clinical director and weekly supervision from a senior clinician at the affiliate agency. Intensive four-day training on the Child First model.

Home Visitor Provider Qualifications – **Healthy Families of America (HFA)**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Family Direct Support Staff (Includes Family Support and Family Resource Staff) – Hired by each site	Minimum of high school diploma	Experience providing services to families and children, soft skills, experience working with culturally diverse communities representative of site's population.	Not Listed	Must have 1.5 to 2 hours of individual supervision a week and be shadowed by supervisors at least twice a year. Mandatory four day similar delivered by nationally certified HFA trainers.

Family Supervisor	Bachelor's degree	Must have either three years in a supervisory position or a master's degree with a clinical and reflective background.	Infant Mental Health Endorsement	Mandatory four day similar delivered by nationally certified HFA trainers, and an additional day focused on administrative, clinical, and reflective supervision.

Home Visitor Provider Qualifications – **Family Connects**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Nurse Home Visitor– Hired by site with consultation from local department of social services.	Registered Nurse with active license in New Mexico.	Not Listed	Recommendation that Nurse Home visitors hold a Bachelor's degree.	Pre-service training that is virtual and in-person. In-service training based on training and mentoring approach. Weekly case review and supervision from Nurse Supervisor.
Nurse Supervisor	Registered Nurse with active license in New Mexico.	Not Listed	Recommendation that Nurse Supervisors hold a Master's degree.	In addition to above, must partake in session specific to supervision.

Home Visitor Provider Qualifications – **SafeCare Augmented**				
Staffing Title	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
Provider; Delivers Home-Based Services – Chosen by a local implementing agency	No minimum education requirement.	Good communication and interpersonal skills, comfortable delivering interventions to families in home setting, responsive to constructive feedback, etc.	Not Listed	Multi-day provider workshop delivered by National SafeCare Training and Resource Center (NSTRC) specialists. Pre-service training in Motivational Interviewing from national trainers.
Coach; Monitors fidelity of implementation, coaching, and service delivery of model	No minimum education requirement.	Same as above	Not Listed	In addition to the above, must receive certification as a SafeCare Coach and complete two-day coaching workshop delivered by NSTRC.

ATTACHMENT C:
SUBSTANCE USE DISORDER CONTINUUM OF CARE

I. ASAM Level 0.5 Early Intervention

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – New Mexico was part of the first cohort of states selected to receive SBIRT funding. In August 2013, SAMHSA awarded NM with a new five-year, $10 million grant to implement SBIRT at selected locations. SBIRT services integrate BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or those having a substance use disorder and offers brief intervention, brief treatment, and appropriate referral as needed. The following are the seven NM SBIRT medical partner sites and locations: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; Christus St. Vincent Family Medicine Center, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; Santa Fe Indian Hospital, Santa Fe; University of New Mexico Hospital, Albuquerque. As of September 2017, 37,536 screens were conducted with 34,092 individuals screened. Grant funding ends July 30, 2018.

II. ASAM Level 1 Outpatient

This is a covered Medicaid benefit, covering a wide range of services including assessment, treatment plan development, individual and group therapy, crisis intervention, pharmacological management, suboxone induction, and methadone maintenance.

III. ASAM Level 2.1 Intensive Outpatient

This is a covered Medicaid benefit. Intensive outpatient (IOP) services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MH providers. The intent is to not exclude consumers with co-occurring disorders. IOP is available for adults with SUD or COD that meet ASAM patient placement criteria for Level II Intensive Outpatient Treatment.

IV. ASAM Level 2.5 Partial Hospitalization Services

Defined in the ASAM criteria as 20 or more hours of clinically intensive programming per week for multidimensional instability not requiring 24-hour care. This is currently a covered benefit for MH but not SUD. The state is currently revising the rule on partial hospitalization to include SUD as a covered benefit.

V. ASAM Level 3 Adult Residential Treatment

This is currently not a covered Medicaid benefit. SUD services at 11 adult residential treatment centers (RTCs) are state-funded. $7.2 million was spent in CY16, with a projection of close to $8 million for CY17. A recent survey of eleven RTC providers showed 199 beds, with 126 for men and 73 for women, far less than what is needed. Nine of ten responding providers use ASAM admission criteria. Only two of ten are CARF accredited, but others are in process. The planned state plan amendment to include adult RTCs in the Medicaid program would enable important transitions of care within the SUD continuum to produce better outcomes for Medicaid members.

ATTACHMENT C:
SUBSTANCE USE DISORDER CONTINUUM OF CARE

VI. Educational and Prevention Efforts

Naloxone Pharmacy Technical Assistance -New Mexico's Office of Substance Abuse Prevention (OSAP) has contracted with the Southwest CARE Center under the Opioid STR grant to provide technical assistance to NM pharmacies reimbursed by Medicaid to dispense naloxone for 100 pharmacy trainings over the two-year grant period, to be completed by September 2018.
Opioid treatment training – the Opioid STR grant supports training on MAT, including buprenorphine, to increase the availability of qualified staff and programs to address the needs of peoples with OUD and improve access to services.

Prescription drug monitoring – New Mexico's OSAP received SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF Rx), which provides $371,616 award per year for five years beginning September 1, 2016. The purpose of the grant is to raise awareness about the dangers of sharing medications, and promote collaboration between states, pharmaceutical and medical communities to understand the risks of over-prescribing to youth and adults; bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and users in a targeted community of high need; and promote increased incorporation of Prescription Monitoring Program (PMP) data into state and community level needs assessments and strategic plans.

Training on Medical Detoxification – Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guide medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in NM. To improve capacity, through CBHTR, New Mexico's Health Care Authority supports training in evidence-based, medically-managed detoxification in community hospitals throughout the state.

Underage Drinking and Prescription Drug Abuse - New Mexico's OSAP was awarded a SAMHSA grant of $1.68 annually for 5 years ($8 million total) beginning October 2015 to address underage drinking and youth prescription drug abuse through targeted strategic planning for selected New Mexico communities. Implementation of evidence-based strategies began August 2017.

PAX Good Behavior Game – PAX is an evidence-based practice that teaches students self-regulation, self-control, and self-management. Long-term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity; and increases in high school graduation rates and college attendance. The Health Care Authority, Behavioral Health Services Division, funded a pilot project in 2016 to train 172 teachers in PAX, reaching 3,329 students. A 2017 RFA is expected to extend the reach to an additional 139 elementary school teachers. The STR will build on SGF efforts to expand PAX to 12 tribal schools.

ATTACHMENT C:
SUBSTANCE USE DISORDER CONTINUUM OF CARE

VII. Opioid Treatment Services

Defined as daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. OTS is a Medicaid funded service. New Mexico's Health Care Authority approves licensing of Opioid Treatment Programs (OTPs). Currently there are 19 OTP, serving approximately 5,800 patients. There is a high concentration of OTPs in Albuquerque, NM's largest population center; thus, the Opioid STR grant (above) is providing training to expand OTC capacity throughout the state.

VIII. Utilization of Buprenorphine

State direction to MCOs to cover buprenorphine in any formulation for the treatment of OUD without requiring a prior authorization.

IX. Behavioral Health Investment Zones

The state has developed and funded two Investment Zones in counties with high rates of OUD: Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted an old hospital into a SUD RTC.

X. Programs for Justice-Involved Individuals

Through state general funds, New Mexico supports a range of programs for adult substance abuse offenders and their families, from jail diversion to treatment to reentry, aftercare and recovery planning. Funding supports district courts, county alternative sentencing programs, and other community providers of services for justice-involved individuals.

XI. Recovery Support Services

New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD. In addition, Medicaid covers the following recovery services: Comprehensive Community Support Services, Behavioral Management Skills Development, Adaptive Skills Building, Psychosocial Rehab, Family Support Services, Recovery Services, and BH Respite Services.

XII. Supportive Housing

NM has a number of supportive housing programs (Crisis Housing, Move-in Assistance and Eviction Prevention, Oxford House, Linkages Permanent Supportive Housing, Special Needs Housing, SAMHSA Permanent Supportive Housing Grant) that provide a continuum of support for individuals with behavioral health issues (SUD, SMI, and COD), from Crisis Housing to Transitional Housing to Permanent Supportive Housing. Some programs allow a primary SUD diagnosis, while others require primary SMI diagnosis. A combination of state funds and federal grants supports these housing programs. Medicaid covers certain supportive housing services through CCSS.

ATTACHMENT C:
SUBSTANCE USE DISORDER CONTINUUM OF CARE

XIII. Collaborative Efforts

The state continues to have strong collaboration and partnership with Counties & Municipalities to provide better coordinated behavioral health services: The January 2017 New Mexico Association of Counties (NMAC) Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana; June 2017 conference: Opioid crisis & increased access to naloxone in detention centers; 2018: Crisis triage and Emergency Department Information Exchange (EDIE). In addition, Bernalillo County approved 1/8 GRT ($16 million) to fund behavioral health services in Albuquerque and Bernalillo County.

ATTACHMENT D
Developing the Evaluation Design

Introduction

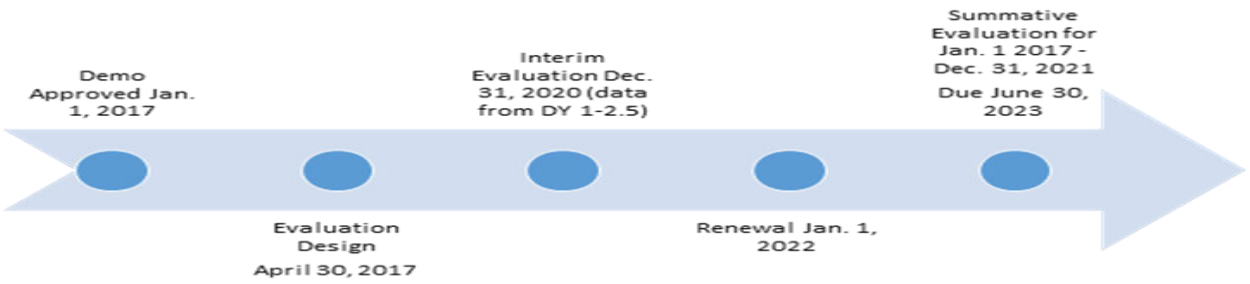
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration;

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (member, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

    b. Qualitative analysis methods may be used, and must be described in detail.

    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

    f. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

    g. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison

groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid members -Members with diabetes diagnosis	Medicaid fee-for-service and encounter claims records	Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	Sample, e.g., PPS administrators	Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published

regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

State of New Mexico Health Care Authority

Medicaid Section 1115 Demonstration Waiver – Turquoise Care

Evaluation Design

June 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Background

Since 2014, New Mexico has utilized Section 1115 Demonstration Waiver Authority to operate its comprehensive managed care system, Centennial Care, along with the home- and community-based services (HCBS) Community Benefit (CB) program and several pilot programs serving Medicaid and Children's Health Insurance Program (CHIP) members. On December 9, 2022, the New Mexico Health Care Authority (HCA) submitted an application to the Centers for Medicare & Medicaid Services (CMS) to extend its Section 1115 Demonstration Waiver, Centennial Care 2.0, under a new name, Turquoise Care.[1-1] Aside from the name change, Turquoise Care aims to continue to build upon the successes of Centennial Care (January 2014–December 2018) and Centennial Care 2.0 (January 2019–June 2024) by providing critical healthcare coverage and access, improving health outcomes, and addressing the social and economic determinants of health. CMS approved Turquoise Care on July 25, 2024, with a demonstration period of July 25, 2024, through December 31, 2029.[1-2] Through Turquoise Care, the State intends to accomplish four distinct goals:

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

Turquoise Care specifically targets five population groups due to their historical experiences of social inequities, disparities, and demands for healthcare services. The waiver's key initiatives and authorities were created to support these populations in receiving equitable care. These targeted populations include:

- Prenatal, postpartum, and members parenting children, including children in State custody.
- Seniors and members with long-term support services (LTSS) needs.
- Members with behavioral health (BH) conditions.
- Native American members.
- Justice-involved individuals.

Turquoise Care expands on several key initiatives introduced during Centennial Care and Centennial Care 2.0, including:

- Expanding access to LTSS through the CB.
- Expanding Member Rewards (MR), formerly known as Centennial Rewards (CR), and providing incentives for members to pursue healthy behaviors.

1-1 Centers for Medicare & Medicaid Services. State Application – Demonstration Extension. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa5.pdf. Accessed on: Oct 10, 2024.

1-2 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Oct 10, 2024.

- Expanding New Mexico's care coordination program for members requiring additional support and coordination, including high fidelity wraparound (HFW) intensive care coordination for children and youth with complex care requirements.
- Expanding home visiting services focused on perinatal care and early childhood development.
- Implementing initiatives to improve substance use disorder (SUD) services and ensure that the appropriate level of treatment is provided, medication-assisted treatment (MAT) is available, and care coordination between levels of care is enhanced.
- Implementing pre-tenancy and tenancy services for members who are homeless or at risk of experiencing homelessness and meet specific eligibility criteria.
- Maintaining and enhancing access to mental health services and expanding the delivery system to provide more comprehensive and coordinated treatment to members with serious mental illness (SMI) and serious emotional disturbance (SED).

In addition to expanding many of the Centennial Care 2.0 initiatives, CMS approved two new programs through Turquoise Care. First, New Mexico can provide reentry services for eligible individuals up to 90 days prior to their release from incarceration. This pre-release benefit package aims to improve inmates' transition back into the community by promoting continuity of coverage, access to care, quality of care, and early identification of physical health (PH), BH, and health-related social needs (HRSN). The benefits include case management, MAT services, diagnostic services, prescription medication, peer support, and PH and BH consultation services.

Additionally, Turquoise Care authorizes New Mexico to provide HRSN support services for individuals meeting State-defined social and clinical eligibility criteria. HRSN services include short-term post-hospitalization recuperative services with room and board for up to six months, as well as medically tailored meals tailored to the health risk of pregnant individuals who meet specific risks and needs-based criteria. Finally, the housing supports expansion through Turquoise Care authorizes providers to refer members who are homeless or at risk of experiencing homelessness to pre-tenancy and tenancy supports.

CMS approved an amendment to Turquoise Care on October 16, 2024, which granted New Mexico the authority to provide Medicaid reimbursement for traditional health care practices (THCP) provided through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, and facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act. [1-3, 1-4] The amendment expands American Indian and Alaska Native (AI/AN) members' access to culturally appropriate care within the State, as determined by each Tribe, Pueblo, or Nation, which is intended to improve health outcomes and quality of care, and reduce disparities among AI/AN members. Provider participation in the THCP initiative is voluntary.

[1-3] Urban Indian Organizations will not deliver Medicaid reimbursable THCP services through Turquoise Care.
[1-4] Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-dmnstrtn-aprvl-10162024.pdf. Accessed on: Apr 8, 2025.

Impacted Populations

Table 1-1 presents the eligibility groups served through Turquoise Care, as defined in the Special Terms and Conditions (STCs).[1-5] As of May 2024, New Mexico's Medicaid program provides care for over 776,000 members throughout the State.[1-6] In June 2023, 83 percent of Medicaid members in New Mexico were enrolled in managed care.[1-7]

Table 1-1—Turquoise Care Covered Eligibility Groups

Group	Covered Populations
TANF and Related	• Parents/caretakers • Extension due to spousal support • Pregnant individuals • Children under 19 • Current and former foster care children • Breast and Cervical Cancer Program • Transitional Medical Assistance
Medicaid Expansion	• Non-pregnant adults ages 19 years through 64 years with income at or below 133 percent FPL
SSI Medicaid	• Aged, blind, and disabled • Institutionalized individuals
SSI Dual Eligible	• Aged, blind, and disabled • Institutionalized individuals

Note: FPL: federal poverty level; SSI: supplemental security income; TANF: Temporary Assistance for Needy Families

The following populations are excluded from Turquoise Care:

- Qualified Medicare members – 1902(a)(10)(E)(i); 1905(p)
- Specified low-income Medicare members – 1902(a)(10)(E)(iii)
- Qualifying individuals – 1902(a)(10)(E)(iv)
- Qualified disabled working individuals – 1902(a)(10)(E)(ii); 1905(s)
- Non-citizens only eligible for emergency medical services – 1903(v)
- Program for All-Inclusive Care for the Elderly (PACE) participants – 1934

1-5 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Oct 10, 2024.

1-6 KKF. Medicaid and CHIP Monthly Enrollment. Available at: https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-mexico%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on: Oct 10, 2024.

1-7 New Mexico Legislative Finance Committee. 2023 Accountability Report. Available at: https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Medicaid%20Accountability%20Report.pdf. Accessed on: Oct 10, 2024.

- Individuals residing in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) – 1905(a)(15)
- Developmental Disabilities Waiver, Mi Via Waiver, Medically Fragile Waiver participants and Supports Waiver participants for HCBS only
- Individuals receiving family planning-only benefits through the Family Planning category of eligibility (except as provided in STC 4.9)

Previous Report Findings

The April 2023 Centennial Care 2.0 Interim Evaluation Report, approved by CMS on September 29, 2023, demonstrated New Mexico's progress toward its Section 1115 Demonstration Waiver goals.[1-8] Despite the challenges and disruptions to the healthcare system resulting from the coronavirus disease 2019 (COVID-19) public health emergency (PHE), there were several notable successes of Centennial Care 2.0. Members who received peer support showed improvements in engagement of SUD treatment. Additionally, members engaged with a HH maintained high rates of preventive care visits, even when care was disrupted due to the COVID-19 PHE. Utilization of telemedicine increased between the start of Centennial Care 2.0 and the start of the COVID-19 PHE, which necessitated a shift toward this care delivery model and significantly increased its usage. However, the COVID-19 PHE impacted care in several areas, including Centennial Care 2.0 members' access to preventive and well-care visits. The measures utilized to evaluate CR were insufficient to rigorously evaluate the impact of the program, as they did not control for participant self-selection bias. Additionally, some programs, such as the Centennial Home Visiting (CHV) program, did not include a comparison group to properly identify a counterfactual and only included one measure to assess the program. The independent evaluator recommended that the State identify additional robust measures to successfully evaluate CR and CHV.

Turquoise Care Evaluation Design Additions

This Evaluation Design builds upon the Evaluation Design used to evaluate Centennial Care 2.0.[1-9] To address the introduction of multiple new programs with the approval of Turquoise Care and to further refine pre-existing programs, additional research questions and measures have been added to the Turquoise Care Evaluation Design. Table 1-2 lists the research questions that are new to Turquoise Care.

Table 1-2—New Research Questions

New Turquoise Care Research Questions
Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care while maintaining cost-effective care.
Has the number of continuous NFLOC approvals maintained or increased?
Has the percentage of members ages 0–5 years with continuous enrollment increased?
Has the percentage of members ages 0–5 years with access to preventive services increased?
Has the percentage of members ages 0–5 years utilization of hospital services changed?

1-8 Centers for Medicare & Medicaid Services. Interim Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-interim-evaluation-rpt.pdf. Accessed on: Oct 10, 2024.

1-9 Additional supplemental information to the Evaluation Design including the evaluation timeline, proposed budget, and measure specifications are available in Appendix A, Attachments.

New Turquoise Care Research Questions
Is the rate of preventive health services the same or higher than prior to the renewal period?
Is the rate of management of BH conditions the same or better than prior to the renewal period?
Have members' self-assessed healthcare quality and outcomes maintained or improved?
Has access to telemedicine services maintained or improved?
Has the percentage of Turquoise Care members participating in MR and accessing preventive health services increased?
Does the HFW program increase utilization of preventive health services?
Have the payment amounts for providers in VBP arrangements increased?
Does Turquoise Care provide cost-effective care?
Aim Two: Improve quality of care and outcomes for Medicaid members with SUD.
Did Turquoise Care provide cost-effective care among members with an SUD diagnosis?
Aim Three: Improve quality of care and outcomes for Medicaid members with SMI/SED.
Did Turquoise Care provide cost-effective care among members with SMI/SED diagnoses?
Aim Four: Improve health outcomes and reduce health inequities among members through HRSN services and the reentry program.
Did members eligible for short-term post-hospitalization recuperative services have increased access to recuperative services?
Did members eligible for short-term post-hospitalization recuperative services increase utilization of preventive care?
Did members utilizing short-term post-hospitalization recuperative services change their utilization of hospital services?
Did the short-term post-hospitalization recuperative services provide cost-effective care for members?
How did local investments in short-term post-hospitalization recuperative services change over the course of the evaluation?
Did the expansion of pre-tenancy and tenancy services increase the number of members receiving housing supports?
Did the expansion of pre-tenancy and tenancy services improve follow-up care among eligible members?
Did the expansion of pre-tenancy and tenancy services improve members' health outcomes?
Did nutrition assistance increase access to medically tailored meals?
Did nutrition assistance increase utilization of preventive care?
Did nutrition assistance impact hospital utilization?
Did nutrition assistance improve health outcomes?
Did the nutrition assistance program provide cost-effective care for members?
How did local investments in nutrition assistance change over the course of the evaluation?
Do home visiting services improve health outcomes among perinatal individuals and infants?
What are barriers or facilitators to implementing the reentry program?
Does engagement in the reentry program increase members' access to preventive health services?
Does engagement in the reentry program increase members' access to BH treatment?
Does engagement in the reentry program increase members' access to SUD providers and treatment?
Does engagement in the reentry program impact hospital utilization?
Do members participating in the reentry program have reduced rates of mortality, overdose, and suicide?
Did the reentry program provide cost-effective care for members?

New Turquoise Care Research Questions
What are barriers or facilitators of the THCP initiative?
Did members access services covered under the THCP initiative?
Did the THCP initiative provide cost-effective care for members?

Note: BH: behavioral health; HFW: high-fidelity wraparound; HRSN: health-related social needs; MR: member rewards; NFLOC: nursing facility level of care; SED: serious emotional disturbance; SMI: serious mental illness; SUD: substance use disorder; THCP: traditional health care practices; VBP: value-based purchasing

2. Evaluation Questions and Hypotheses

This section provides the logic models, hypotheses, research questions, and measures for each aim of the evaluation of the Turquoise Care Section 1115 Demonstration Waiver.

Aim One

Logic Model

Figure 2-1 illustrates that by maintaining or expanding the array of healthcare services, enhancing the integration of behavioral health (BH) and physical health (PH) services, and increasing access to ambulatory and preventive services, members will experience improved access to services and better quality of care. New Mexico aims to achieve these goals by promoting cost-effective care, sustaining or improving service eligibility and provider rates, and enhancing hospital and provider efficiency and effectiveness.

Figure 2-1—Aim One Logic Model

Aim One

Continue the use of appropriate services by members to enhance member access to services and quality of care while maintaining cost-effective care

Primary Drivers	Secondary Drivers	Interventions
Healthcare services array	Expand or maintain the availability of HCBS	Continue to expand access to LTSS and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities Increase the total enrollment limit for the CB program
	Maintain continuity of healthcare	Provide continuous eligibility for children ages 0–5 years Continue to provide a continuous NFLOC approval system for members whose condition is not expected to change
	Provide integrated healthcare through the Medicaid delivery system	Expand telemedicine providers and services Contract with MCOs to provide comprehensive care to members, including acute care, pharmacy benefits, BH services, institutional services, and HCBS
PH and BH integration	Maintain member engagement with HH	Continue to promote participation in HH for eligible members
	Enhance care coordination expectations	Refine care coordination to better meet the needs of high-cost, high-need members Provide HFW to children with an SED diagnosis
Ambulatory and preventive services	Increase access and incentivize members to engage in preventive services	Expand MR Increase utilization of preventive care services
Hospital and provider efficiency and effectiveness	Incentivize hospitals to improve the health of members and quality of services	Provide hospital-directed payment and primary care payment reform incentives
	Cost-effective care	Promote coordinated care and preventive services for members through Turquoise Care

Note: BH: behavioral health; CB: Community Benefit; HCBS: home- and community-based services; HFW: high-fidelity wraparound; HH: health home; LTSS: long-term services and supports; MCO: managed care organization; MR: Member Rewards; NFLOC: Nursing Facility Level of Care; PH: physical health; SED: serious emotional disturbance

Hypotheses and Research Questions

To comprehensively evaluate Aim One, eight hypotheses will be tested using 17 research questions (Table 2-1).

Table 2-1—Aim One Hypotheses

	Aim One Hypotheses
1	Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain or increase the number of members accessing CB services.
2	The ability for LRI to provide PCS to individuals receiving CB or EPSDT PCS will ensure member access to CB or EPSDT PCS and improve continuity of care through NFLOC approvals.
3	Providing continuous eligibility will improve continuity of care among children ages 0 to 5 years.
4	Managed care or care coordination through the HH program will maintain access to effective and quality care.
5	Expanding member incentives for preventive care through the MR program will encourage members to engage in preventive care services.
6	The continuation of the HFW program will serve high-needs members with an SED diagnosis.
7	Turquoise Care will provide cost-effective care.

Note: CB: community benefit; EPSDT: Early and Period Screening, Diagnostic, and Treatment; HFW: high-fidelity wraparound; HH: Health Homes; LRI: legally responsible individuals; LTSS: long-term services and supports; MR: Member Rewards; NFLOC: nursing facility level of care PCS: personal care services; SED: serious emotional disturbance

Hypothesis 1 (Table 2-2) measures whether the number of members accessing Community Benefit (CB) services will be maintained through expanding access to long-term services and supports (LTSS) and rebalancing services to deliver care to more members in their homes and communities.

Table 2-2—Hypothesis 1 Research Questions and Measures

Hypothesis 1: Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain or increase the number of members accessing CB services.	
Research Question 1.1: Has the percentage of members accessing CB services increased or maintained year-over-year?	
1	Number and percentage of Turquoise Care members enrolled and receiving CB services
2	Number and percentage of CB members receiving home-delivered meals

Note: CB: community benefit; LTSS: long-term services and supports

Hypothesis 2 (Table 2-3) measures whether authorizing legally responsible individuals (LRIs) to provide personal care services (PCS) to members receiving CB or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) PCS will ensure member access to CB or EPSDT PCS. In addition, Hypothesis 2 assesses if the number of members eligible for nursing facility level of care (NFLOC) maintained or increased during the Demonstration renewal.

Table 2-3—Hypothesis 2 Research Questions and Measures

Hypothesis 2: The ability for LRI to provide PCS to individuals receiving CB or EPSDT PCS will ensure member access to CB or EPSDT PCS and improve continuity of care through NFLOC approvals.	
Research Question 2.1: Is the percentage of members receiving CB or EPSDT PCS the same or higher after the implementation of this benefit?	
3	Percentage of members receiving EPSDT PCS
4	Percentage of LTSS-eligible members receiving CB PCS
5	Average number of EPSDT PCS per utilizing member
6	Average number of CB PCS per utilizing member
Research Question 2.2: Has the number of continuous NFLOC approvals maintained or increased?	
7	Number of continuous NFLOC approvals

Note: CB: community benefit; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; LRI: legally responsible individual; LTSS: long-term services and supports; NFLOC: nursing facility level of care; PCS: personal care services

Hypothesis 3 (Table 2-4) determines whether children's continuity of and access to care will be improved through continuous eligibility.

Table 2-4—Hypothesis 3 Research Questions and Measures

Hypothesis 3: Providing continuous eligibility will improve continuity of care among children ages 0 to 5 years.	
Research Question 3.1: Has the percentage of members ages 0–5 years with continuous enrollment increased?	
8	Length of enrollment among members ages 0–5 years
9	Percentage of members ages 0–5 years who had a gap in Medicaid coverage
10	Average number of gaps in Medicaid coverage for members ages 0–5 years
11	Average number of days per gap in Medicaid coverage for members ages 0–5 years
Research Question 3.2: Has the percentage of members ages 0–5 years with access to preventive services increased?	
12	Percentage of members who had a well-child visit in the first 30 months of life
13	Percentage of children and adolescents who had a well-care visit
14	Percentage of children 2 years of age with appropriate immunization status
Research Question 3.3: Has the percentage of members ages 0–5 years utilization of hospital services changed?	
15	Number of potentially preventable ED visits, per 1,000 MM
16	Number of all-cause ED visits, per 1,000 MM

Note: ED: emergency department; MM: member months

Hypothesis 4 (Table 2-5) evaluates whether there will be increased access to preventive and BH services among members enrolled in Turquoise Care and among those participating in a Health Home (HH).

Table 2-5—Hypothesis 4 Research Questions and Measures

Hypothesis 4: Managed care or care coordination through the HH program will maintain access to effective and quality care.	
Research Question 4.1: Is there an increase in the percentage of members enrolled in a HH?	
17	Number/percentage of Turquoise Care members enrolled in a HH
Research Question 4.2: Does the HH program increase access to care coordination?	
18	Number and percentage of members receiving care coordination
Research Question 4.3: Does engagement in a HH increase utilization of preventive health services and improve disease management and quality of care?	
19	Percentage of adults who accessed preventive/ambulatory health services
20	Percentage of children and adolescents who had a well-care visit
21	Percentage of members with schizophrenia or bipolar disorder who are using antipsychotic medications who are screened for diabetes
22	Percentage of members who remained on an antidepressant medication treatment
23	Percentage of members with a follow-up visit after hospitalization for mental illness
Research Question 4.4: Is the rate of preventive health services the same or higher than prior to the renewal period?	
24	Percentage of adults who accessed preventive/ambulatory health services
25	Percentage of children and adolescents who had a well-care visit in the first 30 months of life
26	Percentage of children and adolescents who had a well-care visit
Research Question 4.5: Is the rate of management of BH conditions the same or better than prior to the renewal period?	
27	Percentage of members who remained on an antidepressant medication treatment
28	Percentage of members with a follow-up visit after hospitalization for mental illness
Research Question 4.6: Have members' self-assessed healthcare quality and outcomes maintained or improved?	
29	Percentage of members who reported a high rating of overall healthcare (8, 9, or 10)
30	Percentage of respondents who reported a high rating of health plan (8, 9, or 10)
31	Percentage of respondents who reported a rating of overall health as very good or excellent
32	Percentage of respondents who reported a rating of overall mental or emotional health as very good or excellent
Research Question 4.7: Has access to telemedicine services maintained or improved?	
33	Number of telemedicine providers
34	Number of members receiving telemedicine services

Note: BH: behavioral health; HH: Health Home

Hypothesis 5 evaluates if participation in Member Rewards (MR) will improve member engagement in preventive care. The research question and measures associated with Hypothesis 5 are presented in Table 2-6.

Table 2-6—Hypothesis 5 Research Questions and Measures

Hypothesis 5: Expanding member incentives for preventive care through the MR program will encourage members to engage in preventive care services.	
Research Question 5.1: Has the percentage of Turquoise Care members participating in MR and accessing preventive health services increased?	
35	Percentage of Turquoise Care members participating in MR
36	Percentage of MR participating members and non-participating members with an annual preventive service
37	Percentage of MR participating and redeeming, and MR participating and non-redeeming members with an annual preventive service

Note: MR: Member Rewards

Hypothesis 6 measures the impact of the high-fidelity wraparound (HFW) program on members with a serious emotional disturbance (SED). The research questions and measures associated with Hypothesis 6 are presented in Table 2-7.

Table 2-7—Hypothesis 6 Research Questions and Measures

Hypothesis 6: The continuation of the HFW program will serve high-needs members with an SED diagnosis.	
Research Question 6.1: Is the HFW program enrolling the intended target population?	
38	Number of HFW members enrolled in the program
39	Percentage of HFW members with SED diagnosis in the 11 months prior to enrollment
Research Question 6.2: Does the HFW program increase utilization of preventive health services?	
40	Percentage of children and adolescents who had a well-care visit
41	Percentage of members with a follow-up visit after hospitalization for mental illness
42	Percentage of members with a follow-up visit after ED visit for mental illness

Note: ED: emergency department; HFW: high-fidelity wraparound; SED: serious emotional disturbance

Hypothesis 7 (Table 2-8) measures the cost-effectiveness of Turquoise Care.

Table 2-8—Hypothesis 7 Research Questions and Measures

Hypothesis 7: Turquoise Care will provide cost-effective care.	
Research Question 7.1: Have the payment amounts for providers in VBP arrangements increased?	
43	Percentage of total payments that are for providers in VBP arrangements
Research Question 7.2: Does Turquoise Care provide cost-effective care?	
44	Total and PMPM cost (among managed care members)
45	Total and PMPM cost (among managed care users)

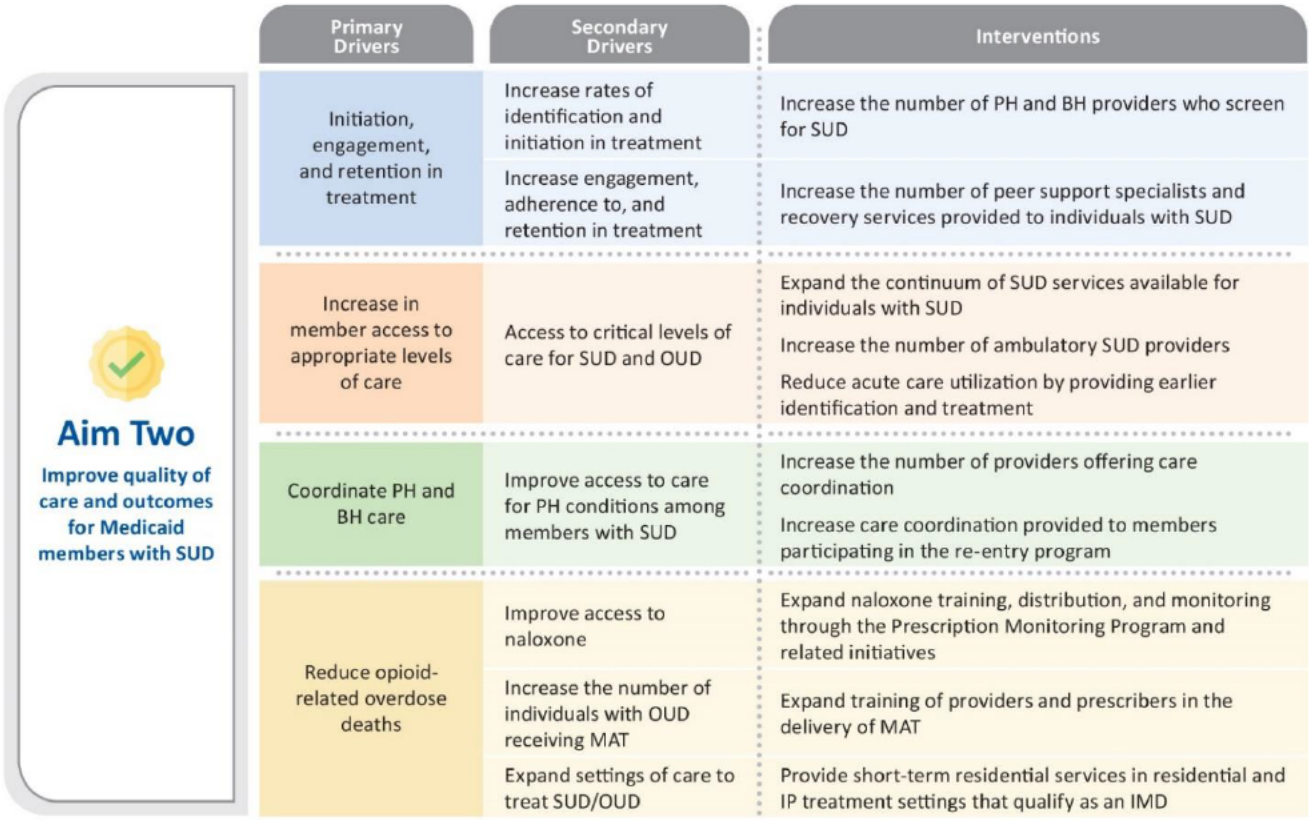
Note: PMPM: per-member per-month; VBP: value-based purchasing

Aim Two

Logic Model

Figure 2-2 illustrates that the quality of care and outcomes for members with a substance use disorder (SUD) will be improved by enhancing members' initiation, engagement, and retention in SUD treatment; improving access to appropriate levels of care; coordinating BH and PH services; and reducing deaths caused by opioid overdoses.

Figure 2-2—Aim Two Logic Model



Note: BH: behavioral health; IMD: Institution for Mental Diseases; IP: inpatient; MAT: medication-assisted treatment; OUD: opioid use disorder; PH: physical health; SUD: substance use disorder

Hypotheses and Research Questions

To comprehensively evaluate Aim Two, five hypotheses will be tested using six research questions (Table 2-9).

Table 2-9—Aim Two Hypotheses

	Aim Two Hypotheses
1	Turquoise Care will increase or maintain the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for SUD.
2	Turquoise Care will increase or maintain peer support services, which will result in more individuals engaging in and retaining in SUD treatment.

Aim Two Hypotheses	
3	Turquoise Care will improve or maintain access to a comprehensive continuum of SUD care, which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.
4	Turquoise Care will maintain or increase use of MAT and reduce the number of high dosage opioid prescriptions, which will result in fewer overdose deaths due to opioid use
5	Turquoise Care will provide cost-effective care for members with an SUD.

Note: ED: emergency department; IP: inpatient; MAT: medication-assisted treatment; SUD: substance use disorder

Hypothesis 1 (Table 2-10) measures whether screening for and initiation in SUD treatment will increase as the number of providers screening for SUD is increased or maintained.

Table 2-10—Hypothesis 1 Research Questions and Measures

Hypothesis 1: Turquoise Care will increase or maintain the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for SUD.	
Research Question 1.1: Did the number of individuals screened and treated for SUD maintain or increase?	
46	Number/percentage of individuals screened for SUD
47	Percentage of individuals with an SUD diagnosis who received any SUD service during the MY

Note: MY: measurement year; SUD: substance use disorder

Hypothesis 2 measures if Turquoise Care increases the availability of peer support services, which will increase engagement and retention in treatment for SUD. The research questions and measures associated with Hypothesis 2 are presented in Table 2-11.

Table 2-11—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Turquoise Care will increase or maintain peer support services, which will result in more individuals engaging in and retaining in SUD treatment.	
Research Question 2.1: Has the percentage of individuals with an SUD diagnosis who received peer support services and treatment maintained or increased?	
48	Percentage of individuals with an SUD diagnosis who received peer support
49	Initiation of SUD treatment
50	Engagement of SUD treatment
51	Continuity of pharmacotherapy for OUD

Note: OUD: opioid use disorder; SUD: substance use disorder

Hypothesis 3 (Table 2-12) measures whether an increased or maintained continuum of SUD services will decrease emergency department (ED) and inpatient (IP) utilization and SUD IP readmissions.

Table 2-12—Hypothesis 3 Research Questions and Measures

Hypothesis 3: Turquoise Care will improve or maintain access to a comprehensive continuum of SUD care, which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.	
Research Question 3.1: Has the utilization of acute care settings by individuals with SUD decreased?	
52	Percentage of members with an SUD diagnosis who used SUD services stratified by the following settings: any setting, early intervention, OP, intensive OP, and residential and IP
53	Percentage of ED visits among individuals with SUD diagnoses

Hypothesis 3: Turquoise Care will improve or maintain access to a comprehensive continuum of SUD care, which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.	
54	Average LOS in an ED among members with an SUD diagnosis prior to admission to an IMD
55	Percentage of IP admissions for SUD-related treatment
56	7- and 30-day IP and residential SUD readmission rates

Note: ED: emergency department; IMD: Institutions for Mental Diseases; IP: inpatient; LOS: length of stay; MM: member months; OP: outpatient; SUD: substance use disorder

Hypothesis 4 measures if there will be fewer opioid deaths as a result of medication-assisted treatment (MAT) and the prescription monitoring program. The research questions and measures associated with Hypothesis 4 are presented in Table 2-13.

Table 2-13—Hypothesis 4 Research Questions and Measures

Hypothesis 4: Turquoise Care will maintain or increase use of MAT and reduce the number of high dosage opioid prescriptions, which will result in fewer overdose deaths due to opioid use.	
Research Question 4.1: Has the number of individuals with OUD or SUD receiving MAT increased or maintained?	
57	Percentage of members who have a claim for MAT for SUD
Research Question 4.2: Is there a decrease or maintenance of the number of deaths due to overdose?	
58	Use of opioids at high dosage in persons without cancer
59	Rate of deaths due to overdose

Note: MAT: medication-assisted treatment; OUD: opioid use disorder; SUD: substance use disorder

Hypothesis 5 (Table 2-14) assesses whether Turquoise Care provides cost-effective care for members with an SUD.

Table 2-14—Hypothesis 5 Research Questions and Measures

Hypothesis 5: Turquoise Care will provide cost-effective care for members with an SUD.	
Research Question 5.1: Did Turquoise Care provide cost-effective care among members with an SUD diagnosis?	
60	Total and PMPM cost
61	Total and PMPM cost of SUD, SUD-IMD, SUD-other, and non-SUD care, by setting (including claims data, IP, OP, pharmacy, LTC, and capitated payments to MCOs)

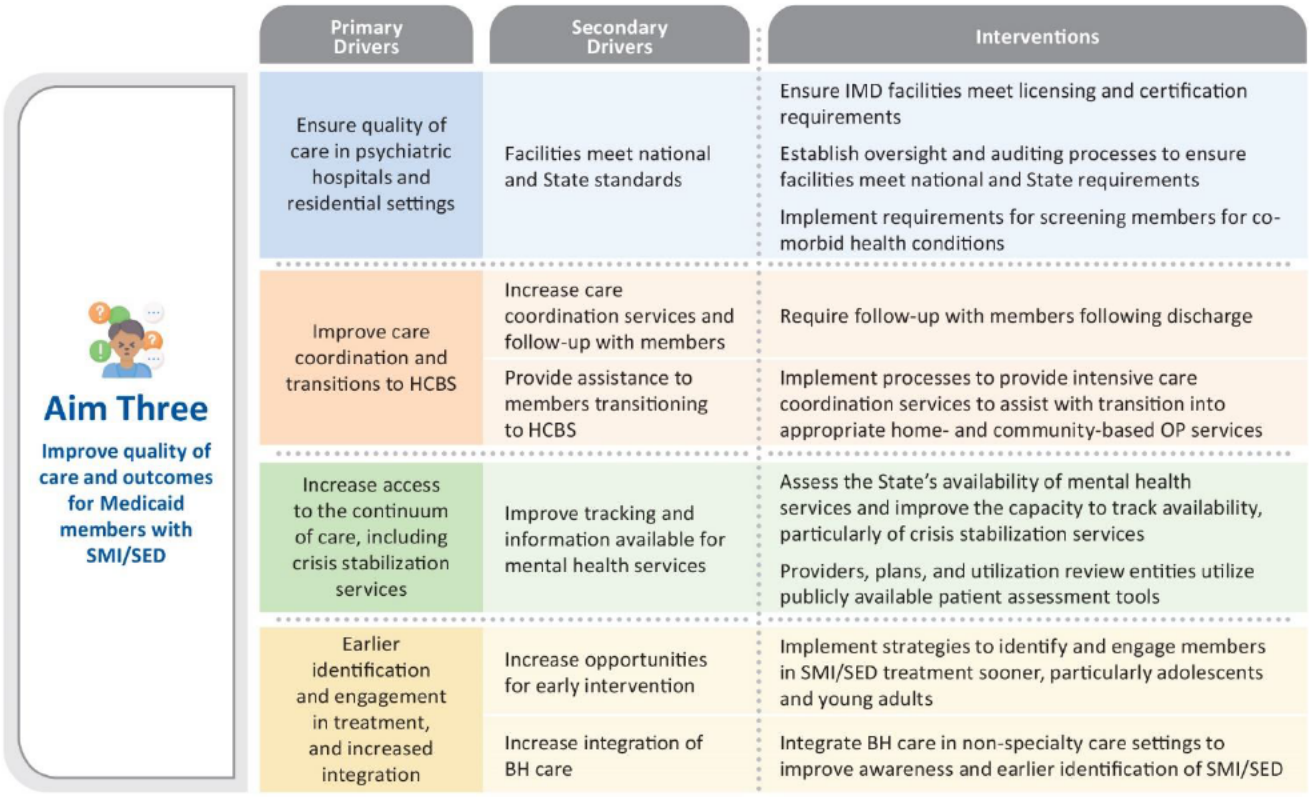
Note: IMD: Institutions for Mental Diseases; IP; inpatient; LTC: long-term care; MCO: managed care organization; OP: outpatient; PMPM: per member per month; SUD: substance use disorder

Aim Three

Logic Model

Figure 2-3 illustrates that the quality of care and outcomes for members with a serious mental illness (SMI)/SED will be improved by ensuring quality of care in psychiatric and residential settings, enhancing care coordination and transitions to community-based care, expanding access to the continuum of care, and promoting early identification and engagement in treatment.

Figure 2-3—Aim Three Logic Model



Note: BH: behavioral health; HCBS: home- and community- based services; OP: outpatient; SED: serious emotional disturbance; SMI: serious mental illness

Hypotheses and Research Questions

To comprehensively evaluate Aim Three, five hypotheses will be tested using five research questions (Table 2-15).

Table 2-15—Aim Three Hypotheses

	Aim Three Hypotheses
1	Turquoise Care will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.
2	Turquoise Care will maintain an average LOS for IMDs of 30 days.
3	Turquoise Care will result in increased rates of care coordination for members with SMI/SED.
4	Turquoise Care will decrease utilization and LOS in EDs among Medicaid members who met eligibility criteria of members with SMI/SED.
5	Turquoise Care will provide cost-effective care for members with an SMI/SED diagnosis.

Note: ED: emergency department; IMD: Institution for Mental Diseases; LOS: length of stay; SED: serious emotional disturbance; SMI: serious mental illness

Hypothesis 1 assesses if there will be an increase in the engagement and integration of SMI/SED treatment as a result of Turquoise Care. The research questions and measures associated with Hypothesis 1 are presented in Table 2-16.

Table 2-16—Hypothesis 1 Research Questions and Measures

Hypothesis 1: Turquoise Care will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.	
Research Question 1.1: Has the number of individuals identified and/or engaged in SMI/SED treatment increased?	
62	Percentage of individuals identified with an SMI/SED who have used services related to mental health
63	Number of members diagnosed with an SMI/SED condition by non-BH providers
64	Number of registered mobile crisis providers
65	Number of members with antipsychotic medications that received psychosocial care
66	Number of members newly prescribed an antipsychotic medication, who received follow-up care

Note: BH: behavioral health; SED: serious emotional disturbance; SMI: serious mental illness

Hypothesis 2 (Table 2-17) measures whether the average length of stay (LOS) in an Institution for Mental Diseases (IMD) will be maintained at 30 days during Turquoise Care.

Table 2-17—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Turquoise Care will maintain an average LOS for IMDs of 30 days.	
Research Question 2.1: Has the average LOS for IMDs been maintained at 30 days?	
67	Average LOS in an IMD

Note: IMD: Institution for Mental Diseases; LOS: length of stay

Hypothesis 3 (Table 2-18) measures whether care coordination for members with SMI/SED will increase during Turquoise Care.

Table 2-18—Hypothesis 3 Research Questions and Measures

Hypothesis 3: Turquoise Care will result in increased rates of care coordination for members with SMI/SED.	
Research Question 3.1: Has the percentage of members with SMI/SED receiving care coordination increased?	
68	Percentage of members with SMI/SED receiving care coordination
69	Percentage of members with a follow-up visit after an ED visit for mental illness
70	Percentage of members with a follow-up visit after hospitalization for mental illness

Note: ED: emergency department; SED: serious emotional disturbance SMI: serious mental illness

Hypothesis 4 assesses if Turquoise Care will decrease ED utilization by members with SUD. The research questions and measures associated with Hypothesis 4 are presented in Table 2-19.

Table 2-19—Hypothesis 4 Research Questions and Measures

Hypothesis 4: Turquoise Care will decrease utilization and LOS in EDs among Medicaid members who met eligibility criteria of members with SMI/SED.	
Research Question 4.1: Has the utilization of hospital services by individuals with SMI/SED decreased?	
71	Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of members with an SMI/SED
72	Number of members with an SMI/SED who used ED services for mental health during the measurement period
73	Average LOS in an ED among members with an SMI/SED prior to admission to an IMD
74	Number of members with an SMI/SED all-cause unplanned readmission within 30 days of psychiatric hospitalization

Note: ED: emergency department; LOS: length of stay; MM: member months; SED: serious emotional disturbance; SMI: serious mental illness

Hypothesis 5 (Table 2-20) measures whether Turquoise Care will provide cost-effective SMI/SED care.

Table 2-20—Hypothesis 5 Research Questions and Measures

Hypothesis 5: Turquoise Care will provide cost-effective care for members with an SMI/SED diagnosis.	
Research Question 5.1: Did Turquoise Care provide cost-effective care among members with SMI/SED diagnoses?	
75	Total and PMPM cost
76	Total and PMPM cost of SMI/SED diagnosis, by IMD and other setting (including claims data, IP, OP, pharmacy, LTC, and capitated payments to MCOs)

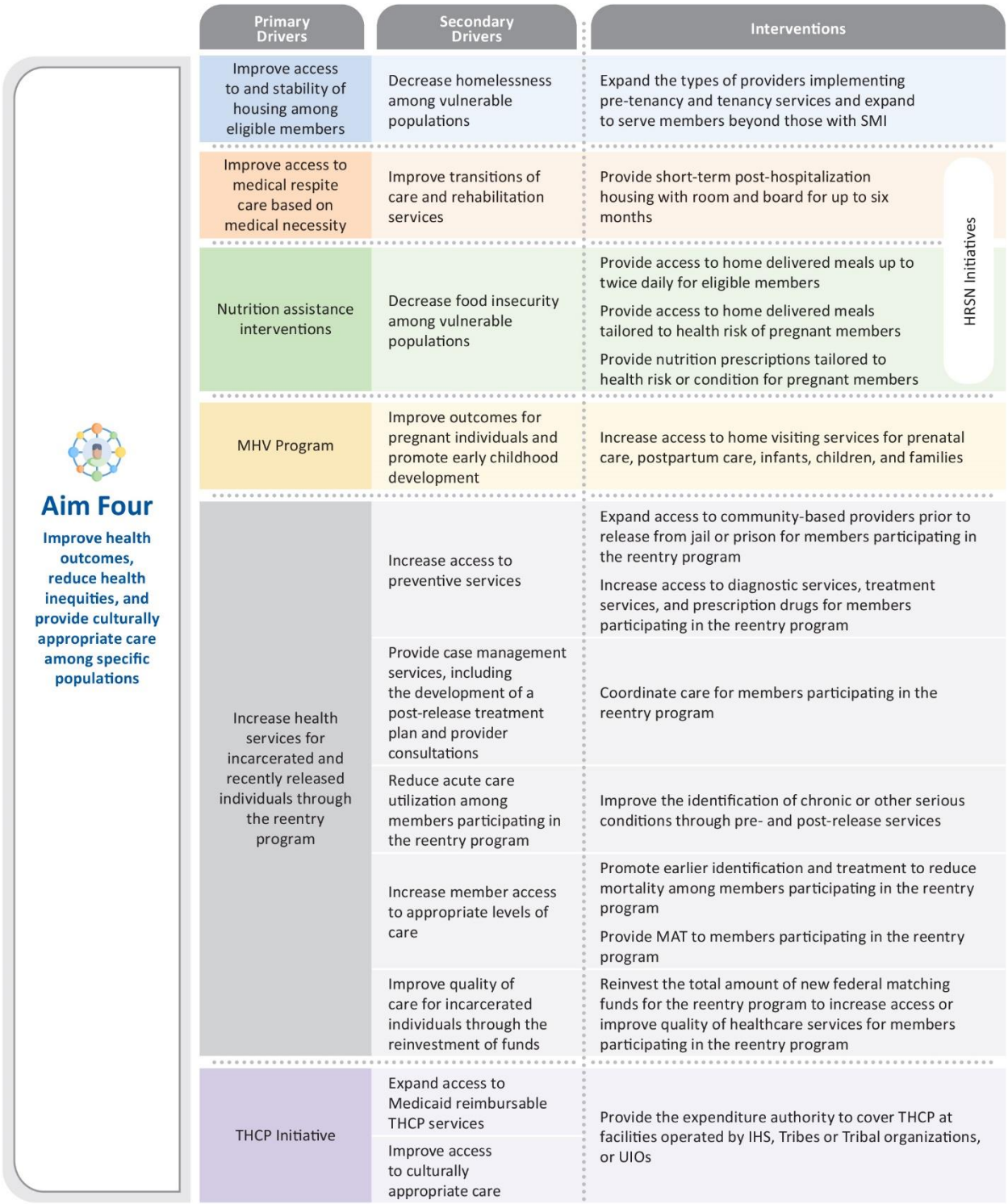
Note: IMD: Institution for Mental Diseases; IP: inpatient; LTC: long-term care; MCO: managed care organization; OP; outpatient; PMPM: per member per month; SED: serious emotional disturbance; SMI: serious mental illness

Aim Four

Logic Model

Figure 2-4 illustrates that members in the reentry program and those with health-related social needs (HRSN) will experience improved outcomes and reduced inequities through enhanced access to stable housing, nutrition assistance, home visitation opportunities, and increased health services provided by the reentry program.

Figure 2-4—Aim Four Logic Model



Note: HRSN: health-related social needs; IHS: Indian Health Service; MAT: medication-assisted treatment; MHV: Medicaid Home Visiting; SMI: serious mental illness; THCP: traditional healthcare practices; UIO: Urban Indian Organization

Hypotheses and Research Questions

To comprehensively evaluate Aim Four, seven hypotheses will be tested using 18 research questions (Table 2-21).

Table 2-21—Aim Four Hypotheses

	Aim Four Hypotheses
1	Providing post-hospitalization recuperative support and rehabilitation services will improve health outcomes and housing stability to prevent rehospitalization.
2	Short-term post-hospitalization recuperative services will provide cost-effective services.
3	Expanding providers implementing pre-tenancy and tenancy services will decrease homelessness in vulnerable populations.
4	Providing nutrition assistance will decrease food insecurity and improve healthcare among vulnerable populations.
5	Nutrition assistance will provide cost-effective services.
6	Expanding member access to MHV will improve perinatal and infant health.
7	The reentry program will improve access to preventive services.
8	The reentry program will provide cost-effective care for members.
9	Eligible members will access services covered under the THCP initiative.
10	The THCP initiative will provide cost-effective services.

Note: MHV: Medicaid Home Visiting; THCP: traditional health care practices

Hypothesis 1 (Table 2-22) measures if providing post-hospitalization recuperative support and rehabilitation services will improve health outcomes and housing stability.

Table 2-22—Hypothesis 1 Research Questions and Measures

Hypothesis 1: Providing post-hospitalization recuperative support and rehabilitation services will improve health outcomes and housing stability to prevent rehospitalization.	
Research Question 1.1: Did members eligible for short-term post-hospitalization recuperative services have increased access to recuperative services?	
77	Number of members receiving short-term post-hospitalization recuperative services
Research Question 1.2: Did members eligible for short-term post-hospitalization recuperative services increase utilization of preventive care?	
78	Percentage of adults who accessed preventive/ambulatory health services
Research Question 1.3: Did members utilizing short-term post-hospitalization recuperative services change their utilization of hospital services?	
79	Number of potentially preventable ED visits, per 1,000 MM
80	Number of all-cause ED visits, per 1,000 MM
81	Number of IP visits, per 1,000 MM
82	Number of unplanned readmissions for any diagnosis within 30 days

Note: ED: emergency department; IP: inpatient; MM: member month

Hypothesis 2 measures if providing post-hospitalization recuperative support and rehabilitation services is cost-effective. The research questions and measures associated with Hypothesis 2 are presented in Table 2-23.

Table 2-23—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Short-term post-hospitalization recuperative services will provide cost-effective services.	
Research Question 2.1: Did the short-term post-hospitalization recuperative services provide cost-effective care for members?	
83	Total and PMPM cost among members receiving short-term post-hospitalization recuperative services
Research Question 2.1: How did local investments in short-term post-hospitalization recuperative services change over the course of the evaluation?	
84	Key informants' description of changes in short-term post-hospitalization recuperative services outside of Turquoise Care

Note: PMPM: per-member per-month

Hypothesis 3 measures if homelessness in vulnerable populations will be reduced when providers implement pre-tenancy and tenancy services. Additionally, this hypothesis assesses care coordination and health outcomes among members receiving pre-tenancy and tenancy services. The research questions and measures associated with Hypothesis 3 are presented in Table 2-24.

Table 2-24—Hypothesis 3 Research Questions and Measures

Hypothesis 3: Expanding providers implementing pre-tenancy and tenancy services will improve housing stability and utilization of health services	
Research Question 3.1: Did the expansion of pre-tenancy and tenancy services increase the number of members receiving housing supports?	
85	Number of members eligible for and receiving pre-tenancy and tenancy services
Research Question 3.2: Did the expansion of pre-tenancy and tenancy services improve follow-up care among eligible members?	
86	Percentage of members with a follow-up visit after an ED visit for mental illness
87	Percentage of members with a follow-up visit after hospitalization for mental illness
Research Question 3.3: Did the expansion of pre-tenancy and tenancy services improve members' health outcomes?	
88	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent
89	Percentage of members with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy
90	All-cause mortality rate

Note: ED: emergency department

Hypothesis 4 (Table 2-25) assesses if food insecurity in vulnerable populations will be decreased through the provision of nutrition assistance.

Table 2-25—Hypothesis 4 Research Questions and Measures

Hypothesis 4: Providing nutrition assistance will decrease food insecurity and improve healthcare among vulnerable populations.	
Research Question 4.1: Did nutrition assistance increase access to medically tailored meals?	
91	Number of medically tailored meals provided to eligible members
Research Question 4.2: Did nutrition assistance increase utilization of preventive care?	
92	Percentage of adults who accessed preventive/ambulatory health services
93	Percentage of members who accessed timely prenatal care

Hypothesis 4: Providing nutrition assistance will decrease food insecurity and improve healthcare among vulnerable populations.	
Research Question 4.3: Did nutrition assistance impact hospital utilization?	
94	Number of potentially preventable ED visits, per 1,000 MM
Research Question 4.4: Did nutrition assistance improve health outcomes for mothers and newborns?	
95	Percentage of births with low birth weight
96	Percentage of births with high birth weight
97	Percentage of births with cesarean delivery
98	Percentage of preterm births
99	Percentage of members with gestational diabetes developing type 2 diabetes

Note: ED: emergency department; IP: inpatient; MM: member months

Hypothesis 5 measures if providing nutrition assistance is cost-effective. The research questions and measures associated with Hypothesis 5 are presented in Table 2-26.

Table 2-26—Hypothesis 5 Research Questions and Measures

Hypothesis 5: Nutrition assistance will provide cost-effective services.	
Research Question 5.1: Did the nutrition assistance program provide cost-effective care for members?	
100	Total and PMPM cost among members receiving nutrition assistance
Research Question 5.2: How did local investments in nutrition assistance change over the course of the evaluation?	
101	Key informants' description of changes in nutrition assistance provided outside of Turquoise Care

Note: PMPM: per-member per-month

Hypothesis 6 determines whether perinatal and infant health will be improved by increased access to perinatal services provided by the Medicaid Home Visiting (MHV) program. The research questions and measures associated with Hypothesis 6 are presented in Table 2-27.

Table 2-27—Hypothesis 6 Research Questions and Measures

Hypothesis 6: Expanding member access to MHV will improve perinatal and infant health.	
Research Question 6.1: Do home visiting services improve health outcomes among perinatal individuals and infants?	
102	Number of members receiving home visiting services
103	Percentage of pregnant or postpartum members diagnosed with a mental health disorder
104	Percentage of members with a postpartum visit between 7 and 84 days after delivery
105	Percentage of members who had a well-child visit in the first 30 months of life (15 months)
106	Percentage of children 2 years of age with appropriate immunization status

Note: MHV: Medicaid Home Visiting

Hypothesis 7 (Table 2-28) measures if access to preventive services will be improved through the reentry program.

Table 2-28—Hypothesis 7 Research Questions and Measures

Hypothesis 7: The reentry program will improve access to preventive services.	
Research Question 7.1: What are barriers or facilitators to implementing the reentry program?	
107	Stakeholders' reported barriers and facilitators of success to implementing the reentry program
108	Stakeholders' experience with cross-system communication and coordination
109	Stakeholders' experience with connections between correctional and community services
110	Stakeholders' experiences providing pre-release services with potentially short duration (e.g., among individuals incarcerated for less than 30 days)
Research Question 7.2: Does engagement in the reentry program increase members' access to preventive health services?	
111	Number of members receiving pre-release services
112	Number and types of pre-release services provided to members
113	Number of eligible members accessing care coordination services prior to release from jail or prison
114	Percentage of adults who accessed preventive/ambulatory health services in the 12 months following release
115	Percentage of children and adolescents who had a well-care visit in the 12 months following release
Research Question 7.3: Does engagement in the reentry program increase members' access to BH treatment?	
116	Percent of individuals identified with an SMI/SED who have used services related to mental health in the 12 months following release
117	Percentage of members who remained on antidepressant medication treatment in the 12 months following release
Research Question 7.4: Does engagement in the reentry program increase members' access to SUD providers and treatment?	
118	Percentage of members who have a claim for MAT or MOUD for SUD in the 12 months following release
119	Number of MOUD providers
120	Number of OP pharmacy providers
Research Question 7.5: Does engagement in the reentry program impact hospital utilization?	
121	Number of potentially preventable ED visits in the 12 months following release, per 1,000 MM
122	Number of all-cause ED visits in the 12 months following release, per 1,000 MM
123	Number of IP visits in the 12 months following release, per 1,000 MM
Research Question 7.6: Do members participating in the reentry program have reduced rates of mortality, overdose, and suicide?	
124	All-cause mortality in the 12 months following release
125	Rate of deaths due to overdose in the 12 months following release
126	Rate of suicide in the 12 months following release

Note: BH: behavioral health; ED: emergency department; IP: inpatient; MAT: medication-assisted treatment; MM: member months; MOUD: medication for opioid use disorder; OP: outpatient; SUD: substance use disorder

Hypothesis 8 (Table 2-29) measures the cost-effectiveness of the reentry program.

Table 2-29—Hypothesis 8 Hypotheses and Research Questions

Hypothesis 8: The reentry program will provide cost-effective care for members.	
Research Question 8.1: Did the reentry program provide cost-effective care for members?	
127	Total and PMPM cost (among members in the reentry program)

Note: PMPM: per-member per-month

Hypothesis 9 (Table 2-30) outlines the two measures to which HCA limited the evaluation of the traditional health care practices (THCP) amendment, consisting of the number of providers offering THCP services and the number of members receiving THCP services.

Table 2-30—Hypothesis 9 Hypotheses and Research Questions

Hypothesis 9: Eligible members will access services covered under the THCP initiative.	
Research Question 9.1: What are barriers or facilitators of the THCP initiative?	
128	Stakeholders' reported barriers and successes of the THCP initiative
129	Stakeholders' reported accessibility and quality of care provided through the THCP initiative
Research Question 9.2: Did members access services covered under the THCP initiative?	
130	Number of providers enrolled in or offering Medicaid reimbursable THCP services
131	Number of members receiving Medicaid reimbursable THCP services
132	Number and type of Medicaid reimbursable THCP services provided to eligible members

Note: THCP: traditional health care practices

Hypothesis 10 (Table 2-31) measures the cost-effectiveness of THCP services.

Table 2-31—Hypothesis 10 Hypotheses and Research Questions

Hypothesis 10: The THCP initiative will provide cost-effective services.	
Research Question 10.1: Did the THCP initiative provide cost-effective care for members?	
133	Total and PMPM cost among members accessing services covered under the THCP initiative

Note: PMPM: per-member per-month; THCP: traditional health care practices

3. Methodology

To assess the impact of Turquoise Care, a comparison of outcomes between the intervention group and a valid counterfactual—the intervention group had they not been exposed to the intervention—must be made. The gold standard for experimental design is a randomized controlled trial, which would be implemented by first identifying an intervention population, and then randomly assigning individuals to the intervention and the rest to a comparison group, which would serve as the counterfactual. However, random assignment is rarely feasible or desirable in practice, particularly as it relates to healthcare policies.

As such, a variety of quasi-experimental or observational methodologies have been developed for evaluating the effect of policies on outcomes. The research questions presented in the previous section will be addressed using at least one of these methodologies. The selected methodology depends on data availability factors relating to: (1) data to measure the outcomes, (2) data for a valid comparison group, and (3) data during the time periods of interest—typically defined as the year prior to implementation and annually thereafter. Table 3-1 illustrates a sampling of standard analytic approaches and whether the approach requires data gathered at the baseline (i.e., pre-implementation), requires a comparison group, or allows for causal inference to be drawn. It also notes key requirements unique to a particular approach.

Table 3-1—Sampling of Analytic Approaches

Analytic Approach	Baseline Data	Comparison Group	Allows Causal Inference	Notes
Difference-in-Differences	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline.
Interrupted Time Series	✓	--	✓	Requires sufficient data points prior to and following implementation.
Pre-Test/Post-Test	✓	--	--	
Descriptive Time Series	--	--	--	Relies on descriptive interpretation; does not involve statistical testing.

Note: -- signifies that the element is not applicable to the analytic approach.

Evaluation Design Summary

This Evaluation Design builds upon the Centennial Care 2.0 Evaluation Design by incorporating new programs and modified pre-existing programs, as necessary. Turquoise Care will be evaluated through a mixed-methods approach, utilizing both quantitative and qualitative methods coupled with a wide variety of data sources to address metrics pertaining to program participation, access to and quality of care, health outcomes, and obtaining stakeholders' perspectives. Specifically, qualitative methods will be utilized to gather stakeholder perspectives on implementing the reentry program. Quantitative methods outlined in this Evaluation Design include descriptive time series to show change over time in rates and counts, as well as pre-test/post-test and interrupted time series (ITS) analyses to assess Turquoise Care's impact on outcome measures. For measures in which a comparison group can be identified, a difference-in-differences (DiD) or comparative ITS approach will be considered. Comparison groups may be constructed through propensity score matching to ensure that the comparison group shares similar baseline characteristics with the treatment group. The independent evaluator may compare rates within the Turquoise Care managed care population to national benchmarks to provide additional context for

Turquoise Care performance. Noninferiority testing will determine if the rates calculated in the evaluation period were the "same or better" than the baseline period. A health equity analysis will be conducted for measures where reliable demographic data are available. The independent evaluator will employ the most rigorous method that is supported by the data for all outlined analytic approaches.

Target and Comparison Populations

The target population includes all members enrolled in Turquoise Care at any point during each year of the demonstration period, including those in managed care and subgroups receiving specific Turquoise Care interventions and programs. Where possible, comparison groups based on member self-selection or specific outreach criteria will be utilized, with adjustments to account for differences between the target and comparison groups. Table 3-2 details the specific member subgroups receiving specific Turquoise Care interventions and indicates where a comparison group will be feasible. Some Turquoise Care programs do not have viable comparison groups.

Table 3-2—Turquoise Care Target and Comparison Populations

Turquoise Care Program/Initiative	Comparison Group
Managed care	--
Community Benefit program receiving LTSS	--
Continuous eligibility	--
High-Fidelity Wraparound	✓
Health Homes	✓
Medicaid Home Visiting	✓
Member Rewards	✓
Pre-tenancy and tenancy services	--
Nutrition assistance	✓
Reentry	--
Short-term post-hospitalization recuperative services	--
Serious Mental Illness/Serious Emotional Disturbance	--
SUD peer support	✓
Traditional health care practices	--

Note: -- represent programs that do not have viable comparison groups. LTSS: long-term services and supports; SUD: substance use disorder

Evaluation Period

Table 3-3 presents the baseline and evaluation periods for the Turquoise Care evaluation.[3-1] Baseline periods indicated as N/A reflect that no pre-implementation data are available to assess changes in pre and post implementation outcomes. Although Turquoise Care was approved on July 25, 2024, the evaluation will treat July 1, 2024, as the effective start date to align the evaluation with state fiscal year (SFY) and/or calendar year (CY) measurement periods.[3-2]

Table 3-3—Evaluation Periods

Program	Baseline Period	Evaluation Period
Managed care	July 1, 2021–June 30, 2024	July 1, 2024–December 31, 2029
Reentry	N/A	July 1, 2025–December 31, 2029
Short-term post-hospitalization recuperative services	N/A	July 1, 2025–December 31, 2029[1]
Nutrition assistance	N/A	July 1, 2025–December 31, 2029[1]
Traditional health care practices	N/A	October 1, 2025–December 31, 2029[1]

Note: The managed care population includes all sub-programs that are tailored to provide more intensive care to members, unless otherwise noted.
N/A signifies that there will not be a baseline period as there are no available and supportive data.
[1]The start of the evaluation period is subject to change based on when the program is implemented.

3-1 The managed care population includes all sub-programs that are tailored to provide more intensive care to members, unless otherwise noted. Not all sub-programs were approved concurrently, and the baseline and evaluation periods will be modified during the interim and summative evaluations, as necessary.

3-2 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Oct 10, 2024.

Evaluation Measures

Table 3-4 presents the evaluation measures, comparison groups, data sources, analytic approaches, frequency of calculation, and measure stewards for the evaluation of Aim One. Full measure specifications, including the numerator, denominator, stratifications, and desired direction are provided in Appendix A, Attachments.

Table 3-4—Aim One Evaluation Measures

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 1: Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain or increase the number of members accessing CB services.						
Research Question 1.1: Has the percentage of members accessing CB services increased or maintained year-over-year?	1: Number and percentage of Turquoise Care members enrolled and receiving CB services	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	2: Number and percentage of CB members receiving home-delivered meals	• MMIS • Program participation data	• N/A	• Descriptive time series	• Annually/ monthly	• N/A
Hypothesis 2: The ability for LRI to provide PCS to individuals receiving CB or EPSDT PCS will ensure member access to CB or EPSDT PCS and improve continuity of care through NFLOC approvals.						
Research Question 2.1: Is the percentage of members receiving CB or EPSDT PCS the same or higher after the implementation of this benefit?	3: Percentage of members receiving EPSDT PCS	• MMIS	• N/A	• ITS • Pre-test/post-test • Descriptive time series	• Annually/ monthly	• N/A
	4: Percentage of LTSS-eligible members receiving CB PCS	• MMIS	• N/A	• ITS • Pre-test/post-test • Descriptive time series	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	5: Average number of EPSDT PCS per utilizing member	• MMIS	• N/A	• ITS • Pre-test/post-test • Descriptive time series	• Annually/ monthly	• N/A
	6: Average number of CB PCS per utilizing member	• MMIS	• N/A	• ITS • Pre-test/post-test • Descriptive time series	• Annually/ monthly	• N/A
Research Question 2.2: Has the number of continuous NFLOC approvals maintained or increased?	7: Number of continuous NFLOC approvals	• Summary report of open-ended LTC spans • MCO reports	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Hypothesis 3: Providing continuous eligibility will improve continuity of care among children ages 0 to 5 years.						
Research Question 3.1: Has the percentage of members ages 0–5 years with continuous enrollment increased?	8: Length of enrollment among members ages 0–5 years	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	9: Percentage of members ages 0–5 years who had a gap in Medicaid coverage	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	10: Average number of gaps in Medicaid coverage for members ages 0–5 years	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	11: Average number of days per gap in Medicaid coverage for members ages 0–5 years	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 3.2: Has the percentage of members ages 0–5 years with access to preventive services increased?	12: Percentage of members who had a well-child visit in the first 30 months of life	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
	13: Percentage of children and adolescents who had a well-care visit	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• Modified CMS Child Core Set
	14: Percentage of children 2 years of age with appropriate immunization status	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
Research Question 3.3: Has the percentage of members ages 0–5 years utilization of hospital services changed?	15: Number of potentially preventable ED visits, per 1,000 MM	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• Modified AHRQ
	16: Number of all-cause ED visits, per 1,000 MM	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• NCQA
Hypothesis 4: Managed care or care coordination through the HH program will maintain access to effective and quality care.						
Research Question 4.1: Is there an increase in the percentage of members enrolled in a HH?	17: Number and percentage of Turquoise Care members enrolled in a HH	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Research Question 4.2: Does the HH program increase access to care coordination?	18: Number and percentage of members receiving care coordination	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 4.3: Does engagement in a HH increase utilization of preventive health services and improve disease management and quality of care?	19: Percentage of adults who accessed preventive/ambulatory health services	• MMIS • Program participation data	• Propensity score adjusted members who have never participated in the HH program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• NCQA
	20: Percentage of children and adolescents who had a well-care visit	• MMIS • Program participation data	• Propensity score adjusted members who have never participated in the HH program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
	21: Percentage of members with schizophrenia or bipolar disorder who are using antipsychotic medications who are screened for diabetes	• MMIS • Program participation data	• Propensity score adjusted members who have never participated in the HH program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult Core Set
	22: Percentage of members who remained on an antidepressant medication treatment	• MMIS • Program participation data	• Propensity score adjusted members who have never participated in the HH program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult Core Set
	23: Percentage of members with a follow-up visit after hospitalization for mental illness	• MMIS • Program participation data	• Propensity score adjusted members who have never participated in the HH program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child and Adult Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 4.4: Is the rate of preventive health services the same or higher than prior to the renewal period?	24: Percentage of adults who accessed preventive/ambulatory health services	• MMIS • National/regional benchmarks	• N/A	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks	• Annually/ monthly	• NCQA
	25: Percentage of children and adolescents who had a well-care visit in the first 30 months of life	• MMIS • National/regional benchmarks	• N/A	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks	• Annually/ monthly	• CMS Child Core Set
	26: Percentage of children and adolescents who had a well-care visit	• MMIS • National/regional benchmarks	• N/A	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks	• Annually/ monthly	• CMS Child Core Set
Research Question 4.5: Is the rate of management of BH conditions the same or better than prior to the renewal period?	27: Percentage of members who remained on an antidepressant medication treatment	• MMIS • National/regional benchmarks	• N/A	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks	• Annually/ monthly	• CMS Adult Core Set
	28: Percentage of members with a follow-up visit after hospitalization for mental illness	• MMIS • National/regional benchmarks	• N/A	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks	• Annually/ monthly	• CMS Child and Adult Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 4.6: Have members' self-assessed healthcare quality and outcomes maintained or improved?	29: Percentage of respondents who reported a high rating of overall healthcare (8, 9, or 10)	• CAHPS statewide survey	• N/A	• ITS • Pre-test/post-test	• Annually	• NCQA
	30: Percentage of respondents who reported a high rating of health plan (8, 9, or 10)	• CAHPS statewide survey	• N/A	• ITS • Pre-test/post-test	• Annually	• NCQA
	31: Percentage of respondents who reported a rating of overall health as very good or excellent	• CAHPS statewide survey	• N/A	• ITS • Pre-test/post-test	• Annually	• NCQA
	32: Percentage of respondents who reported a rating of overall mental or emotional health as very good or excellent	• CAHPS statewide survey	• N/A	• ITS • Pre-test/post-test	• Annually	• NCQA
Research Question 4.7: Has access to telemedicine services maintained or improved?	33: Number of telemedicine providers	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	34: Number of members receiving telemedicine services	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Hypothesis 5: Expanding member incentives for preventive care through the MR program will encourage members to engage in preventive care services.						
Research Question 5.1: Has the percentage of Turquoise Care members participating in MR and accessing preventive health services increased?	35: Percentage of Turquoise Care members participating in MR	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	36: Percentage of MR participating members and non-participating members with an annual preventive service	• MMIS • Program participation data	• Members not participating in MR	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	37: Percentage of MR participating and redeeming, and MR participating and non-redeeming members with an annual preventive service	• MMIS • Program participation data	• Members participating but not redeeming MR	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Hypothesis 6: The continuation of the HFW program will serve high-needs members with an SED diagnosis.						
Research Question 6.1: Is the HFW program enrolling the intended target population?	38: Number of HFW members enrolled in the program	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	39: Percentage of HFW members with SED diagnosis in the 11 months prior to enrollment	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Research Question 6.2: Does the HFW program increase utilization of preventive health services?	40: Percentage of children and adolescents who had a well-care visit	• MMIS • Program participation data	• Members who have never participated in the HFW program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
	41: Percentage of members with a follow-up visit after hospitalization for mental illness	• MMIS • Program participation data	• Members who have never participated in the HFW program	• DiD • ITS • Pre-test/post-test	• Annually	• CMS Child Core Set
	42: Percentage of members with a follow-up visit after ED visit for mental illness	• MMIS • Program participation data	• Members who have never participated in the HFW program	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 7: Turquoise Care will provide-cost effective care.						
Research Question 7.1: Have the payment amounts for providers in VBP arrangements increased?	43: Percentage of total payments that are for providers in VBP arrangements	• MCO reports	• N/A	• ITS • Pre-test/post-test	• Annually	• N/A
Research Question 7.2: Does Turquoise Care provide cost-effective care?	44: Total and PMPM cost (among managed care members)	• MMIS	• N/A	• ITS	• Annually	• N/A
	45: Total and PMPM cost (among managed care users)	• MMIS	• N/A	• ITS	• Annually	• N/A

Note: AHRQ: Agency for Healthcare Research and Quality; BH: behavioral health; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CB: community benefit; CMS: Centers for Medicare & Medicaid Services; DiD: difference-in-differences; ED: emergency department; EPSDT: Early and Period Screening, Diagnostic, and Treatment; HFW: high-fidelity wraparound; HH: Health Home; ITS: interrupted time series; LRI: legally responsible individuals; LTC: long-term care; LTSS: long-term services and supports; MCO: managed care organization; MM: member months; MMIS: Medicaid Management Information System; MR: Member Rewards; NCQA: National Committee for Quality Assurance; PCS: personal care services; PMPM: per-member per-month; SED: serious emotional disturbance; VBP: value-based purchasing

Table 3-5 presents the evaluation measures, comparison groups, data sources, analytic approaches, frequency of calculation, and measure stewards for the evaluation of Aim Two. Full measure specifications, including the numerator, denominator, stratifications, and desired direction are provided in Appendix A, Attachments.

Table 3-5—Aim Two Evaluation Measures

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 1: Turquoise Care will increase or maintain the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for SUD.						
Research Question 1.1: Did the number of individuals screened and treated for SUD maintain or increase?	46: Number and percentage of individuals screened for SUD	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SUD Monitoring Metrics
	47: Percentage of individuals with an SUD diagnosis who received any SUD service during the MY	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• Modified CMS SUD Monitoring Metrics
Hypothesis 2: Turquoise Care will increase or maintain peer support services, which will result in more individuals engaging in and retaining in SUD treatment.						
Research Question 2.1: Has the percentage of individuals with an SUD diagnosis who received peer support services and treatment maintained or increased?	48: Percentage of individuals with an SUD diagnosis who received peer support	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• Modified CMS SUD Monitoring Metrics
	49: Initiation of SUD treatment	• MMIS • National/regional benchmarks	• Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support	• DiD • ITS • Pre-test/post-test • Comparison to national benchmarks	• Annually/ monthly	• NCQA
	50: Engagement of SUD treatment	• MMIS • National/regional benchmarks	• Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support	• DiD • ITS • Pre-test/post-test • Comparison to national benchmarks	• Annually/ monthly	• NCQA

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	51: Continuity of pharmacotherapy for OUD	• MMIS	• Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• USC NQF #3175
Hypothesis 3: Turquoise Care will improve or maintain access to a comprehensive continuum of SUD care, which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.						
Research Question 3.1: Has the utilization of acute care settings by individuals with SUD decreased?	52: Percentage of members with an SUD diagnosis who used SUD services stratified by the following settings: any setting, early intervention, OP, intensive OP, and residential and IP	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SUD Monitoring Metrics
	53: Percentage of ED visits among individuals with SUD diagnoses	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	54: Average LOS in an ED among members with an SUD diagnosis prior to admission to an IMD	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	55: Percentage of IP admissions for SUD-related treatment	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SUD Monitoring Metrics
	56: 7- and 30-day IP and residential SUD readmission rates	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 4: Turquoise Care will maintain or increase use of MAT and reduce the number of high dosage opioid prescriptions, which will result in fewer overdose deaths due to opioid use.						
Research Question 4.1: Has the number of individuals with OUD or SUD receiving MAT increased or maintained?	57: Percentage of members who have a claim for MAT for SUD	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SUD Monitoring Metrics
Research Question 4.2: Is there a decrease or maintenance of the number of deaths due to overdose?	58: Use of opioids at high dosage in persons without cancer	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult Core Set
	59: Rate of deaths due to overdose	• MMIS • Vital statistics • ACS • DOH, overdose and mortality reports • CDC WONDER	• Statewide rate	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Hypothesis 5: Turquoise Care will provide cost-effective care for members with an SUD.						
Research Question 5.1: Did Turquoise Care provide cost-effective care among members with an SUD diagnosis?	60: Total and PMPM cost	• MMIS	• N/A	• ITS	• Annually/ monthly	• N/A
	61: Total and PMPM costs of SUD, SUD-IMD, SUD-other, and non-SUD care, by setting (including claims data, IP, OP, pharmacy, LTC, and capitated payments to MCOs)	• MMIS	• N/A	• ITS	• Annually/ monthly	• N/A

Note: ACS: American Community Survey; BHSD: Behavioral Health Services Division; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; DiD: difference-in-differences; DOH: Department of Health; ED: emergency department; IMD: institution for Mental Diseases; IP: inpatient; ITS: interrupted time series; LOS: length of stay; LTC: long-term care; MAT: medication-assisted treatment; MCO: managed care organization; MM: member months; MMIS: Medicaid Management Information System; MY: measurement year; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OMI: Office of the Medical Investigator; OP: outpatient; OUD: opioid use disorder; PMPM: per member per month; SUD: substance use disorder; USC: University of Southern California; WONDER: Wide-Ranging Online Data for Epidemiologic Research

Table 3-6 presents the evaluation measures, comparison groups, data sources, analytic approaches, frequency of calculation, and measure stewards for the evaluation of Aim Three. Full measure specifications, including the numerator, denominator, stratifications, and desired direction are provided in Appendix A, Attachments.

Table 3-6—Aim Three Evaluation Measures

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 1: Turquoise Care will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.						
Research Question 1.1: Has the number of individuals identified and/or engaged in SMI/SED treatment increased?	62: Percentage of individuals identified with an SMI/SED who have used services related to mental health	• MMIS • DOH, BHSD reports	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SMI/SED Monitoring Metrics
	63: Number of members diagnosed with an SMI/SED condition by non-BH providers	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	64: Number of registered mobile crisis providers	• MMIS • DOH, BHSD reports	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	65: Number of members with antipsychotic medications that received psychosocial care	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
	66: Number of members newly prescribed an antipsychotic medication, who received follow-up care	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SMI/SED Monitoring Metrics
Hypothesis 2: Turquoise Care will maintain an average LOS for IMDs of 30 days.						
Research Question 2.1: Has the average LOS for IMDs been maintained at 30 days?	67: Average LOS in an IMD	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SMI/SED Monitoring Metrics

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 3: Turquoise Care will result in increased rates of care coordination for members with SMI/SED.						
Research Question 3.1: Has the percentage of members with SMI/SED receiving care coordination increased?	68: Percentage of members with SMI/SED receiving care coordination	• MMIS • Program participation data	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	69: Percentage of members with a follow-up visit after an ED visit for mental illness	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult and Child Core Set
	70: Percentage of members with a follow-up visit after hospitalization for mental illness	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult and Child Core Set
Hypothesis 4: Turquoise Care will decrease utilization and LOS in EDs among Medicaid members who met eligibility criteria of members with SMI/SED.						
Research Question 4.1: Has the utilization of hospital services by individuals with SMI/SED decreased?	71: Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of members with an SMI/SED	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	72: Number of members with an SMI/SED who used ED services for mental health during the measurement period	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SMI/SED Monitoring Metrics
	73: Average LOS in an ED among members with an SMI/SED prior to admission to an IMD	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	74: Number of members with an SMI/SED all-cause unplanned readmission within 30 days of psychiatric hospitalization	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS SMI/SED Monitoring Metrics

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 5: Turquoise Care will provide cost-effective care for members with an SMI/SED diagnosis.						
Research Question 5.1: Did Turquoise Care provide cost-effective care among members with SMI/SED diagnoses?	75: Total and PMPM cost	• MMIS	• N/A	• ITS	• Annually/ monthly	• N/A
	76: Total and PMPM costs of SMI/SED diagnosis, by IMD and other setting (including claims data, IP, OP, pharmacy, LTC, and capitated payments to MCOs)	• MMIS	• N/A	• ITS	• Annually/ monthly	• N/A

Note: BHSD: Behavioral Health Services Division: BH: behavioral health; CMS: Centers for Medicare & Medicaid Services; DOH: Department of Health; ED: emergency department; IMD: Institution for Mental Diseases; IP: inpatient; ITS: interrupted time series; LOS: length of stay; LTC: long-term care; MCO: managed care organization; MM: member months; MMIS: Medicaid Management Information System; NQF: National Quality Forum; OP: outpatient; PMPM: per member per month; SED: serious emotional disturbance; SMI: serious mental illness; SPC: statistical processing control

Table 3-7 presents the evaluation measures, comparison groups, data sources, analytic approaches, frequency of calculation, and measure stewards for the evaluation of Aim Four. Full measure specifications, including the numerator, denominator, stratifications, and desired direction are provided in Appendix A, Attachments.

Table 3-7—Aim Four Evaluation Measures

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 1: Providing post-hospitalization recuperative support and rehabilitation services will improve access to housing services and health outcomes.						
Research Question 1.1: Did members eligible for short-term post-hospitalization recuperative services have increased access to recuperative services?	77: Number of members receiving short-term post-hospitalization recuperative services	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• N/A
Research Question 1.2: Did members eligible for short-term post-hospitalization recuperative services increase utilization of preventive care?	78: Percentage of adults who accessed preventive/ambulatory health services	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• NCQA
Research Question 1.3: Did members utilizing short-term post-hospitalization recuperative services change their utilization of hospital services?	79: Number of potentially preventable ED visits, per 1,000 MM	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• AHRQ
	80: Number of all-cause ED visits, per 1,000 MM	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• NCQA
	81: Number of IP visits, per 1,000 MM	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• NCQA
	82: Number of unplanned readmissions for any diagnosis within 30 days	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• CMS Adult Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 2: Short-term post-hospitalization recuperative services will provide cost-effective services.						
Research Question 2.1: Did the short-term post-hospitalization recuperative services provide cost-effective care for members?	83: Total and PMPM cost among members receiving short-term post-hospitalization recuperative services	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• N/A
Research Question 2.2: How did local investments in short-term post-hospitalization recuperative services change over the course of the evaluation?	84: Key informants' description of changes in short-term post-hospitalization recuperative services outside of Turquoise Care	• Key Informant Interviews	• N/A	• Qualitative Synthesis	• Two rounds	• N/A
Hypothesis 3: Expanding providers implementing pre-tenancy and tenancy services will improve housing stability and utilization of health services.						
Research Question 3.1: Did the expansion of pre-tenancy and tenancy services increase the number of members receiving housing supports?	85: Number of members eligible for and receiving pre-tenancy and tenancy services	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Research Question 3.2: Did the expansion of pre-tenancy and tenancy services improve follow-up care among eligible members?	86: Percentage of members with a follow-up visit after an ED visit for mental illness	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult and Child Core Set
	87: Percentage of members with a follow-up visit after hospitalization for mental illness	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult and Child Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 3.3: Did the expansion of pre-tenancy and tenancy services improve members' health outcomes?	88: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult and Child Core Set
	89: Percentage of members with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• NCQA
	90: All-cause mortality rate	• MMIS • Vital Records	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Hypothesis 4: Providing nutrition assistance will decrease food insecurity and improve healthcare among vulnerable populations.						
Research Question 4.1: Did nutrition assistance increase access to medically tailored meals?	91: Number of medically tailored meals provided to eligible members	• MMIS	• N/A	• Descriptive time series	• Annually/ monthly	• N/A
Research Question 4.2: Did nutrition assistance increase utilization of preventive care?	92: Percentage of adults who accessed preventive/ambulatory health services	• MMIS	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually	• NCQA

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	93: Percentage of members who accessed timely prenatal care	• MMIS	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually	• CMS Child and Adult Core Set
Research Question 4.3: Did nutrition assistance impact hospital utilization?	94: Number of potentially preventable ED visits, per 1,000 MM	• MMIS	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• Modified AHRQ
Research Question 4.4: Did nutrition assistance improve health outcomes for mothers and newborns?	95: Percentage of births with low birth weight	• MMIS • Vital statistics	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• CMS Child Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	96: Percentage of births with high birth weight	• MMIS • Vital statistics	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• N/A
	97: Percentage of births with cesarean delivery	• MMIS • Vital statistics	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• CMS Child Core Set
	98: Percentage of preterm births	• MMIS • Vital statistics	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	99: Percentage of members with gestational diabetes developing type 2 diabetes	• MMIS	• Members who are eligible, but not receiving nutrition assistance • Members who are participating in MHV, but not receiving nutrition assistance	• Descriptive time series	• Annually/ monthly	• N/A
Hypothesis 5: Nutrition assistance will provide cost-effective services.						
Research Question 5.1: Did the nutrition assistance program provide cost-effective care for members?	100: Total and PMPM cost among members receiving nutrition assistance	• MMIS	• Members who were eligible but did not receive nutrition assistance	• Descriptive time series	• Annually/ monthly	• N/A
Research Question 5.2: How did local investments in nutrition assistance change over the course of the evaluation?	101: Key informants' description of changes in nutrition assistance provided outside of Turquoise Care	• Key Informant Interviews	• N/A	• Qualitative Synthesis	• N/A	• N/A
Hypothesis 6: Expanding member access to MHV will improve perinatal and infant health.						
Research Question 6.1: Do home visiting services improve health outcomes among perinatal individuals and infants?	102: Number of members receiving home visiting services	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	103: Percentage of pregnant or postpartum members diagnosed with a mental health disorder	• MMIS	• Non-MHV participating members	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• NCQA

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	104: Percentage of members with a postpartum visit between seven and 84 days after delivery	• MMIS	• Non-MHV participating members	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Adult Core Set
	105: Percentage of members who had a well-child visit in the first 30 months of life (15 months)	• MMIS	• Non-MHV participating members	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
	106: Percentage of children 2 years of age with appropriate immunization status	• MMIS	• Non-MHV participating members	• DiD • ITS • Pre-test/post-test	• Annually/ monthly	• CMS Child Core Set
Hypothesis 7: The reentry program will improve access to preventive services.						
Research Question 7.1: What are barriers or facilitators to implementing the reentry program?	107: Stakeholders' reported barriers and facilitators of success to implementing the reentry program	• Key informant interviews	• N/A	• Qualitative synthesis	• Two rounds	• N/A
	108: Stakeholders' experience with cross-system communication and coordination	• Key informant interviews	• N/A	• Qualitative synthesis	• Two rounds	• N/A
	109: Stakeholders' experience with connections between correctional and community services	• Key informant interviews	• N/A	• Qualitative synthesis	• Two rounds	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	110: Stakeholders' experiences providing pre-release services with potentially short duration (e.g., among individuals incarcerated for less than 30 days)	• Key informant interviews	• N/A	• Qualitative synthesis	• Two rounds	• N/A
Research Question 7.2: Does engagement in the reentry program increase members' access to preventive health services?	111: Number of members receiving pre-release services	• Program participation data	• N/A	• Descriptive time series • Subgroup analysis	• Annually/ monthly	• N/A
	112: Number and types of pre-release services provided to members	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis	• Annually/ monthly	• N/A
	113: Number of eligible members accessing care coordination services prior to release from jail or prison	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis	• Annually/ monthly	• N/A
	114: Percentage of adults who accessed preventive/ambulatory health services in the 12 months following release	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test	• Annually/ monthly	• Modified NCQA
	115: Percentage of children and adolescents who had a well-care visit in the 12 months following release	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified CMS Child Core Set

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Research Question 7.3: Does engagement in the reentry program increase members' access to BH treatment?	116: Percentage of individuals identified with an SMI/SED who have used services related to mental health in the 12 months following release	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified CMS SMI/SED Monitoring Metrics
	117: Percentage of members who remained on antidepressant medication treatment in the 12 months following release	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified CMS Adult Core Set
Research Question 7.4: Does engagement in the reentry program increase members' access to SUD providers and treatment?	118: Percentage of members who have a claim for MAT or MOUD for SUD in the 12 months following release	• MMIS • Program participation data	• Members with SUD not receiving 30-day MOUD prescriptions prior to release	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified CMS SUD Monitoring Metrics
	119: Number of MOUD providers	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
	120: Number of OP pharmacy providers	• MMIS	• N/A	• ITS • Pre-test/post-test	• Annually/ monthly	• N/A
Research Question 7.5: Does engagement in the reentry program impact hospital utilization?	121: Number of potentially preventable ED visits in the 12 months following release, per 1,000 MM	• MMIS • Program participation data	• N/A	• Descriptive time series • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified AHRQ
	122: Number of all-cause ED visits in the 12 months following release, per 1,000 MM	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified NCQA

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
	123: Number of IP visits in the 12 months following release, per 1,000 MM	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• Modified NCQA
Research Question 7.6: Do members participating in the reentry program have reduced rates of mortality, overdose, and suicide?	124: All-cause mortality in the 12 months following release	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• N/A
	125: Rate of deaths due to overdose in the 12 months following release	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• N/A
	126: Rate of suicide in the 12 months following release	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 8: The reentry program will provide cost-effective care for members.						
Research Question 8.1: Did the reentry program provide cost-effective care for members?	127: Total and PMPM cost (among members in the reentry program)	• MMIS • Program participation data	• N/A	• Descriptive time series • Subgroup analysis • ITS • Pre-test/Post-test	• Annually/ monthly	• N/A
Hypothesis 9: Eligible members will access services covered under the THCP initiative.						
Research Question 9.1: What are barriers or facilitators of the THCP initiative?	128: Stakeholders' reported barriers and successes of the THCP initiative	• Key informant interviews	• N/A	• Qualitative synthesis	• N/A	• N/A
	129: Stakeholders' reported accessibility and quality of care provided through the THCP initiative	• Key informant interviews	• N/A	• Qualitative synthesis	• N/A	• N/A
Research Question 9.2: Did members access services covered under the THCP initiative?	130: Number of providers enrolled in or offering Medicaid reimbursable THCP services	• MMIS	• N/A	• Descriptive time series	• Annually	• N/A
	131: Number of members receiving Medicaid reimbursable THCP services	• MMIS	• N/A	• Descriptive time series	• Annually	• N/A
	132: Number and type of Medicaid reimbursable THCP services provided to eligible members	• MMIS	• N/A	• Descriptive time series	• Annually	• N/A

Research Question	Measure(s)	Data Source(s)	Comparison Group	Analytic Approach	Frequency	Steward
Hypothesis 10: The THCP initiative will provide cost-effective services.						
Research Question 10.1: Did the THCP initiative provide cost-effective care for members?	133: Total and PMPM cost among members accessing services covered under the THCP initiative	• MMIS	• N/A	• Descriptive time series	• Annually	• N/A

Note: AHRQ: Agency for Healthcare Research and Quality; BH: behavioral health; CMS: Centers for Medicare & Medicaid Services; CQMS: Clinical Quality Measures; DOH: Department of Health; ED: emergency department; IP: inpatient; ITS: interrupted time series; MAT: medication-assisted treatment; MHV: Medicaid Home Visiting; MIPS: Merit-Based Incentive Payment System; MM: member months; MMIS: Medicaid Management Information System; MOUD: medication for opioid use disorder; NCQA: National Committee for Quality Assurance; OP: outpatient; PMPM: per-member per-month; THCP: traditional health care practices

Data Sources

Multiple data sources—including administrative claims/encounter data, key informant interviews, national/regional benchmarks, and other data sources—will be utilized to evaluate Turquoise Care.

The independent evaluator will prepare and validate all data provided by the State. These processes will include extracting, loading, and transforming data to a standardized format, examining data completeness, testing validity to confirm dates and known medical codes, and analyzing data distribution over time.

The evaluation will rely on several non-standardized data sources that may be susceptible to inconsistencies, such as New Mexico Department of Health (DOH) Behavioral Health Services Division (BHSD) reports. The independent evaluator will conduct verifications assessing duplication, invalid date ranges, and reasonability to ensure data are valid and reliable. Data assessments may include comparing new data to data from prior years to determine alignment based on the number of observations, the format of the data, or major changes in findings. If the results vary greatly across years or are incomplete, the independent evaluator will collaborate with the State to address any data quality concerns identified during validation. Unresolved limitations will be described in the *Methodological Limitations* chapter of the evaluation reports.

Administrative Data

Administrative data extracted from the Medicaid Management Information System (MMIS) will be utilized to calculate most measures in this Evaluation Design. These data include claims and encounter data, member eligibility, enrollment, and demographic data. Provider data will also be used, as necessary, to identify provider type and member attribution.

Use of managed care encounters will be limited to final, paid status claims and encounters. Interim transaction and voided records will be excluded from the evaluation, as these record types introduce a level of uncertainty (from matching adjustments and third-party liabilities to the index claims) that can impact reported rates and cost calculations.

To support the traditional health care practices (THCP) initiative evaluation, the independent evaluator will work with State and Tribal entities to collect THCP-specific data that may be captured outside of the MMIS. Contingent upon data availability, the independent evaluator will identify THCP-specific claims and encounters among managed care organization (MCO) and fee-for-service (FFS) members.

National/Regional Benchmarks

National or regional benchmarks will be incorporated where possible to provide contextual references for the performance of standardized Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] measures. The applicability of national benchmarks is limited, as they represent Medicaid populations as a whole. The managed care program is the most representative of the general population, and therefore provides the most appropriate comparison to national benchmarks.

[3-1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

Key Informant Interviews

Semi-structured key informant interviews will be conducted with stakeholders to assess the reentry, nutrition assistance, short-term post-hospitalization recuperative services, and THCP programs. The stakeholders may be asked about the perceived barriers and facilitators to the implementation of these programs, as well as their experiences with the programs themselves. Stakeholders for the THCP initiative will include, but are not limited to, representatives from the Indian Health Service (IHS) and tribal organizations. The transcripts, coding methodologies, and coded data collected and synthesized from the interviews will be utilized to answer the appropriate research questions.

Additional Data Sources

The following details the additional data sources that will be used to evaluate Turquoise Care.

ACS—Data from the American Community Survey (ACS) will be leveraged to identify the annual New Mexico population and provide a statewide comparison group for rates of overdose and deaths attributable to overdoses.

CAHPS—Data from the statewide Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] will be used to assess respondents' perceptions of healthcare quality and health outcomes.

CDC WONDER—If vital records from DOH are unavailable at the time of the evaluation, the Centers for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologic Research (WONDER) may be utilized to calculate the statewide rate of overdoses. CDC WONDER provides county and state-level data on overdose mortality to support the calculation of Measure 51, *Rate of deaths due to overdose*.

DOH and BHSD Reports—BHSD will provide a summary of counts and operational metrics related to the serious mental illness or serious emotional disturbance (SMI/SED) program. These data are anticipated to include metrics such as the number of registered mobile crisis providers serving members in the SMI/SED program. Furthermore, data from DOH may include Medicaid-specific mortality and overdose rates for the substance use disorder (SUD) and reentry programs if the data cannot be extracted from vital statistics.

MCO Reports—Data from MCO reports will support the evaluation of measures relating to detail on payments to providers through value-based purchasing (VBP) arrangements.

Program Participation Data—Program participation data will be provided for Member Rewards (MR), Health Home (HH), high-fidelity wraparound (HFW), and reentry programs. These data will include metrics such as length of participation, program enrollment type, and services provided.

Summary Report of Open-Ended LTC Spans—Summary reports of open-ended long-term care (LTC) spans will be utilized with MCO reports to calculate the number of individuals eligible for nursing facility level of care (NFLOC) who are granted continuous eligibility.

Vital Statistics—Vital statistics, including the number of deliveries, premature deliveries, and low-birth weight deliveries, will be utilized to analyze the percentage of babies born prematurely and those with low birthweight to individuals participating in the nutrition assistance program. These data may be used in tandem with or as a

[3-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

supplement to the HCA-supplied list of deliveries described above. Additionally, vital statistics may be used in tandem with or as a supplement to DOH and BHSD reports to identify the number of all-cause mortalities, deaths due to overdose, and deaths due to suicide. If vital statistics data are unavailable at the time of the evaluation, the independent evaluator may utilize MMIS data. MMIS may not provide comprehensive data on outcomes such as the number of live births with low birth weight or overdose deaths attributable to opioid use. The independent evaluator will narrate these limitations as necessary.

Analytic Methods

Multiple analytic techniques will be utilized depending on the type and availability of data.

DiD

A DiD analysis will be performed on all measures for which a suitable comparison group can be identified. The analysis will compare rates of the weighted average of participating states to rates among Turquoise Care members. Further, rates will be compared to national rates and rates of eligible members who are not enrolled in Turquoise Care, where possible. This approach will compare the changes in outcome rates between the baseline period and the evaluation period across the intervention and comparison groups. For the DiD analysis to be valid, the comparison group must accurately represent the change in outcomes that would have been experienced by the intervention group in the absence of the program. The DiD analysis will be conducted with member-level rates using a logistic regression model for measures with binary outcomes.

The logistic regression form of the DiD model is:

$$\ln\left(\frac{Y_{it}}{1-Y_{it}}\right) = \beta_0 + \beta_1 T_i + \beta_2 post_t + \beta_3(post_t \times T_i) + \gamma \mathbf{D'}_{it} + \varepsilon_{it}$$

where Y is the probability of an outcome for group i in year t, T is a binary indicator of the intervention group, *post* is a binary indicator for the evaluation period, the vector D' represents any observed confounding variables that may account for differences between the intervention and comparison groups (described in additional detail below), γ is a coefficient vector, and ε is an error term. The intercept β_0 represents the log-odds of an outcome for the comparison group during the baseline. The coefficient β_1 identifies the average difference in the log-odds of an outcome between the groups during the baseline period prior to the implementation of Turquoise Care. The time period dummy coefficient β_2 captures the change in the log-odds of an outcome between the baseline and evaluation time periods for the non-intervention group. The coefficient on the interaction term β_3 represents the DiD estimate of interest in this evaluation. In other words, it is how the log-odds of an outcome for the intervention group is changed in the implementation period compared to the pre-implementation period.

The DiD approach will be used where possible, as it controls for any factors external to the program that are applied equally to both groups, such as the coronavirus disease 2019 (COVID-19) public health emergency (PHE). However, DiD is still susceptible to external factors that may have differentially impacted one group and not the other. If sufficient pre-intervention data are available, it is possible to test if external factors are applied equally to the intervention and comparison groups by visually verifying and testing the assumption that both groups exhibit parallel trends in the baseline period. In the absence of treatment, the intervention and comparison groups used in DiD should experience similar changes, manifested as parallel lines during the baseline period. Specifically, statistical testing may be used to determine if the pre-treatment periods meet the parallel trends assumption. If the parallel trend assumption does not hold, the two-period DiD may still be useful as data during

the baseline and evaluation periods will be aggregated into a single pre-intervention and post-intervention average, respectively. Furthermore, the DiD model proposed estimates a single average treatment effect, under the assumption that any heterogeneity in the treatment effect is due to random variation. This assumption is explicit in the model, as the DiD treatment effect is represented by a single coefficient (β_3), and therefore any heterogeneity in treatment effects between individuals cannot be modeled. The independent evaluator recognizes the limitations of this approach and will, therefore, consider estimating additional models, such as panel data models, fixed and random effects models, or hierarchical models. Results from adjusted models will be presented and interpreted, keeping in mind the limitations of each approach.

Suitable out-of-state comparison groups are not anticipated to be available for Turquoise Care as a whole; however, multiple programs with smaller member subgroups (HH, SUD peer support, HFW MHV, and the nutrition assistance programs) will allow for an in-state comparison group. The independent evaluator will utilize matching methods to construct a counterfactual group comprised of members eligible for, but not receiving, program services. To ensure that the comparison is appropriate, controls for overserved characteristics, such as demographics and Chronic Illness and Disability Payment System (CDPS) risk score, will be utilized.

If a valid comparison group cannot be constructed, the most rigorous method supported by the data will be utilized.

ITS

When a suitable comparison group cannot be found and data can be collected at multiple points in time before and after the implementation of the program, an ITS methodology can be used. This analysis is quasi-experimental in design and will compare a trend in outcomes between the baseline period and the evaluation period for those who were subject to the program.

In ITS, the measurements taken before a demonstration was initiated are used to predict the outcome if Turquoise Care did not occur. The measurements collected after the demonstration are then compared to the predicted outcome to evaluate the impact Turquoise Care had on the outcome.

The ITS model is:

$$Y_t = \beta_0 + \beta_1\, time + \beta_2\, post + \beta_3\, time \times post + \gamma \mathbf{D'_{it}} + \mu_t$$

where Y_t is the outcome of interest for the time period *t*, *time* represents a linear time trend, post is a dummy variable to indicate the time periods post-implementation, $time{\times}post$ is the linear time trend variable for the post-implementation time period, the matrix $\boldsymbol{D'}$ represents any observed confounding variables that may account for differences between the intervention and comparison groups, and γ is a coefficient vector. For ITS analyses utilizing aggregate-level data, confounding variables will take the form of average values in the population, such as average age, average risk score, or percent female. For analysis utilizing individual-level data, control variables may include age, sex, race/ethnicity, county of residence, CDPS risk score, dual eligibility status, or duration of Medicaid enrollment. The intercept, β_0, identifies the starting level of outcome *Y*, β_1 is the slope of the outcome between the measurements before the program, β_2 is the change in the outcome when the program began, β_3 is the change in the slope for the measurements after the program, and μ_t is the error term.

Comparative ITS may be used to assess measures where there are sufficient pre-implementation data points, a valid comparison group, and a DiD approach is not viable. This analysis will be estimated using linear regression modeling of the following comparative ITS equation:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 T X_t + \beta_4 Z + \beta_5 ZT + \beta_6 Z X_t + \beta_7 Z X_t T + \varepsilon$$

Where *Y* is the measure rate, *T* is time, *X* is study phase (pre- or post-interruption), *XT* is time after interruption, *Z* is treatment or control, *ZT* is time for treatment, *ZX* is study phase for treatment, and *ZXT* is time after interruption for treatment.

Assuming that the measurements taken after the implementation of Turquoise Care would have been equal to the expectation predicted from the measurements taken before Turquoise Care in the absence of the intervention, any changes in the observed rates after implementation can be attributed to the program. However, as the ITS approach relies on a pre- and post-period, it is unable to differentiate between mechanisms that may have impacted observed changes; it is possible that external events could have occurred simultaneously with Turquoise Care and influenced the outcomes of interest. Where required, the independent evaluator will rely on best practices to mitigate the potentially confounding effect of simultaneously occurring confounding events, such as the COVID-19 PHE and the post-PHE Medicaid "unwinding," by including the use of dummy variables for each time period. When baseline data include the impact of the COVID-19 PHE, ITS models will incorporate dummy variables to adjust for the confounding effects if sufficient data are available. An indicator variable for quarter 2 (Q2) 2020 will represent the initial wave of the COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 2020 through the end of Q1 2021 will reflect subsequent New Mexico-specific public health orders. For measures calculated annually, an indicator variable for 2020 will be included in the model to adjust for the COVID-19 PHE. Furthermore, the independent evaluator will consider several sensitivity analyses to test the robustness of the main model results. In cases where baseline years overlap with the COVID-19 PHE and Medicaid "unwinding," the independent evaluator will explore how the results change when excluding the years most impacted by these external events, or when estimating program effects separately by each year, rather than aggregating baseline years and evaluation years. A similar approach will be taken to account for the "unwinding" period in which the Medicaid continuous enrollment condition authorized ended and HCA began eligibility redeterminations. Furthermore, the independent evaluator will consider several sensitivity analyses to test the robustness of the main model results. These tests may include modifying regression specifications and control variables to better estimate program impact and/or assess the degree to which findings materially change given alternative specifications. One example of sensitivity testing is the inclusion and specification of COVID-19 controls, where applicable. The most appropriate controls for each ITS analysis will be identified.

A second assumption of the proposed ITS model is that the expected mean of the error term is zero; however, if current observations are correlated with prior observations, this regression assumption would be violated. The independent evaluator will test this assumption by examining error autocorrelation; if subsequent error terms are highly correlated, then parameter estimates and variance obtained from the model may be biased, resulting in misleading conclusions. During analyses, the independent evaluator will take steps to test for autocorrelation and assess the model fit. If the model is a poor fit for the data, additional procedures will be explored, such as transformation of the model to remove autocorrelation or estimating an autoregressive model.

A limitation of ITS is the need for sufficient data points both before and after program implementation.[3-3, 3-4, 3-5] To facilitate this methodology, the independent evaluator may consider additional baseline data points using prior year calculations, and/or calculating quarterly rates where feasible, if multiple years both pre-and post-implementation are available to control for seasonality.

Health Equity Analysis

A health equity analysis will address research questions focused on exploring the impact that Turquoise Care has on health disparities among members with health-related social needs (HRSN). Outcome measures for relevant demographic subgroups (e.g., race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) will be compared to a reference group and assessed for statistically significant and clinically meaningful differences in relative percentages and effect sizes. A two-tailed t-test will be conducted to determine the statistical significance between the reference and comparison groups. Clinically meaningful outcomes will be assessed through effect sizes and relative percentage point differences between the groups of interest.

Cohen's *h* will be utilized to determine the effect size between comparison and reference group rates. Effect sizes can fall into small, medium, or large categories.[3-6] This method is applicable to measures where the rate is bound between 0 and 1. The formula for Cohen's *h* is given by:

$$h = \left(2 * arcsin\sqrt{P_1}\right) - \left(2 * arcsin\sqrt{P_2}\right)$$

where P_1 is the annual rate for the comparison group and P_2 is the annual rate for the reference group.

For measures where the rates are not bound between 0 and 1, the relative percent difference between each demographic stratification and reference category will be calculated by subtracting the reference group rate from the comparison group rate, then dividing by the reference group rate.

Rates will be compared across reference and comparison demographic groups where data are available, accurate, and relevant to support a health equity analysis. Subgroup analyses will assess program impacts by each demographic group, allowing the independent evaluator to take an exploratory approach in identifying disparities. The independent evaluator may limit reporting to groups with either statistically significant or clinically meaningful differences, with complete results presented in an appendix. Demographic data are anticipated to be available for race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography. The independent evaluator will work with the State to develop a method for identifying and reporting results by additional stratifications, such as disability status and high-need, high-cost. The proposed measure specifications in Appendix A, Attachments, identify the demographic stratification groups for each measure based on the anticipated available demographic data.

3-3 Baicker K., Svoronos T., Testing the Validity of the Single ITS Design. *NBER Working Paper 26080*. 2019. Available at: https://www.nber.org/papers/w26080.pdf. Accessed on: Oct 3, 2024.

3-4 Bernal JL, Cummins S, Gasparrini A. Interrupted time series regression for the evaluation of public health interventions: a tutorial. *International Journal of Epidemiology*. 2017:46(1): 348–355. Available at: https://doi.org/10.1093/ije/dyw098. Accessed on: Oct 3, 2024.

3-5 Penfold RB, Zhang F. Use of Interrupted Time Series Analysis in Evaluating Health Care Quality Improvements. *Academic Pediatrics*. 2013:13(6): S38 - S44. Available at: https://doi.org/10.1016/j.acap.2013.08.002. Accessed on: Oct 3, 2024.

3-6 Cohen J. *Statistical Power Analysis for the Behavioral Sciences*. 2nd ed. Hillsdale, NJ: L. Erlbaum Associates; 1988:25.

In accordance with the Centers for Medicare & Medicaid Services (CMS) suppression guidance, rates with a numerator or denominator greater than one but less than 10 will be suppressed due to potentially unreliable rate calculation and to ensure anonymity.[3-7] In addition, rates may be suppressed in accordance with HEDIS general guidelines, which requires rates with denominator counts less than 30 to be suppressed to ensure reliability of reporting. The most stringent suppression method will be used for each rate. Sample sizes will reflect the denominator counts for each subgroup by measure. The feasibility of reporting each subgroup will be dependent on numerator and denominator counts meeting suppression criteria.

Propensity Score Matching

For measures in which a comparison group of members is viable and a DiD approach or comparative ITS is planned, propensity score matching may construct the most appropriate comparison group for the treatment populations. A logistic regression model will be used to predict the probability that each member participates in the respective programs (e.g., HH or MHV), conditional on their observed baseline characteristics (i.e., the propensity score). These characteristics will include variables that impact an individual's participation, such as sex, age, race/ethnicity, geography, a CDPS risk score, etc. If the sample size of the propensity-score matched comparison group is too small, the inverse probability of treatment weight using the propensity score may be considered to create weights based on the propensity score and create a sample in which the distribution of baseline covariates is independent of treatment assignment.

Noninferiority Testing

To support testing of hypotheses that suggest program impacts will "be maintained or improve," the independent evaluator may consider employing noninferiority statistical testing. Specifically, this approach can be utilized for measures that employ a pre-test/post-test, ITS, or DiD framework.

For measures that include a pre/post or ITS framework, non-inferiority testing can determine whether measure rates in the evaluation period were meaningfully different from rates in the baseline period (i.e., to statistically test whether rates were "the same or better" than baseline rates). Non-inferiority testing allows for an assessment of meaningful difference in rates by comparing the change in rates between the baseline and evaluation period to a predetermined threshold. This threshold represents the greatest difference between the baseline and evaluation period that can exist while still being considered "equivalent." Specifically, the predetermined threshold (δ) will be calculated using the following variation of the Cohen's *h* equation:

$$\delta = P_2 - \sin\left(\frac{2 * \arcsin(\sqrt{P_2}) \pm h}{2}\right)^2$$

where P_2 is the baseline average rate and *h* is the chosen Cohen's *h* effect size. While an effect size of 0.20 has commonly been deemed to represent a "small" effect, as originally suggested by Cohen, Cohen writes, "the terms 'small,' 'medium,' and 'large' are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation."[3-8] Because the application of effect size in this context is to identify a minimum acceptable difference between

[3-7] U.S. Department of Health & Human Services. CMS Cell Suppression Policy. Available at: https://www.hhs.gov/guidance/document/cms-cell-suppression-policy. Accessed on: Nov 15, 2024.

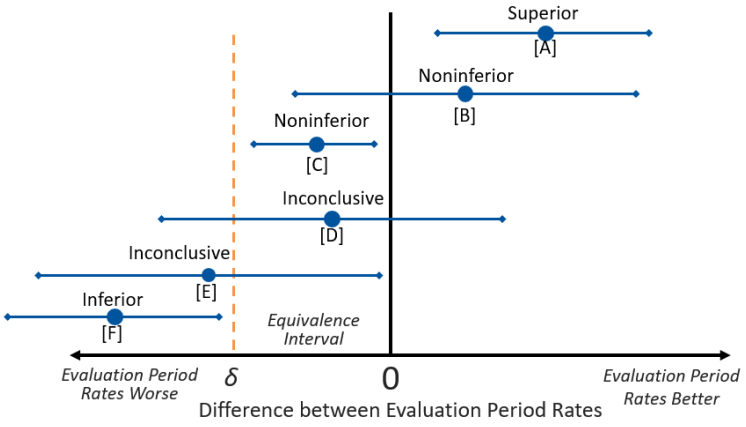
[3-8] Cohen J. *Statistical Power Analysis for the Behavioral Sciences*. 1988.

proportions while still considering them "equal" for practical purposes, a stricter threshold than what may be typically used is appropriate. Therefore, δ for each measure will be calculated based off a predetermined threshold of Cohen's *h* of 0.05 or 0.10.

Statistical testing will be conducted by assessing whether the observed difference between the average baseline and evaluation period rates is different from δ. The calculated change in rate threshold will be compared to the 95 percent confidence interval (CI) from performed pre-test/post-test results to determine whether rates were meaningfully different in the demonstration period.

Non-inferiority testing characterizes results in one of four ways shown in Figure 3-1: superior, non-inferior, inconclusive, or inferior. Superior results [A] indicate the CI from the pre-test/post-test is entirely above both the predefined threshold value and zero (i.e., the pre-test/post-test is found to be statistically significant). Non-inferior findings [B/C] indicate that while results from statistical testing may be inconclusive or significantly worsening, non-inferiority testing shows any worsening in rates are not practically/clinically significant and therefore can be characterized as being not inferior to baseline rates. Inconclusive findings [D/E] occur when the 95 percent CI captures the non-inferiority threshold value. Inferior results [F] indicate the CI from the pre-test/post-test is entirely below the predefined threshold value.

Figure 3-1—Non-Inferiority Testing



For measures that use a DiD framework and are hypothesized to perform at least as well as or better than a comparison group, a prespecified fraction (δ) of the change in the comparison group (coefficient on time, β_2) is used to define an "equivalence range," which would conclude that the treatment group performed as well as the comparison group. The equivalence range is bounded by the change in rates for the comparison group, plus or minus 10 percent of the change in the comparison group. The change in the treatment group will be compared against this equivalence range using a 95 percent confidence interval. Figure 3-2 illustrates how the equivalence window will be calculated and how statistical significance will be determined.

Figure 3-2—Illustration of Non-Equivalence Testing Procedure

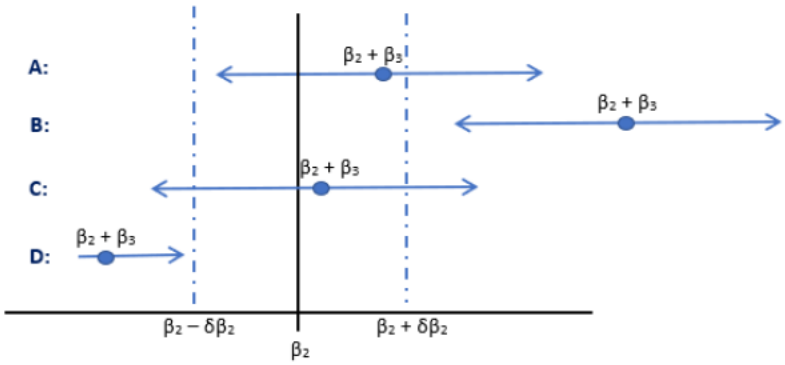


Table 3-8 defines the equivalence intervals used for each scenario in Figure 3-2.

Table 3-8—Noninferiority Equivalence Intervals

Desired Direction	Equivalence Interval	Noninferiority Threshold
Higher is better and $\beta_2 > 0$ OR lower is better and $\beta_2 < 0$	$(\beta_2 - \delta\beta_2)$ to β_2	$(\beta_2 - \delta\beta_2)$
Lower is better and $\beta_2 > 0$ OR higher is better and $\beta_2 < 0$	β_2 to $(\beta_2 + \delta\beta_2)$	$(\beta_2 + \delta\beta_2)$

In Figure 3-2, given a measure in which higher is better, the confidence interval in Scenario A, denoted by the arrows, includes β_2 but not the noninferiority threshold $(\beta_2 - \delta\beta_2)$. Therefore, evidence supports the finding that the treatment group is not inferior to the comparison group. The confidence interval in Scenario B is above β_2, which suggests that the treatment group is superior to the comparison group. The confidence interval in scenario C spans both β_2 and $(\beta_2 - \delta\beta_2)$. Therefore, there is insufficient evidence to establish noninferiority and the results are inconclusive. The confidence interval in Scenario D falls below the noninferiority threshold $(\beta_2 - \delta\beta_2)$ and supports the finding that the treatment group is inferior to the comparison group.

Comparison to National Benchmarks

The independent evaluator may compare Turquoise Care rates against national benchmarks to provide additional context without conducting formal statistical testing. Although statistical testing through a DiD or pre-test/post-test approach would be preferable, comparison to national benchmarks may be necessary if the comparison group data are not granular enough to support statistical testing.

Pre-Test/Post-Test

Rates will be calculated and compared before and after Turquoise Care implementation for measures for which national or regional benchmarks are not available and there are too few observations to support an ITS analysis. Statistical testing will be conducted through a Chi-square analysis. A Chi-square test allows for comparison between two groups with a categorical outcome, such as survey results or numerator compliance, to determine if the observed counts differ from the expectation. Specifically, comparisons will be made using the model:

$$Y = \beta_0 + \beta_1 * post$$

where Y is the rate of the outcome being measured each year, β_0 captures the average rate in the baseline years, and the coefficient β_1 for the dummy variable, *post*, representing the evaluation years, captures the change in average outcome between the baseline and evaluation time periods. For measures that utilized pre/post-testing, a weighted average of the evaluation period is also presented and represents a pooled average of the numerator and denominator counts across all three evaluation years.

Binomial logistic regression may be utilized to evaluate measures with binary outcomes or presented as rates. Due to limited comparison group options, it is difficult to conclude whether the changes in rates are a direct result of the specific program, as simultaneous external factors occurring during the same time period may have also had an unaccounted-for impact. When possible, control variables will be utilized to better isolate program impact, including controls for confounding events, such as the COVID-19 PHE.

Descriptive Time Series

Measures in which there are not sufficient data points for a robust ITS analysis and no viable comparison group for DiD testing will be assessed through a descriptive analysis of trends in the data. Analysis of the reentry, nutrition assistance, and short-term post-hospitalization recuperative support programs may rely on analysis of the post-implementation trend if sufficient data on provided services are not available or not collected prior to its implementation. Data during the post-implementation period will be analyzed to assess how measures have changed over the course of Turquoise Care. A regression line fit to the post-implementation data points will test for any statistically significant changes in measure rates.

Subgroup Analysis

The reentry program evaluation will include a subgroup analysis of members who received pre-release services between 30 days and 90 days compared to those who received services for less than 30 days, for measures where data are available and surpasses suppression standards. If possible, statistical testing such as a chi-squared test may assess if performance between the two groups is statistically significant.

Qualitative Synthesis

To evaluate qualitative measures relating to the reentry, nutrition assistance, short-term post-hospitalization recuperative services, and THCP programs, two rounds of semi-structured key informant interviews with stakeholders familiar with the programs will be conducted to obtain qualitative data prior to the Interim and Summative Evaluation Reports. A qualitative synthesis will be utilized to assess the results of the interviews.

Key informants will be identified by HCA as having experience and subject matter expertise regarding the programs. Each informant will be requested to participate in a 45-minute interview to provide insights into the implementation of the programs. A limited number of key informant interviews per program should be sufficient because there will be a limited number of stakeholders with a working knowledge of the activities associated with each program, and the challenges and successes that accompanied the implementation.

A flexible, semi-structured interview protocol will be developed. Interview questions will seek information about the implementation of the reentry, nutrition assistance, short-term post-hospitalization recuperative services, and THCP programs, including:

- Barriers to implementation
- Facilitators of success to implementation
- Experiences with cross-system coordination and communication
- Experiences with connections between correctional and community services
- Experiences providing pre-release services with potentially short duration
- Tribal entities' experience with program implementation and program effectiveness
- Description of changes in local investments outside of Turquoise Care

Early interviews will inform the development of topics and the selection of additional informants to complete the list of individuals to be interviewed for this evaluation. Open-ended questions will maximize the diversity and richness of responses and ensure a more holistic understanding of the subject's experience. Probing follow-up questions will be used, as appropriate, to elicit additional detail and understanding of critical points, terminology, and perspectives. The sessions will be recorded and transcribed with participant consent.

The information obtained from these interviews will be synthesized with the results from other quantitative data analyses, providing an in-depth discussion of each of the domains/objectives to be considered. As the key informant interviews are being conducted, the independent evaluator will perform ongoing and iterative review of the interview responses and notes to identify overall themes and common response patterns. Unique responses that are substantively interesting and informative will also be noted and may be used to develop probing questions for future interviews. The results of these preliminary analyses will be used to document the emergent and overarching themes related to each research question. The documentation of emergent themes will be reviewed iteratively to determine if responses to interview questions are continuing to provide new perspectives and answers, or if the responses are converging on a common set of response patterns indicating saturation on a particular interview question. As additional interview data are collected, the categories, themes, and relationships will be adjusted to reflect the broader set of concepts and different types of relationships identified. The documentation of emergent themes will also be used as an initial starting point for organizing the analysis of the interview data once all interviews are completed.

Following the completion of the key informant interviews, the interview notes and transcripts will be reviewed using standard qualitative analysis techniques. The data will first be examined through open coding to identify key concepts and themes that may not have been captured as emergent themes during previous analyses. After identifying key concepts, axial coding techniques will be used to develop a more complete understanding of the relationships among categories identified by respondents. The result of the open and axial coding analysis will be an account of the scope of issues raised by respondents, and a synthesis of how those concepts are related as presented in the participants' own words and experiences. This thematic coding process will ensure a thorough qualitative analysis with direct links to respondents' exact responses. The open and axial coding will be performed with a focus on identifying the dimensionality and breadth of responses to the research questions posed for the overall project. The open and axial coding will identify additional themes and develop a more complete understanding of the themes and relationships among categories identified by respondents. Interviewee responses will be identified through the analysis to illustrate and contextualize the conclusions drawn from the research and will be used to support the development of the final evaluation reports. The responses to key informant interview questions will add context to the quantitative findings. Opinions identifying opportunities for improving the efficacy of the reentry program will inform the *Lessons Learned and Recommendations* chapter of the evaluation reports.

Disentangling Confounding Effects

It is possible that co-interventions or other events coinciding with Turquoise Care may confound measure rates; as such, a comparison of baseline rates to the evaluation period would not be able to disentangle those effects from the effects of Turquoise Care. These effects may include policy changes at the State or federal level. Known confounding effects will be controlled for using appropriate methods during the Turquoise Care evaluation.

4. Methodological Limitations

This Evaluation Design builds on the foundation of the evaluation for the preceding Centennial Care 2.0 program. To maintain a rigorous evaluation of New Mexico's Section 1115 Demonstration Waiver, this design includes a variety of data sources which provide a holistic view of metrics spanning access to services, healthcare outcomes, person-centered care, and health-related social needs (HRSN). Additionally, this Evaluation Design includes standardized performance metrics from recognized measure stewards which allows for comparisons to national rates. However, despite the planned rigor, several limitations may affect the ability to attribute changes in performance metrics directly to Turquoise Care.

Data Sources

The data from the Medicaid Management Information System (MMIS) used to calculate performance metrics is generated through the Medicaid billing process. These data may not be as complete or sensitive for identifying specific healthcare processes and outcomes as may be expected from medical chart review. This limitation may be mitigated if the lack of sensitivity in the MMIS data remains stable over time and if the measures calculated from these data follow trends consistent with the underlying processes and outcomes of interest.

Additional data sources, such as managed care organization (MCO) report data, may contain varying data elements reported from year to year or plan to plan. For example, during the interim evaluation of Centennial Care 2.0, the independent evaluator found that changes in reporting templates made it difficult to determine if the data provided reflected a true change in measure outcomes, or merely an artifact of reporting. These data will be provided to the independent evaluator as reported by each MCO, and the independent evaluator may not be able to confirm or independently validate the data. The independent evaluator will review data sources for consistency with prior evaluation reports where applicable and ensure comparability over time to the extent possible. Any unresolved data quality issues will be reported in the *Methodological Limitations* chapter of the evaluation reports.

The Medicaid Home Visiting (MHV) program evaluation design includes measures for adults (postpartum women) and their children. Data that either identifies children as participants or allows for the independent evaluator to match infants to their participating parents must be available to calculate Measures 89 and 90, *Percentage of members who had a well-child visit in the first 30 months of life (15 months)* and *Percentage of children 2 years of age with appropriate immunization status*. If linking participating adults to children is not possible, these measures may only assess the general Turquoise Care population and will not reflect the true impact of MHV on infant health.

Analytic Methods

The evaluation methodology for the evaluation of Turquoise Care includes difference-in-differences (DiD), interrupted time series (ITS), pre-test/post-test, and descriptive time series. DiD and ITS approaches provide an understanding of whether the applicable measures exhibited statistically significant changes after the implementation of Turquoise Care. However, for certain programs, such as reentry and nutrition assistance, pre-implementation data may be unavailable for assessing changes in post-implementation trends. In these cases, the evaluation will rely on a descriptive time series, comparing outcomes year-over-year during the post-implementation period to assess any improvements. This approach will not allow the independent evaluator to conclude if Turquoise Care caused the changes in rates, as external factors may have contributed to changes.

Furthermore, there are limitations in identifying a suitable comparison group for program participants. The most appropriate comparison group for program participants would be Medicaid members with similar demographic and health characteristics who did not enroll in the respective program. Eligible members who did not enroll in each program is proposed as a close approximation for the ideal comparison group. However, the extent to which individuals are prioritized and selected into each program may indicate a difference in need among program participants and the comparison group that could impact the results. The use of propensity-score matching methods is designed to account for inherent differences in the groups and may limit the impact of this bias. Similarly, some programs may not have a valid comparison group nor pre-implementation data that can be used to establish casual inference. Data from another state with similar population characteristics and Medicaid policies and procedures in place are unlikely to be available due to limitations and challenges in securing cross-state data sharing agreements. While the Centers for Medicare & Medicaid Services (CMS) has suggested to utilize Transformed Medicaid Statistical Information System (T-MSIS) data to create a viable comparison group, use of these data was not feasible at the time of developing this Evaluation Design. T-MSIS data may become available for use in forming a counterfactual comparison group for the Turquoise Care population when the Interim Evaluation Report or the Summative Evaluation Report are developed.

The evaluation of the programs that allow for valid comparison groups presents several limitations. A DiD approach requires that the treatment and comparison groups meet the parallel trends assumption in the baseline period. For programs such as Health Home (HH), the same cohort of members must be followed from the baseline into the evaluation period. However, due to high churn rates among Medicaid members, tracking these cohorts over extended periods of time is difficult. In these cases, the independent evaluator will narrate the limitations of this approach or will use the most appropriate analytic technique supported by the data, such as an ITS analysis.

Additionally, even when a comparison group is identified, there may be differences unaccounted for between the groups even after propensity score matching that can contribute to biased results. Unlike in a randomized controlled trial, participating in the HH program or peer support services is voluntary, which means that participants may differ systematically from eligible non-participants in ways not captured by administrative data. While using a matched comparison population for the comparison group should, in theory, mitigate bias caused by the lack of randomization, no method can completely remove the effect of self-selection bias.

Finally, the independent evaluator recognizes that health equity is a complex subject and that there have been many discussions on the measurement of health equity within the scientific community. There is no single approach to evaluating health equity that is without limitations; this Evaluation Design employs multiple methods to identify varying impacts of Turquoise Care across demographic groups. The proposed health equity analysis is designed to provide an overview of how health disparities have changed during Turquoise Care and acknowledges that any changes in health disparities identified in the evaluation cannot be causally attributed to the Turquoise Care program, as co-occurring external factors may impact the measured outcomes. Finally, the availability of stratifications will vary by year and data source. The independent evaluator will stratify results by key fields where data are available and accurate. For example, sexual orientation and gender identity stratifications may not be available or consistent due to CMS rescinding guidance to add sexual orientation or gender identity to State Medicaid and Children's Health Insurance Program (CHIP) applications.[4-1]

[4-1] Centers for Medicare & Medicaid Services. CMCS Informational Bulletin. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06052025.pdf. Accessed on: Jun 5, 2025.

Appendix A. Attachments

Independent Evaluator

The New Mexico Health Care Authority (HCA) selected an independent evaluator with experience and expertise to conduct a scientifically and rigorous Medicaid Section 1115 waiver evaluation that meets all the requirements specified in the Special Terms and Conditions (STCs).[A-1] The independent evaluator was required to have the following qualifications:

- Knowledge of public health programs and policy
- Experience in healthcare research and evaluation
- Understanding of New Mexico's programs and populations
- Expertise with conducting complex program evaluations
- Relevant work experience
- Skills in data management and analytic capacity
- Medicaid experience and technical knowledge

Based on State protocols, HCA followed established policies and procedures to acquire the independent entity to conduct the waiver evaluation. In addition, HCA will ensure that the selected independent evaluator does not have any conflicts of interest and will require the independent evaluator to sign a "No Conflict of Interest" statement.

Evaluation Budget

Table A-1 presents the cost estimate for the evaluation of Turquoise Care.

Table A-1—Evaluation Budget

New Mexico Turquoise Care 1115 Waiver Evaluation									
Deliverables	**SFY 2025**	**SFY 2026**	**SFY 2027**	**SFY 2028**	**SFY 2029**	**SFY 2030**	**SFY 2031**	**SFY 2032**	**Total Cost**
Project Management (Activity Reports, Annual and Quarterly Monitoring Reports)	$ 30,000	$ 53,000	$ 56,000	$ 60,000	$ 64,000	$ 68,000	$ 73,000	$ -	**$ 404,000**
Key Informant Interviews (Instrument, Administration,	$ -	$ -	$ -	$ 24,000	$ -	$ 22,000	$ -	$ -	**$ 46,000**
Data Collection and Validation	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ -	**$ 35,000**
Interim Evaluation Report, Draft	$ -	$ -	$ 41,000	$ 286,000	$ 53,000	$ -	$ -	$ -	**$ 380,000**
Interim Evaluation Report, Final	$ -	$ -	$ -	$ -	$ 75,000	$ -	$ -	$ -	**$ 75,000**
Summative Evaluation Report, Draft	$ -	$ -	$ -	$ -	$ -	$ 125,000	$ 236,000	$ -	**$ 361,000**
Summative Evaluation Report, Final	$ -	$ -	$ -	$ -	$ -	$ -	$ 49,000	$ 54,000	**$ 103,000**
Turquoise Care 1115 Waiver Evaluation Total	**$ 35,000**	**$ 58,000**	**$ 102,000**	**$ 375,000**	**$ 197,000**	**$ 220,000**	**$ 363,000**	**$ 54,000**	**$ 1,404,000**

A-1 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Oct 24, 2024.

Timeline and Major Milestones

Table A-2 is the proposed evaluation timeline for Turquoise Care. This timeline is preliminary and is subject to changed based on the approval of the Evaluation Design.

Table A-2—Evaluation Timeline

Task	SFY2025		SFY2026		SFY2027		SFY2028		SFY2029		SFY2030		SFY2031	
	CY2024	CY2025	CY2026	CY2027	CY2028	CY2029	CY2030	CY2031						
	Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2						
Prepare and Implement Evaluation Design														
Conduct kick-off meeting														
Prepare workplan														
Data Collection														
Obtain claims and encounter data														
Perform gap analysis and data quality checks														
Obtain non-claims/encounters data														
Perform gap analysis and data quality checks														
Conduct Analysis														
Qualitative Analysis														
Develop protocols and conduct interviews														
Conduct qualitative analyses														
Quantitive Analysis														
Prepare and calculate metrics														
Conduct statistical testing and comparison														
Reporting														
Draft Interim Evaluation Report														
Final Interim Evaluation Report														
Draft Summative Evaluation Report														
Final Summative Evaluation Report														

Note: CY: calendar year; SFY: state fiscal year; Q: quarter

Proposed Measure Specifications

The tables in this section provide the detailed measure specifications for the Turquoise Care evaluation.

Aim One

Hypothesis 1: Continuing to expand access to long-term services and supports (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain or increase the number of members accessing community benefit (CB) services.

Research Question 1.1: Has the percentage of members accessing CB services increased or maintained year-over-year?

Number and percentage of Turquoise Care members enrolled and receiving CB services (Measure 1)	
Numerator/Denominator	Numerator: Number of LTSS-eligible Turquoise Care members enrolled and receiving CB services in the measurement year Denominator: Number of LTSS-eligible Turquoise Care members enrolled and receiving CB services in the prior year
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography[A-2]

A-2 The measure stratifications presented are based on the anticipated best available data. The independent evaluator will collaborate with HCA to review the data available at the time of the evaluation report development to identify appropriate and feasible stratifications.

Number and percentage of Turquoise Care members enrolled and receiving CB services (Measure 1)	
Measure Steward	N/A
Measure Name	N/A
Data Source	Medicaid Management Information System (MMIS)
Desired Direction	No change or higher is better
Analytic Approach	• Interrupted time series (ITS) • Pre-test/post test
Frequency	Annually/monthly

Number and percentage of CB members receiving home-delivered meals (Measure 2)	
Numerator/Denominator	Numerator: Number of CB members receiving home-delivered meals Denominator: Number of CB members
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	No change or higher is better
Analytic Approach	Descriptive time series
Frequency	Annually/monthly

Hypothesis 2: The ability for legally responsible individuals (LRI) to provide personal care services (PCS) to individuals receiving CB or Early and Period Screening, Diagnostic, and Treatment (EPSDT) PCS will ensure member access to CB or EPSDT PCS and improve continuity of care through nursing facility level of care (NFLOC) approvals.

Research Question 2.1: Is the proportion of members receiving CB or EPSDT PCS the same or higher after the implementation of this benefit?

Percentage of members receiving EPSDT PCS (Measure 3)	
Numerator/Denominator	Numerator: Number of Turquoise Care members receiving EPSDT PCS Denominator: Number of Turquoise Care members
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better

Percentage of members receiving EPSDT PCS (Measure 3)	
Analytic Approach	• ITS • Pre-test/post test • Descriptive time series
Frequency	Annually/monthly

Percentage of LTSS-eligible members receiving CB PCS (Measure 4)	
Numerator/Denominator	Numerator: Number of LTSS-eligible Turquoise Care members receiving CB PCS Denominator: Number of LTSS-eligible Turquoise Care members
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post test • Descriptive time series
Frequency	Annually/monthly

Average number of EPSDT PCS per utilizing member (Measure 5)	
Numerator/Denominator	Numerator: Number of EPSDT PCS services Denominator: Number of EPSDT PCS utilizing members
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post test • Descriptive time series
Frequency	Annually/monthly

Average number of CB PCS per utilizing member (Measure 6)	
Numerator/Denominator	Numerator: Number of CB PCS services Denominator: Number of CB PCS utilizing members
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post test • Descriptive time series
Frequency	Annually/monthly

Research Question 2.2: Has the number of continuous NFLOC approvals maintained or increased?

Number of continuous NFLOC approvals (Measure 7)	
Numerator/Denominator	Numerator: The number of nursing facility members enrolled in Turquoise Care with a continuous NFLOC approval Denominator: The number of nursing facility members enrolled in Turquoise Care
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• Summary report of open-ended long-term care (LTC) spans • MCO reports
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Hypothesis 3: Providing continuous eligibility will improve continuity of care among children ages 0 to 5 years.

Research Question 3.1: Has the percentage of members ages 0–5 years with continuous enrollment increased?

Length of enrollment among members ages 0–5 years (Measure 8)	
Numerator/Denominator	Numerator 1: Number of Turquoise Care members ages 0–5 years enrolled less than six months Numerator 2: Number of Turquoise Care members ages 0–5 years enrolled for six to 11 months Numerator 3: Number of Turquoise Care members ages 0–5 years enrolled for at least 12 months Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better (Numerator 3); Lower is better (Numerator 1)
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members ages 0–5 years who had a gap in Medicaid coverage (Measure 9)	
Numerator/Denominator	Numerator: Number of Turquoise Care members ages 0–5 years with one or more gaps in Medicaid enrollment. A gap is defined as one day or more without enrollment (i.e., if a member disenrolls on December 31 and re-enrolls on January 1, there is no gap. However, if a member disenrolls on December 31 and re-enrolls on January 2, there is a one-day gap). If a member was born during the measurement period, gaps prior to the member's date of birth will not be counted. Denominator: Number of Turquoise Care members ages 0–5 years. Members turning age 6 years during the measurement period will be excluded from the denominator.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Average number of gaps in Medicaid coverage for members ages 0–5 years (Measure 10)	
Numerator/Denominator	Numerator: Number of gaps in coverage for Turquoise Care members ages 0–5 years. A gap is defined as one day or more without enrollment (i.e., if a member disenrolls on December 31 and re-enrolls on January 1, there is no gap. However, if a member disenrolls on December 31 and re-enrolls on January 2, there is a one-day gap). If a member was born during the measurement year (MY), gaps prior to the member's date of birth will not be counted. Denominator: Number of Turquoise Care members ages 0–5 years with one or more gaps in Medicaid enrollment. Members turning age 6 years during the MY will be excluded from the denominator.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Average number of days per gap in Medicaid coverage for members ages 0–5 years (Measure 11)	
Numerator/Denominator	Numerator: Number of gap days in coverage for Turquoise Care members ages 0–5 years. A gap is defined as one day or more without enrollment (i.e., if a member disenrolls on December 31 and re-enrolls on January 1, there is no gap. However, if a member disenrolls on December 31 and re-enrolls on January 2, there is a one-day gap). If a member was born during the MY, gaps prior to the member's date of birth will not be counted. Denominator: Number of Turquoise Care members ages 0–5 years with one or more gaps in Medicaid enrollment. Members turning age 6 years during the MY will be excluded from the denominator.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 3.2: Has the percentage of members ages 0–5 years with access to preventive services increased?

Percentage of members who had a well-child visit in the first 30 months of life (Measure 12)	
Numerator/Denominator	Numerator: Number of members with well-child visits on different dates. Two rates are reported: Rate 1: Six or more well-child visits on different dates of service on or before the 15-month birthday, and Rate 2: Two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday Denominator: Two rates are reported: Rate 1: Number of members who turn 15 months old during the MY and are continuously enrolled between 31 days and 15 months old with no more than one gap in enrollment of up to 45 days Rate 2: Number of members who turn 30 months old during the MY and are continuously enrolled between 15 months plus one day and 30 months of age with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Centers for Medicare & Medicaid Services (CMS) Child Core Set
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Percentage of children and adolescents who had a well-care visit (Measure 13)	
Numerator/Denominator	Numerator: Members among the denominator with one or more well-care visits during the MY Denominator: Number of members ages 3–5 years who are continuously enrolled during the MY with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Percentage of children 2 years of age with appropriate immunization status (Measure 14)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophiles influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. Denominator: Number of children who turn two years old during the MY who were continuously enrolled 12 months prior to the child's second birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Childhood Immunization Status (CIS)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Research Question 3.3: Has the percentage of members ages 0–5 years utilization of hospital services changed?

Number of potentially preventable emergency department (ED) visits, per 1,000 member months (MM) (Measure 15)	
Numerator/Denominator	Numerator: Discharges, for patients in the denominator and meet numerator criteria for any of the following prevention quality indicators (PQIs): • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission 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 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges The PQIs must meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Denominator: MM among members ages 0 to 5 years in a metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000.
Comparison Population	N/A

Number of potentially preventable emergency department (ED) visits, per 1,000 member months (MM) (Measure 15)	
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified Agency for Healthcare Quality and Research (AHRQ)
Measure Name	PQI-90
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Number of all-cause ED visits, per 1,000 MM (Measure 16)	
Numerator/Denominator	Numerator: Number of ED visits Denominator: Number of MM among members ages 0 to 5 years, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	National Committee for Quality Assurance (NCQA)
Measure Name	Ambulatory Care (AMB)
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Hypothesis 4: Managed care or care coordination through the Health Home (HH) program will maintain access to effective and quality care.

Research Question 4.1: Is there an increase in the percentage of members enrolled in a HH?

Number and percentage of Turquoise Care members enrolled in a HH (Measure 17)	
Numerator/Denominator	Numerator: Among members identified in the denominator, the number of unique Medicaid members contained in HH roster files during the measurement period Denominator: The number of unique Medicaid members with Turquoise Care enrollment (i.e., paid capitation) during the measurement period
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better

Number and percentage of Turquoise Care members enrolled in a HH (Measure 17)	
Analytic Approach	• ITS • Pre-test/post test
Frequency	Annually/monthly

Research Question 4.2: Does the HH program increase access to care coordination?

Number and percentage of members receiving care coordination (Measure 18)	
Numerator/Denominator	Numerator: Number of members receiving care coordination Denominator: Number of members enrolled in a HH
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post test
Frequency	Annually/monthly

Research Question 4.3: Does engagement in a HH increase utilization of preventive health services and improve disease management and quality of care?

Percentage of adults who accessed preventive/ambulatory health services (Measure 19)	
Numerator/Denominator	Numerator: Among members identified in the denominator for each group, the number of unique members who had an ambulatory or preventive care visit during the measurement period. Denominator: Treatment Group: Number of Turquoise Care members ages 20 years and older continuously enrolled in Turquoise Care with no more than one gap of up to 45 days during the MY. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months concurrently in a HH and Turquoise Care during the MY, and had no exposure to a HH prior to July 25, 2024. Comparison Group: The number of Turquoise Care members ages 20 years and older continuously enrolled in Turquoise Care with no more than one gap of up to 45 days during the MY. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period and had no exposure to a HH during or prior to the MY.
Comparison Population	Propensity score adjusted members who have never participated in the HH program.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• MMIS • Program participation data

Percentage of adults who accessed preventive/ambulatory health services (Measure 19)	
Desired Direction	Higher is better
Analytic Approach	• Difference-in-Differences (DiD) • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of children and adolescents who had a well-care visit (Measure 20)	
Numerator/Denominator	Numerator: Number of members identified in the denominator for each group, who accessed a well-child visit. Denominator: Treatment Group: The number of Turquoise Care members 3–21 years of age. Children ages 3 years to 6 years must be continuously enrolled in Turquoise Care during the measurement period, and children and adolescents ages 7 to 19 years must be continuously enrolled in Turquoise Care during the measurement period and the year prior to the measurement period. Members must be continuously enrolled in Turquoise Care with no more than one gap of up to 45 days in each year. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months concurrently in a HH and Turquoise Care during the MY, and had no exposure to a HH prior to July 25, 2024. Comparison Group: The number of Turquoise Care members 21 years of age. Children ages 3 years to 6 years must be continuously enrolled in Turquoise Care during the measurement period, and children and adolescents ages 7 to 19 years must be continuously enrolled in Turquoise Care during the measurement period and the year prior to the measurement period. Members must be continuously enrolled with no more than one gap of up to 45 days in each year. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period and had no exposure to a HH during or prior to the MY.
Comparison Population	Propensity score adjusted members who have never participated in the HH program.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with schizophrenia or bipolar disorder who are using antipsychotic medications who are screened for diabetes (Measure 21)	
Numerator/Denominator	Numerator: Among members identified in the denominator for each group, the number of unique Medicaid members who were dispensed an antipsychotic medication and had a diabetes screening test during the MY. Denominator: Treatment group: The number of Turquoise Care members ages 18–64 years with serious mental illness (SMI) (schizophrenia or bipolar disorder), continuously enrolled in Turquoise Care with no more than one gap of up to 45 days. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months concurrently in a HH and Turquoise Care during the MY, and had no exposure to a HH prior to July 25, 2024. Comparison group: The number of Turquoise Care members ages 18–64 years with SMI (schizophrenia or bipolar disorder), continuously enrolled in Turquoise Care with no more than one gap of up to 45 days. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period and had no exposure to a HH during or prior to the MY.
Comparison Population	Propensity score adjusted members who have never participated in the HH program.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members who remained on an antidepressant medication treatment (Measure 22)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Among members identified in the denominator for each group, the number of unique Medicaid members who remained on an antidepressant medication treatment for at least 84 days. Numerator 2: Among members identified in the denominator for each group, the number of unique Medicaid members who remained on an antidepressant medication treatment for at least 180 days. Denominator: Treatment group: The number of Turquoise Care members 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Turquoise Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Turquoise Care 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for 3 continuous months concurrently in a HH and Turquoise Care during the MY, and had no exposure to a HH prior to July 25, 2024. Comparison group: The number of Turquoise Care members 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Turquoise Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Turquoise Care 105 days prior to the IPSD through 231 days after the IPSD. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period and had no exposure to a HH during or prior to the MY.
Comparison Population	Propensity score adjusted members who have never participated in the HH program.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 23)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Of members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within seven days after discharge. Numerator 2: Among members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within 30 days after discharge. Denominator: Treatment group: The number of Turquoise Care members 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Turquoise Care during the measurement period. Members 6 years of age and older must be continuously enrolled in Turquoise Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months concurrently in a HH and Turquoise Care during the MY, and had no exposure to a HH prior to July 25, 2024. Comparison group: The number of Turquoise Care members 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Turquoise Care during the measurement period. Members 6 years of age and older must be continuously enrolled in Turquoise Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months in Turquoise Care during the MY, and had no exposure to a HH during or prior to the MY.
Comparison Population	Propensity score adjusted members who have never participated in the HH program.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 4.4: Is the rate of preventive health services the same or higher than prior to the renewal period?

Percentage of adults who accessed preventive/ambulatory health services (Measure 24)	
Numerator/Denominator	Numerator: The number of Turquoise Care members in the denominator who had an ambulatory or preventive care visit during the MY. Denominator: The number of Turquoise Care members ages 20 years and older and were continuously enrolled with no more than one gap of up to 45 days during the MY.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• MMIS • National/regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks
Frequency	Annually/monthly

Percentage of children and adolescents who had a well-care visit in the first 30 months of life (Measure 25)	
Numerator/Denominator	Numerator: Number of members with well-child visits on different dates. Two rates are reported: Rate 1: Six or more well-child visits on different dates of service on or before the 15-month birthday Rate 2: Two or more well-child visits on different dates of service between the child's 15 month birthday plus one day and the 30 month birthday. Denominator: Two rates are reported: Rate 1: Number of members who turn 15 months old during the MY and are continuously enrolled between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days. Rate 2: Number of members who turn 30 months old during the MY and are continuously enrolled between 15 months plus one day and 30 months of age with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	• MMIS • National/regional benchmarks
Desired Direction	No change or higher is better

Percentage of children and adolescents who had a well-care visit in the first 30 months of life (Measure 25)	
Analytic Approach	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks
Frequency	Annually/monthly

Percentage of children and adolescents who had a well-care visit (Measure 26)	
Numerator/Denominator	Numerator: Members among the denominator with one or more well-care visits during the MY. Denominator: Number of members ages 3–21 years who are continuously enrolled during the MY with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• MMIS • National/regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks
Frequency	Annually/monthly

Research Question 4.5: Is the rate of management of behavioral health (BH) conditions the same or better than prior to the renewal period?

Percentage of members who remained on an antidepressant medication treatment (Measure 27)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Among members identified in the denominator, the number of unique Medicaid members who remained on an antidepressant medication treatment for at least 84 days. Numerator 2: Among members identified in the denominator, the number of unique Medicaid members who remained on an antidepressant medication treatment for at least 180 days. Denominator: The number of Turquoise Care members 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Turquoise Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Turquoise Care 105 days prior to the IPSD through 231 days after the IPSD. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)

Percentage of members who remained on an antidepressant medication treatment (Measure 27)	
Data Source	• MMIS • National/regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks
Frequency	Annually/monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 28)	
Numerator/Denominator	Numerator: Numerator 1: Of members identified in the denominator, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within 7 days after discharge. Numerator 2: Among members identified in the denominator, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within 30 days after discharge. Denominator: The number of Turquoise Care members 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Turquoise Care during the measurement period. Members 6 years of age and older must be continuously enrolled in Turquoise Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period, enrolled for three continuous months in Turquoise Care during the MY.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• MMIS • National/regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test • Comparison to national/regional benchmarks
Frequency	Annually/monthly

Research Question 4.6: Have members' self-assessed healthcare quality and outcomes maintained or improved?

Percentage of respondents who reported a high rating of overall healthcare (8, 9, or 10) (Measure 29)	
Numerator/Denominator	Numerator: Number of respondents indicating they had a high rating of their overall healthcare (8, 9, or 10 out of 10) Denominator: Number of valid responses to the survey question regarding satisfaction of overall healthcare among all managed care members
Comparison Population	N/A

Percentage of respondents who reported a high rating of overall healthcare (8, 9, or 10) (Measure 29)	
Stratification	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-3] Statewide survey
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Percentage of respondents who reported a high rating of health plan (8, 9, or 10 out of 10) (Measure 30)	
Numerator/Denominator	Numerator: Number of respondents indicating they had a high rating of their health plan (8, 9, or 10 out of 10) Denominator: Number of valid responses to the survey question regarding satisfaction of health plan among all managed care members
Comparison Population	N/A
Stratification	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	CAHPS Statewide survey
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Percentage of members who reported a rating of overall health as very good or excellent (Measure 31)	
Numerator/Denominator	Numerator: Number of respondents indicating they had a high rating of overall health (very good or excellent) Denominator: Number of valid responses to the survey question regarding overall health among all managed care members
Comparison Population	N/A
Stratification	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	CAHPS Statewide survey
Desired Direction	No change or higher is better

A-3 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Percentage of members who reported a rating of overall health as very good or excellent (Measure 31)	
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Percentage of respondents who reported a rating of overall mental or emotional health as very good or excellent (Measure 32)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of overall mental or emotional health (very good or excellent) Denominator: Number of valid responses to the survey question regarding overall mental or emotional health among all managed care members
Comparison Population	N/A
Stratification	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	CAHPS Statewide survey
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Research Question 4.7: Has access to telemedicine services maintained or improved?

Number of telemedicine providers (Measure 33)

Numerator/Denominator

Numerator: The number of unique Turquoise Care telemedicine providers that offer telehealth services.

Step 1: Identify encounters for telehealth services using the following codes:

- Any service with a telehealth modifier or place of service (Telehealth Modifier Value Set or Telehealth Place of Service (POS) Value Set)
- A telephone visit (Telephone Visits Value Set)
- An e-visit or virtual check-in (Online Assessments Value set)
- Any service from Table A

Table A—HCA Telemedicine Service Codes

99441	99442	99443	99451	99452	
G2010	G2012	G2061	G2062	G2063	D9995

Step 2: Calculate the number of unique servicing/rendering providers with at least one encounter from Step 1 with a date of service in the measurement period.

Denominator: N/A

Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A

Number of telemedicine providers (Measure 33)	
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Number of members receiving telemedicine services (Measure 34)	
Numerator/Denominator	Numerator: The number of Centennial Care members with a telemedicine visit. Step 1: Identify encounters for telehealth services using the following codes: • Any service with a telehealth modifier or place of service (Telehealth Modifier Value Set or Telehealth Place of Service (POS) Value Set) • A telephone visit (Telephone Visits Value Set) • An e-visit or virtual check-in (Online Assessments Value set) • Any service from Table A. **Table A—HCA Telemedicine Service Codes** 99441, 99442, 99443, 99451, 99452 G2010, G2012, G2061, G2062, G2063, D9995 Step 2: Calculate the number of unique servicing/rendering providers with at least one encounter from Step 1 with a date of service in the measurement period. Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Hypothesis 5: Expanding member incentives for preventive care through the Member Rewards (MR) program will encourage members to engage in preventive care services.

Research Question 5.1: Has the percentage of Turquoise Care members participating in MR and accessing preventive health services increased?

Percentage of Turquoise Care members participating in MR (Measure 35)	
Numerator/Denominator	Numerator: Two rates are reported: Rate 1: The number of members who were engaged in MR. Rate 2: The number of members who were engaged and have completed a reward activity. Denominator: The total number of members who were eligible or conditional. Members are conditional if they failed to appear on at least one monthly eligibility file and are removed from the numerator after they have failed to appear on three consecutive eligibility files and are considered disenrolled.
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of MR participating members and non-participating members with an annual preventive service (Measure 36)	
Numerator/Denominator	Numerator: Number of members in each denominator group who are engaged, earned any reward, have redeemed at least one reward (participated and redeemed), and have completed a second preventive/ambulatory visit in the twelve months following an initial preventive/ambulatory visit. Denominator: Treatment group: Total number of members who are engaged, earned any reward, have redeemed at least one reward (participated and redeemed), and had an initial preventive/ambulatory visit. Comparison group: Total number of members who are engaged, earned any reward, have not redeemed a reward (participated and not redeemed), and had an initial preventive/ambulatory visit.
Comparison Population	Propensity score adjusted MR participating members not participating in MR during the MY.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better

Percentage of MR participating members and non-participating members with an annual preventive service (Measure 36)	
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of MR participating and redeeming, and MR participating and non-redeeming members with an annual preventive service (Measure 37)	
Numerator/Denominator	Numerator: Members in each denominator group redeeming rewards with preventative/ambulatory services in the 12-month period following the initial redemption. Denominator: Treatment group: Turquoise Care members redeeming MR during the MY. Comparison group: Turquoise Care members not redeeming MR during the MY.
Comparison Population	Propensity score adjusted MR participating members not redeeming MR during the MY.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 6: The continuation of the high-fidelity wraparound (HFW) program will serve high-needs members with a serious emotional disturbance (SED) diagnosis.

Research Question 6.1: Is the HFW program enrolling the intended target population?

Number of HFW members enrolled in the program (Measure 38)	
Numerator/Denominator	Numerator: Turquoise Care members enrolled in HFW Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better

Number of HFW members enrolled in the program (Measure 38)	
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Percentage of HFW members with SED diagnosis in the 11 months prior to enrollment (Measure 39)	
Numerator/Denominator	Numerator: HFW members with SED diagnosis in the 11 months prior to enrollment Denominator: HFW members in the 11 months prior to enrollment
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	No desired direction
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 6.2: Does the HFW program increase utilization of preventive health services?

Percentage of children and adolescents who had a well-care visit (Measure 40)	
Numerator/Denominator	Numerator: HFW members ages 3 to18 years who had one or more well-care visits Denominator: Treatment group: Number of members in the HFW ages 3 to 18 years who are continuously enrolled during the MY with no more than one gap in enrollment of up to 45 days. Comparison group: Number of members in who are eligible, but not participating in the HFW program ages 3 to 18 years who are continuously enrolled during the MY with no more than one gap in enrollment of up to 45 days.
Comparison Population	Propensity score adjusted members who are eligible, but not participating in the HFW program
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 41)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Of members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within seven days after discharge. Numerator 2: Of members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within 30 days after discharge. Denominator: Treatment group: The number of Turquoise Care members ages 6 years and older, who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in HFW during the measurement period. Members ages 6 years and older must be continuously enrolled in Turquoise Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period of 2017, enrolled for three continuous months concurrently in a HFW program and Turquoise Care during the MY, and had no exposure to a HFW program prior to January 1, 2018. Comparison group: The number of Turquoise Care members 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Turquoise Care during the measurement period. Members 6 years of age and older must be continuously enrolled in Turquoise Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Turquoise Care for 11 months during the baseline period of 2017, enrolled for three continuous months in Turquoise Care during the MY, and had no exposure to a HFW program during or prior to the MY.
Comparison Population	Propensity score adjusted members who are eligible, but not participating in the HFW program
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually

Percentage of members with a follow-up visit after ED visit for mental illness (Measure 42)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Number of ED visits in the denominator with a follow-up visit for mental illness within seven days of the ED visit. Numerator 2: Number of ED visits in the denominator with a follow-up visit for mental illness within 30 days of the ED visit. Denominator: Treatment group: Number of ED visits for members participating in the HFW program during the measurement period, 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit. Comparison group: Number of ED visits for members who had no exposure to the HFW program during or prior to the measure year, 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit.
Comparison Population	Propensity score adjusted members who are eligible, but not participating in the HFW program
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Follow-Up After ED Visit for Mental Illness (FUM)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 7: Turquoise Care will provide cost-effective care.

Research Question 7.1: Have the payment amounts for providers in VBP arrangements increased?

Percentage of total payments that are for providers in VBP arrangements (Measure 43)	
Numerator/Denominator	Numerator: The total amount of payments to Turquoise Care providers with VBP contracts Denominator: The total amount of payments to Turquoise Care providers
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MCO reports
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Research Question 7.2: Does Turquoise Care provide cost-effective care?

Total and per-member per-month (PMPM) cost (among managed care members) (Measure 44)	
Numerator/Denominator	Numerator: The sum of total managed care organization (MCO) paid claim/encounter amounts for all inpatient (IP), LTC, outpatient (OP), professional, and pharmacy categories of service. Denominator: The sum of all Turquoise Care MM, including members who had claims/encounters and those who had no claims/encounters.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually

Total and PMPM cost (among managed care users) (Measure 45)	
Numerator/Denominator	Numerator: The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional, and pharmacy categories of service Denominator: The sum of all Turquoise Care MM only including members who had claims/encounters.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually

Aim Two

Hypothesis 1: Turquoise Care will increase or maintain the number of providers that provide substance use disorder (SUD) screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for SUD.

Research Question 1.1: Did the number of individuals screened and treated for SUD maintain or increase?

Number and percentage of individuals screened for SUD (Measure 46)	
Numerator/Denominator	Numerator: The number of Turquoise Care members screened for SUD. Identify encounters with any of the following procedure codes: • H0049 – Screening, brief intervention, and referral to treatment (SBIRT) • G0444 – Other BH screening • H2000 – Comprehensive multidisciplinary team evaluation • H0002 – American Society of Addiction Medicine (ASAM) assessment • H0031 – Comprehensive mental health assessment for patients who are not SMI or SED Denominator: Number of de-duplicated Turquoise Care members with encounters from Step 1 in the measurement period
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SUD Monitoring Metrics
Measure Name	Metric #1: Assessed for SUD Treatment Needs Using a Standardized Screening Tool
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of individuals with an SUD diagnosis who received any SUD service during the MY (Measure 47)	
Numerator/Denominator	Numerator: The number of Turquoise Care members among the denominator with an SUD diagnosis who received any SUD service during the MY. Denominator: The number of unique Turquoise Care members (de-duplicated total) enrolled in the measurement period who receive medication assisted treatment (MAT) or have qualifying facility, provider, or pharmacy claims with an SUD diagnosis and an SUD-related treatment service during the measurement period and/or in the 12 months before the measurement period.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS SUD Monitoring Metrics
Measure Name	• Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • Metric #6: Any SUD Treatment
Data Source	MMIS

Percentage of individuals with an SUD diagnosis who received any SUD service during the MY (Measure 47)	
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 2: Turquoise Care will increase or maintain peer support services, which will result in more individuals engaging in and retaining in SUD treatment.

Research Question 2.1: Has the percentage of individuals with an SUD diagnosis who received peer support services and treatment maintained or increased?

Percentage of individuals with an SUD diagnosis who received peer support (Measure 48)	
Numerator/Denominator	Numerator: Among members identified in the denominator, the number of Medicaid members who received peer support services. Denominator: The number of unique members (de-duplicated total) enrolled in the measurement period with an SUD diagnosis.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS SUD Monitoring Metrics
Measure Name	Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly)
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Initiation of SUD treatment (Measure 49)	
Numerator/Denominator	Numerator: The number of Turquoise Care individuals with SUD diagnosis who initiate SUD treatment through an IP admission, OP visit, telemedicine, intensive OP encounter or partial hospitalization or MAT within 14 days of the index episode start date (IESD). Denominator: Treatment group: Number of members ages 13 and over during the MY with an alcohol or opioid diagnosis and 194 days continuous enrollment prior to the SUD episode and 47 days after the index episode, who received peer support services. Comparison group: Number of members ages 13 and over during the MY with an alcohol or opioid diagnosis and 194 days continuous enrollment prior to the SUD episode and 47 days after the index episode, who never received peer support services.
Comparison Population	Propensity score adjusted Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support services.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA

Initiation of SUD treatment (Measure 49)	
Measure Name	Initiation and Engagement of SUD Treatment: Initiation of SUD Treatment (IET)
Data Source	• MMIS • National or regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test • Comparisons to national or regional benchmarks
Frequency	Annually/Monthly

Engagement of SUD treatment (Measure 50)	
Numerator/Denominator	Numerator: Among members identified in the denominator, the number of unique Medicaid members who initiated treatment and who had two or more additional SUD services or MAT within 34 days of the initiation visit. Denominator: Treatment Group: The number of Turquoise Care adolescent and adult members (ages 13 years and older) with a new episode of SUD abuse or dependence and received peer support services within 48 days following the IESD. Comparison Group: The number of Turquoise Care adolescent and adult members (ages 13 years and older) with a new episode of SUD abuse or dependence and had never utilized peer support services within 48 days following the IESD.
Comparison Population	Propensity score adjusted Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support services.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Initiation and Engagement of SUD Treatment: Engagement of SUD Treatment (IET)
Data Source	• MMIS • National or regional benchmarks
Desired Direction	No change or higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test • Comparison to national or regional benchmarks
Frequency	Annually/Monthly

Continuity of pharmacotherapy for opioid use disorder (OUD) (Measure 51)	
Numerator/Denominator	Numerator: Among members identified in the denominator, the number of unique Medicaid members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days. Denominator: Treatment group: The number of Turquoise Care members ages 18–64 years who had a diagnosis of OUD and at least one claim for an OUD medication. Members must have received peer support services (Peer Support Services Value Set) within 180 days after an OUD medication. Comparison Group: The number of Turquoise Care members ages 18–64 years who had a diagnosis of OUD and at least one claim for an OUD medication. Members must not have received peer support services (Peer Support Services Value Set) within 180 days after an OUD medication.
Comparison Population	Propensity score adjusted Turquoise Care members meeting the NCQA eligible population criteria and had never utilized peer support services.
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	University of Southern California (USC) (National Quality Forum [NQF] #3175)
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 3: Turquoise Care will improve or maintain access to a comprehensive continuum of SUD care, which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.

Research Question 3.1: Has the utilization of acute care settings by individuals with SUD maintained or decreased?

Percentage of members with an SUD diagnosis who used services in the last month or year, stratified by the following settings: Any setting, early intervention, OP, intensive OP, and residential and IP (Measure 52)	
Numerator/Denominator	Numerator: Number of members in the denominator, stratified by the following settings: Any setting, early intervention, OP, intensive OP, and residential and IP Denominator: Number of members diagnosed with SUD
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SUD Monitoring Metrics
Measure Name	• Metrics #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • Metric #6: Any SUD Treatment • Metric #7: Early Intervention • Metric #8: OP Services • Metric #9: Intensive OP and Partial Hospitalization Services • Metric #10: Residential and IP Services

Percentage of members with an SUD diagnosis who used services in the last month or year, stratified by the following settings: Any setting, early intervention, OP, intensive OP, and residential and IP (Measure 52)	
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of ED visits among members with SUD diagnoses (Measure 53)	
Numerator/Denominator	Numerator: Step 1. Identify members with an SUD diagnosis (monthly), as specified through Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #3: Medicaid members with SUD Diagnosis (monthly). Step 2. Calculate the number of ED visits among members retained from Step 1. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). Do not include ED visits that result in an IP stay (IP Stay Value Set). Denominator: The number of ED visits among all Turquoise Care members. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set). Do not include ED visits that result in an IP stay (IP Stay Value Set).
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Average length of stay (LOS) in an ED among members with an SUD diagnosis prior to admission to an Institution for Mental Disease (IMD) (Measure 54)	
Numerator/Denominator	Numerator: Number of days members stayed in an ED setting prior to boarding in an IMD. Denominator: Number of ED visits among all Turquoise Care members with an SUD diagnosis during the MY that led to a stay in an IMD. Same day and next day transfers from an ED setting to an IMD will be included in the denominator. For example, an ED visit on January 1 with an IMD admission also on January 1 will have an LOS of one day in the ED. An ED visit spanning from January 1 to January 2 with an IMD admission on January 3 will have a length of stay of two days (January 1 and January 2). Note: It may not be possible to fully identify the ED boarding portion of an IMD stay using exclusively claims/encounter data, particularly within the same facility.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of IP admissions for SUD-related treatment (Measure 55)	
Numerator/Denominator	Numerator: The number of IP services for SUD-related treatment for Turquoise Care members. Step 1: Identify all IP stays (acute and nonacute) during the measurement period (IP Stay Value Set). Step 2: Identify and exclude claims for residential treatment using the Uniform Billing (UB) Revenue codes: • 1001: Residential treatment, psychiatric • 1002: Residential treatment–chemical dependency Step 3: Identify the discharge date for the stay. Retain only stays with discharge dates that fall within the measurement period. Step 4: Among claims retained in the denominator, identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 5: Calculate the number of IP discharges meeting the criteria in Step 1. Denominator: The number of IP admissions for Turquoise Care members. Step 1: Identify all IP stays (acute and nonacute) during the measurement period (IP Stay Value Set). Step 2: Identify and exclude claims for residential treatment using the Uniform Billing (UB) Revenue codes listed below: • 1001: Residential treatment, psychiatric • 1002: Residential treatment – chemical dependency Step 3: Identify the discharge date for the stay. Retain only stays with discharge dates that fall within the measurement period
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Monitoring Metrics
Measure Name	Metric #24: IP Stays for SUD per 1,000 Medicaid Beneficiaries
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

7- and 30-day IP and residential SUD readmission rates (Measure 56)	
Numerator/Denominator	Numerator: Two rates are reported. Rate 1: The number of 7-day IP and residential readmission rates for Turquoise Care users discharged with SUD diagnosis and readmitted to either IP or residential treatment with SUD diagnosis. Rate 2: 30-day IP and residential readmission rates for Turquoise Care members discharged with SUD diagnosis and readmitted to either IP or residential treatment with SUD diagnosis. Denominator: The number of IP discharges with a principal diagnosis of SUD. Step 1: Calculate the Denominator: Count of Index Hospital Stays. Step 1a: Identify all acute IP discharges with any diagnosis in the first 11 months of the MY. To identify acute IP discharges: • Identify all acute and nonacute IP stays (IP Stay Value Set). • Exclude nonacute IP stays (Nonacute IP Stay Value Set). • Determine whether the discharge date for the stay falls in the first 11 months of the MY. IP stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct IP stays. This measure includes acute discharges from any type of acute facility (including BH facilities). Step 1b: Address acute-to-acute direct transfers as described below in "Additional Guidance." Exclude the hospital stay if the direct transfer's discharge date occurs in the last 30 days of the MY. Step 1c: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date. Step 1d: Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Note: For hospital stays where there was an acute-to-acute direct transfer (identified in Step 1), use both the original stay and the direct transfer stay to identify exclusions in this step. Step 1e. Identify stays with a principal diagnosis for SUD. Step 1f: To calculate the count of Index Hospital Stays (i.e., the denominator), count the number of Index Hospital Stays that meet the criteria in Steps 1a-1e.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 4: Turquoise Care will maintain or increase use of MAT and reduce the number of high dose opioid prescriptions, which will result in fewer overdose deaths due to opioid use.

Research Question 4.1: Has the number of members with OUD or SUD receiving MAT increased or maintained?

Percentage of members who have a claim for MAT for SUD (Measure 57)	
Numerator/Denominator	Numerator: Number of members in the denominator with a claim for MAT for SUD Denominator: Number of Turquoise Care members with SUD
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SUD Monitoring Metrics
Measure Name	Metric #12: Medication-Assisted Treatment
Data Source	MMIS
Desired Direction	No change or higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 4.2: Is there a decrease in the number of deaths attributable to overdose?

Use of opioids at high dosage in persons without cancer (Measure 58)	
Numerator/Denominator	Numerator: Number of members in the denominator who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Denominator: Number of members diagnosed with an SUD ages 18 years and older with two or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more. Members with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Rate of deaths due to overdose (Measure 59)	
Numerator/Denominator	Numerator: Rate 1: Proportionate Mortality Rate: The total number of overdose deaths among the denominator. Proportionate mortality and cause-specific death rates are calculated for both the whole New Mexico population and the New Mexico Medicaid population. Proportionate mortality rates are defined as the number of overdose deaths divided by all deaths among the population of interest. Rate 2: Cause-Specific Death Rate: The total number of overdose deaths among the denominator. Cause-specific death rates are defined as the total overdose deaths divided by the size of the population of interest. Denominator: Rate 1: Proportionate Mortality Rate: The total number of deaths among New Mexico Residents. Rate 2: Cause-Specific Death Rate: The total New Mexico population.
Comparison Population	Overall New Mexico population
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Vital statistics • American Community Survey (ACS) • DOH overdose and mortality reports • Centers for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologic Research (WONDER)
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 5: Turquoise Care will provide cost-effective care among members with an SUD.

Research Question 5.1: Did Turquoise Care provide cost-effective care among members with an SUD diagnosis?

Total and PMPM cost (Measure 60)	
Numerator/Denominator	Numerator: Total costs of healthcare. Stratified by the following: • Total costs • IP • OP (ED OP and non-ED OP) • LTC • Professional • Dental • Pharmacy Denominator: Total number of MM among those with an SUD diagnosis
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography

Total and PMPM cost (Measure 60)	
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually/Monthly

Total and PMPM cost of SUD, SUD- IMD, SUD-other, and non-SUD, by setting (including claims data IP, OP, pharmacy, LTC, and capitated payments to MCOs) (Measure 61)	
Numerator/Denominator	Numerator: Total cost of SUD services. Stratified by: • SUD-IMD • SUD-Other • Non-SUD Denominator: Total number of MM among those with an SUD diagnosis
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually/Monthly

Aim Three

Hypothesis 1: Turquoise Care will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.

Research Question 1.1: Has the number of individuals identified and/or engaged in SMI/SED treatment increased?

Percentage of individuals identified with an SMI/SED who have used services related to mental health (Measure 62)	
Numerator/Denominator	Numerator: Number of individuals engaged any SMI/SED treatment Denominator: Number of individuals identified with an SMI/SED
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SMI/SED Monitoring Metrics
Measure Name	Metric #18: Mental Health Services Utilization
Data Source	MMIS

Percentage of individuals identified with an SMI/SED who have used services related to mental health (Measure 62)	
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of members diagnosed with an SMI/SED condition by non-BH providers (Measure 63)	
Numerator/Denominator	Numerator: Number of members diagnosed with SMI/SED conditions by non-BH providers. Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of registered mobile crisis providers (Measure 64)	
Numerator/Denominator	Numerator: Number of registered mobile crisis providers Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • DOH, BHSD reports
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of members with antipsychotic medications that received psychosocial care (Measure 65)	
Numerator/Denominator	Numerator: Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD. Denominator: Children and adolescents ages 1 to 17 years who had a new prescription for an antipsychotic medication
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of members newly prescribed an antipsychotic medication, who received follow-up care (Measure 66)	
Numerator/Denominator	Numerator: Number of members in the denominator who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication Denominator: Number of new antipsychotic prescriptions for Medicaid members ages 18 and older
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SMI/SED Monitoring Metrics
Measure Name	NQF #3313: Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 2: Turquoise Care will maintain an average LOS for IMDs of 30 days.

Research Question 2.1: Has the average LOS for IMDs been maintained at 30 days?

Average LOS in an IMD (Measure 67)	
Numerator/Denominator	Numerator: Average LOS for Turquoise Care individuals with SMI/SED in IMDs Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SMI/SED Monitoring Metrics

Average LOS in an IMD (Measure 67)	
Measure Name	Metric #19a: Average LOS in IMDs
Data Source	MMIS
Desired Direction	Maintained at 30 days
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 3: Turquoise Care will result in increased rates of care coordination for members with SMI/SED.

Research Question 3.1: Has the percentage of members with SMI/SED receiving care coordination increased?

Percentage of members with SMI/SED receiving care coordination (Measure 68)	
Numerator/Denominator	Numerator: Among members identified in the denominator, the number of Turquoise Care members in fully delegated care coordination during the measurement period. Denominator: The number of unique Turquoise Care members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with an SMI/SED diagnosis and an SMI/SED-related treatment service during the measurement period and/or in the 11 months before the measurement period.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members a follow-up visit after an ED visit for mental illness (Measure 69)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for mental illness within seven days of the ED visit. Denominator: Number of ED visits for members diagnosed with an SMI/SED, ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult and Child Core Set
Measure Name	Follow-Up After ED Visit for Mental Illness (FUM)
Data Source	MMIS
Desired Direction	Higher is better

Percentage of members a follow-up visit after an ED visit for mental illness (Measure 69)	
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 70)	
Numerator/Denominator	Numerator: Number of members with a discharge for mental illness and a follow-up visit with a mental health practitioner within seven days after discharge Denominator: Number of members diagnosed with an SMI/SED, ages 6 years or older who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 4: Turquoise Care will decrease utilization and LOS in EDs among Medicaid members who met eligibility criteria of members with SMI/SED.

Research Question 4.1: Has the utilization of hospital services by individuals with SMI/SED decreased?

Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of members with an SMI/SED (Measure 71)	
Numerator/Denominator	Numerator: Number of ED visits of Turquoise Care members with SMI/SED Denominator: Number of MM among Turquoise Care members with SMI/SED, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of members with an SMI/SED who used ED services for mental health during the measurement period (Measure 72)	
Numerator/Denominator	Numerator: Number of Turquoise Care members in the denominator who used ED services for mental health during the measurement period Denominator: Number of Turquoise Care members with SMI/SED
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SMI/SED Monitoring Metric
Measure Name	Metric #16: Mental Health Services Utilization – ED
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Average LOS in an ED among members with an SMI/SED diagnosis prior to admission to an IMD (Measure 73)	
Numerator/Denominator	Numerator: The LOS (in days) for each ED visit. Denominator: The number of ED visits among all Turquoise Care members with an SMI/SED diagnosis during the MY that led to a stay in an IMD. Same day and next day transfers from an ED setting to an IMD will be included in the denominator. For example, an ED visit on January 1 with an IMD admission also on January 1 will have an LOS of one day in the ED. An ED visit spanning from January 1 to January 2 with an IMD admission on January 3 will have a length of stay of two days (January 1 and January 2). Note: It may not be possible to fully identify the ED boarding portion of an IMD stay using exclusively claims/encounter data, particularly within the same facility.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No change or lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of members with an SMI/SED all-cause unplanned readmission within 30 days of psychiatric hospitalization (Measure 74)	
Numerator/Denominator	Numerator: Number of Turquoise Care members in the denominator with an unplanned readmission within 30 days of psychiatric hospitalization Denominator: Number of Turquoise Care members with SMI/SED
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS SMI/SED Monitoring Metrics
Measure Name	Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IP Psychiatric Facility
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 5: Turquoise Care will provide cost-effective care for members with an SMI/SED diagnosis.

Research Question 5.1: Did Turquoise Care provide cost-effective care among members with SMI/SED diagnosis?

Total and PMPM cost (Measure 75)	
Numerator/Denominator	Numerator: Total costs of healthcare. Stratified by the following: • Total costs • IP • OP (ED OP and non-ED OP) • LTC • Professional • Dental • Pharmacy Denominator: Total number of MM among those with an SMI/SED diagnosis
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually/Monthly

Total and PMPM costs of SMI/SED diagnosis by IMD and Other care, by setting (including claims data IP, OP, pharmacy, LTC, and capitated payments to MCOs) (Measure 76)	
Numerator/Denominator	Numerator: Total cost of BH services. Stratified by: • BH-IMD • BH- Other • Non-BH Denominator: Total number of MM among those with an SMI/SED diagnosis
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	ITS
Frequency	Annually/Monthly

Aim Four

Hypothesis 1: Providing post-hospitalization recuperative support and rehabilitation services will improve health outcomes and housing stability to prevent rehospitalization.

Research Question 1.1: Did members eligible for short-term post-hospitalization recuperative services have increased access to recuperative services?

Number of members receiving short-term post-hospitalization recuperative services (Measure 77)	
Numerator/Denominator	Numerator: Number of members receiving short-term post-hospitalization recuperative services, stratified by eligibility type Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually/monthly

Research Question 1.2: Did members eligible for short-term post-hospitalization recuperative services increase utilization of preventive care?

Percentage of adults who accessed preventive/ambulatory health services (Measure 78)	
Numerator/Denominator	Numerator: Number of members with an ambulatory or preventive care visit Denominator: Number of members receiving post-hospitalization recuperative services who are ages 20 years and older, continuously enrolled for the MY, with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Research Question 1.3: Did members utilizing short-term post-hospitalization recuperative services change their utilization of hospital services?

Number of potentially preventable ED visits, per 1,000 MM (Measure 79)	
Numerator/Denominator	Numerator: Discharges, for patients in the denominator and meet numerator criteria for any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission 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 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges These PQIs must meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Denominator: MM among members utilizing short-term hospitalization recuperative services, 18 years old and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified AHRQ

Number of potentially preventable ED visits, per 1,000 MM (Measure 79)	
Measure Name	PQI-90
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Number of all-cause ED visits, per 1,000 MM (Measure 80)	
Numerator/Denominator	Numerator: Number of all-cause ED visits, among members in the denominator Denominator: Number of MM among members utilizing short-term post-hospitalization recuperative services, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Ambulatory Care (AMB)
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Number of IP visits, per 1,000 MM (Measure 81)	
Numerator/Denominator	Numerator: Number of IP visits, among members in the denominator Denominator: Number of MM among members utilizing short-term post-hospitalization recuperative services, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	IP Utilization—General Hospital/Acute Care (IPU)
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Number of unplanned readmissions for any diagnosis within 30 days (Measure 82)	
Numerator/Denominator	Numerator: Number of acute IP stays in the denominator followed by an unplanned acute readmission within 30 days. Denominator: Number of acute IP stays for members receiving post-hospitalization housing recuperative services aged 18 to 64 who were continuously enrolled for 365 days prior to the index discharge date through 30 days after the index discharge date with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Plan All-Cause Readmissions (PCR)
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Hypothesis 2: Short-term post-hospitalization recuperative services will provide cost-effective services.

Research Question 2.1: Did the short-term post-hospitalization recuperative services provide cost-effective care for members?

Total and PMPM cost among members receiving short-term post-hospitalization recuperative services (Measure 83)	
Numerator/Denominator	Numerator: Total costs of care among members receiving short-term post-hospitalization recuperative services Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	N/A
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Research Question 2.2: How did local investments in short-term post-hospitalization recuperative services change over the course of the evaluation?

Key informants' description of changes in short-term post-hospitalization recuperative services outside of Turquoise Care (Measure 84)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A

Key informants' description of changes in short-term post-hospitalization recuperative services outside of Turquoise Care (Measure 84)	
Measure Steward	N/A
Measure Name	N/A
Data Source	Key Informant Interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Hypothesis 3: Expanding providers implementing pre-tenancy and tenancy services will improve housing stability and utilization of health services.

Research Question 3.1: Did the expansion of pre-tenancy and tenancy services increase the number of members receiving hosing supports?

Number of members eligible for and receiving pre-tenancy and tenancy services (Measure 85)	
Numerator/Denominator	Numerator: Two rates are reported: Rate 1: Number of members eligible for pre-tenancy and tenancy services, by service type Rate 2: Number of members receiving pre-tenancy and tenancy services, by service type Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 3.2: Did the expansion of pre-tenancy and tenancy services improve follow-up care among eligible members?

Percentage of members with a follow-up visit after an ED visit for mental illness (Measure 86)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Number of ED visits in the denominator with a follow-up visit for mental illness within seven days of an ED visit for mental illness. Numerator 2: Number of ED visits in the denominator with a follow-up visit for mental illness within 30 days of an ED visit for mental illness Denominator: Number of ED visits for members 18 years of age and older receiving pre-tenancy or tenancy services with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A

Percentage of members with a follow-up visit after an ED visit for mental illness (Measure 86)	
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After ED Visit for Mental Illness (FUM)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 87)	
Numerator/Denominator	Numerator: Two rates are reported: Numerator 1: Number of members in the denominator and a follow-up visit with a mental health practitioner within seven days after discharge Numerator 2: Number of members in the denominator and a follow-up visit with a mental health practitioner within 30 days after discharge Denominator: Number of members ages 6 years or older receiving pre-tenancy or tenancy services who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 3.3: Did the expansion of pre-tenancy and tenancy services improve members' health outcomes?

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 88)	
Numerator/Denominator	Numerator: Number of members participating in the pre-tenancy and tenancy program who had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY Denominator: The number of members participating in the pre-tenancy and tenancy program ages 5–64 years who were identified as having persistent asthma
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 88)	
Measure Steward	NCQA
Measure Name	Asthma Medication Ratio (AMR)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy (Measure 89)	
Numerator/Denominator	Numerator: The percentage of members participating in the pre-tenancy and tenancy program who received statin therapy. Two rates are reported: Numerator 1: Members who were dispensed at least one high-intensity or moderate-intensity statin medication Numerator 2: Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period Denominator: All adult members participating in pre-tenancy and tenancy program (males ages 21–75 years and females ages 40–75 years) who were identified as having clinical atherosclerotic cardiovascular disease
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

All-cause mortality rate (Measure 90)	
Numerator/Denominator	Numerator: Number of deaths from any cause among members participating in the pre-tenancy and tenancy program during the MY Denominator: The total number of members participating in the pre-tenancy and tenancy program during the MY
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A

All-cause mortality rate (Measure 90)	
Data Source	• MMIS • Vital Records
Desired Direction	Lower is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually

Hypothesis 4: Providing nutrition assistance will decrease food insecurity and improve healthcare among vulnerable populations.

Research Question 4.1: Did nutrition assistance increase access to medically tailored meals?

Number of medically tailored meals provided to eligible members (Measure 91)	
Numerator/Denominator	Numerator: Number of medically tailored meals provided to eligible members, stratified by eligibility type Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Research Question 4.2: Did nutrition assistance increase utilization of preventive care?

Percentage of adults who accessed preventive/ambulatory health services (Measure 92)	
Numerator/Denominator	Numerator: Number of members in each denominator group with an ambulatory or preventive care visit Denominator: Treatment Group: Number of members receiving nutrition assistance who are ages 20 years and older, continuously enrolled for the MY, with no more than one gap in enrollment of up to 45 days Comparison Group 1: Number of members eligible for, but not receiving nutrition assistance who are ages 20 years and older, continuously enrolled for the MY, with no more than one gap in enrollment of up to 45 days Comparison Group 2: Number of members participating in MHV eligible for, but not receiving nutrition assistance who are ages 20 years and older, continuously enrolled for the MY, with no more than one gap in enrollment of up to 45 days
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography

Percentage of adults who accessed preventive/ambulatory health services (Measure 92)	
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually

Percentage of members who accessed timely prenatal care (Measure 93)	
Numerator/Denominator	Numerator: Number of deliveries in the denominator that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization Denominator: Treatment Group: Number of members receiving nutrition assistance who are continuously enrolled from at least 219 days prior to delivery through 60 days after delivery Comparison Group 1: Number of members eligible for, but not receiving nutrition assistance who are continuously enrolled from at least 219 days prior to delivery through 60 days after delivery Comparison Group 2: Number of members participating in MHV eligible for, but not receiving nutrition assistance who are continuously enrolled from at least 219 days prior to delivery through 60 days after delivery
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult and Child Core Set
Measure Name	Prenatal and Postpartum Care (PPC2-CH PPC2-AD)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually/monthly

Research Question 4.3: Did nutrition assistance impact hospital utilization?

Number of potentially preventable ED visits, per 1,000 MM (Measure 94)	
Numerator/Denominator	Numerator: Discharges, for members in each denominator group and meet numerator criteria for any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission 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 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges These PQIs must meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Denominator: Treatment group: MM among members receiving nutrition assistance services, 18 years old and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000. Comparison group 1: MM among members eligible for but not receiving nutrition assistance services, 18 years old and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000. Comparison group 2: MM among members in the MHV program, eligible for but not receiving nutrition assistance services, 18 years old and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000.
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified AHRQ
Measure Name	PQI-90
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Research Question 4.4: Did nutrition assistance improve health outcomes for mothers and newborns?

Percentage of births with low birth weight (Measure 95)	
Numerator/Denominator	Numerator: The number of resident live births in each denominator group weighing less than 2,500 grams (low birth weight). Denominator: Treatment group: The number of live births among members receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date. Comparison group 1: The number of live births among members eligible, but not receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date. Comparison group 2: The number of live births among members participating in MHV that are eligible, but not receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date.
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Low-Birth Weight (LBW)
Data Source	• MMIS • Vital statistics
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Percentage of births with high birth weight (Measure 96)	
Numerator/Denominator	Numerator: The number of resident live births in each denominator group weighing more than 4,000 grams (high birth weight). Denominator: Treatment group: The number of live births among members receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date. Comparison group 1: The number of live births among members eligible, but not receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date. Comparison group 2: The number of live births among members participating in MHV that are eligible, but not receiving nutrition assistance in the reporting period and had a delivery on or after their first program enrollment date.
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A

Percentage of births with high birth weight (Measure 96)	
Data Source	• MMIS • Vital statistics
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Percentage of births with cesarean delivery (Measure 97)	
Numerator/Denominator	Numerator: Denominator: Treatment group: The number of single fetus first births completed in the 37th or greater week of pregnancy in a headfirst position among members receiving nutrition assistance in the reporting period. Comparison group 1: The number of single fetus first births completed in the 37th or greater week of pregnancy in a headfirst position among members eligible, but not receiving nutrition assistance in the reporting period. Comparison group 2: The number of single fetus first births completed in the 37th or greater week of pregnancy in a headfirst position among members participating in MHV that are eligible, but not receiving nutrition assistance in the reporting period.
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Low-Risk Cesarean Delivery (LRCD-CH)
Data Source	• MMIS • Vital statistics
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Percentage of preterm births (Measure 98)	
Numerator/Denominator	Numerator: The number of resident live births in the among members in each denominator group, born prematurely Denominator: Treatment group: The number of live births among members in the reporting period who are receiving nutrition assistance and had a delivery on or after their first program enrollment date. Comparison group 1: The number of live births among members in the reporting period who are eligible, but not receiving nutrition assistance and had a delivery on or after their first program enrollment date. Comparison group 2: The number of live births among members in the reporting period who are participating in MHV but are not receiving nutrition assistance and had a delivery on or after their first program enrollment date.
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Vital statistics
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Percentage of women with gestational diabetes developing type 2 diabetes (Measure 99)	
Numerator/Denominator	Numerator: Number of deliveries among members in each denominator group ages 18–75 during the measurement period with a diagnosis of type 2 diabetes between 12 weeks and one year following delivery. Denominator: Treatment group: Number of deliveries during the measurement period among members receiving nutrition assistance with a diagnosis of gestational diabetes within 40 weeks of delivery. Comparison group 1: Number of deliveries during the measurement period among members eligible for, but not receiving nutrition assistance with a diagnosis of gestational diabetes within 40 weeks of delivery. Comparison group 2: Number of deliveries during the measurement period among members who are participating in MHV, but not receiving nutrition assistance with a diagnosis of gestational diabetes within 40 weeks of delivery
Comparison Population	• Propensity score adjusted members who are eligible, but not receiving nutrition assistance • Propensity score adjusted members who are participating in MHV, but not receiving nutrition assistance
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography

Percentage of women with gestational diabetes developing type 2 diabetes (Measure 99)	
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Hypothesis 5: Nutrition assistance will provide cost-effective services.

Research Question 5.1: Did the nutrition assistance program provide cost-effective care for members?

Total and PMPM cost among members receiving nutrition assistance (Measure 100)	
Numerator/Denominator	Numerator: Total costs of care among members receiving nutrition assistance Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	N/A
Analytic Approach	Descriptive time series
Frequency	Annually/Monthly

Research Question 5.2: How did local investments in nutrition assistance change over the course of the evaluation?

Key informants' description of changes in nutrition assistance outside of Turquoise Care (Measure 101)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key Informant Interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Hypothesis 6: Expanding member access to Medicaid Home Visitation (MHV) will improve perinatal and infant health.

Research Question 6.1: Do home visiting services improve health outcomes among perinatal individuals and infants?

Number of members receiving home visiting services (Measure 102)	
Numerator/Denominator	Numerator: Number of members participating in the MHV program, by service type Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of pregnant or postpartum members diagnosed with a mental health disorder (Measure 103)	
Numerator/Denominator	Numerator: Number of members in the denominator for each group diagnosed with a mental health disorder. Denominator: Treatment group: Number of pregnant or postpartum members participating in the MHV program 18 years old and older who are continuously enrolled with a gap in enrollment no greater than 45 days. Comparison group: Number of pregnant or postpartum members who have never participated in the MHV program services 18 years old and older who are continuously enrolled with a gap in enrollment no greater than 45 days.
Comparison Population	Propensity score adjusted members eligible for, but not participating in MHV
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	NCQA
Measure Name	Diagnosed Mental Health (DMH)
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a postpartum visit between 7 and 84 days after delivery (Measure 104)	
Numerator/Denominator	Numerator: The number of deliveries in the denominator that had a postpartum visit on or between seven and 84 days after delivery. Denominator: Treatment group: The number of live births among Turquoise Care members between October 8 of the year prior to the reporting year and October 7 of the reporting year who are MHV program participants and had a delivery on or after their first program enrollment date. Comparison group: The number of live births among Turquoise Care members between October 8 of the year prior to the reporting year and October 7 of the reporting year who have never participated in the MHV program.
Comparison Population	Propensity score adjusted members eligible for, but not participating in MHV
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Adult Core Set
Measure Name	Prenatal and Postpartum Care (PPC)
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members who had a well-child visit in the first 30 months of life (15 months) (Measure 105)	
Numerator/Denominator	Numerator: Number of members with six or more well-child visits on different dates of service on or before the 15-month birthday Denominator: Treatment group: Number of members who turn 15 months old during the MY and are continuously enrolled between 31 days and 15 months old with no more than one gap in enrollment of up to 45 days associated with the MHV program. Comparison group: Number of members who turn 15 months old during the MY and are continuously enrolled between 31 days and 15 months old with no more than one gap in enrollment of up to 45 days who are not associated with the MHV program.
Comparison Population	Propensity score adjusted members eligible for, but not participating in MHV
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	CMS Child Core Set
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/monthly

Percentage of children 2 years of age with appropriate immunization status (Measure 106)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: four DTaP; three IPV; one MMR; three HiB; three HepB, one VZV; four PCV; one HepA; two or three RV; and two flu vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. Denominator: Treatment group: Number of children who turn two years old during the MY who were continuously enrolled 12 months prior to the child's second birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday, among members associated with the MHV program. Comparison group: Number of children who turn two years old during the MY who were continuously enrolled 12 months prior to the child's second birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday, among members who are not associated with the MHV program.
Comparison Population	Propensity score adjusted members eligible for, but not participating in MHV
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS Child Core Set
Measure Name	Childhood Immunization Status (CIS)
Data Source	MMIS
Desired Direction	Lower is better
Analytic Approach	• DiD • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 7: The reentry initiative will improve access to preventive services.

Research Question 7.1: What are barriers or facilitators to implementing the reentry program?

Stakeholders' reported barriers and facilitators of success to implementing the reentry program (Measure 107)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Stakeholders' experience with cross-system communication and coordination (Measure 108)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Stakeholders' experience with connections between correctional and community services (Measure 109)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Stakeholders' experiences providing pre-release services with potentially short duration (e.g., among individuals incarcerated for less than 30 days) (Measure 110)	
Numerator/Denominator	Numerator: N/A Denominator: N/A Questions to stakeholders center around the coverage timeline of pre-release services (90 days). Stakeholders will be asked to describe any differences in reentry planning, care coordination, and health outcomes among members who were incarcerated for shorter durations compared to those incarcerated for longer durations, and/or among members who received more than 30 days of pre-release services compared to members who received fewer than 30 days of pre-release services.
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Research Question 7.2: Does engagement in the reentry program increase members' access to preventive health services?

Number of members receiving pre-release services (Measure 111)	
Numerator/Denominator	Numerator: Number of members receiving pre-release services Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis
Frequency	Annually/Monthly

Number and types of pre-release services provided to members (Measure 112)	
Numerator/Denominator	Numerator: Number of pre-release services provided to members Denominator: N/A
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis
Frequency	Annually/Monthly

Number of eligible members accessing care coordination services prior to release from jail or prison (Measure 113)	
Numerator/Denominator	Numerator: Number of members who accessed care coordination services while incarcerated Denominator: Number of members enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A

Number of eligible members accessing care coordination services prior to release from jail or prison (Measure 113)	
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis
Frequency	Annually/Monthly

Percentage of adults who accessed preventive/ambulatory health services in the 12 months following release (Measure 114)	
Numerator/Denominator	Numerator: Number of members enrolled in the reentry program with an ambulatory or preventive care visit Denominator: The number of Turquoise Care members enrolled in the reentry program, ages 20 years and older and were continuously enrolled with no more than one gap of up to 45 days during the MY
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of children and adolescents who had a well-care visit in the 12 months following release (Measure 115)	
Numerator/Denominator	Numerator: Members among the denominator with one or more well-care visits during the MY Denominator: Number of members enrolled in the reentry program, ages 3–21 years who are continuously enrolled during the MY with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better

Percentage of children and adolescents who had a well-care visit in the 12 months following release (Measure 115)	
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 7.3: Does engagement in the reentry program increase members' access to BH treatment?

Percent of individuals identified with an SMI/SED who have used services related to mental health 12 months following release (Measure 116)	
Numerator/Denominator	Numerator: Number of members engaged any SMI/SED treatment Denominator: Number of members identified with an SMI/SED who are enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS SMI/SED Monitoring Metrics
Measure Name	Metric #18: Mental Health Utilization
Data Source	• MMIS • Program participation data
Desired Direction	No desired direction
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members who remained on antidepressant medication treatment in the 12 months following release (Measure 117)	
Numerator/Denominator	Numerator: Number of members in the denominator who remained on an antidepressant medication treatment. Two rates are reported: Members who remained on antidepressant medication treatment for at least 84 days Members who remained on antidepressant medication treatment for at least 180 days Denominator: Number of members ages 18 years and older who were treated with antidepressant medication and had a diagnosis of major depression who were continuously enrolled from 105 days prior to the IPSD through 231 days after the IPSD with no more than one gap in enrollment of up to 45 days during the continuous enrollment period
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)

Percentage of members who remained on antidepressant medication treatment in the 12 months following release (Measure 117)	
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 7.4: Does engagement in the reentry program increase members' access to SUD providers and treatment?

Percentage of members who have a claim for MAT or medication for opioid use disorder (MOUD) for SUD in the 12 months following release (Measure 118)	
Numerator/Denominator	Numerator: Number of members in each denominator group who have a claim for MAT or MOUD for SUD during the measurement period Denominator: Treatment group: Number of members enrolled in the reentry program, with a diagnosis of SUD who received a 30-day MOUD upon release Comparison group: Number of members enrolled in the reentry program, with a diagnosis of SUD who did not receive a 30-day MOUD upon release
Comparison Population	Members in the reentry program diagnosed with an SUD without a 30-day MOUD prior to release
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified CMS Monitoring Metric #12
Measure Name	Medication Assisted Treatment (MAT)
Data Source	• MMIS • Program participation data
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of MOUD providers (Measure 119)	
Numerator/Denominator	Numerator: Number of MOUD providers Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of OP pharmacy providers (Measure 120)	
Numerator/Denominator	Numerator: Number of OP pharmacy providers Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 7.5: Does engagement in the reentry program impact hospital utilization?

Number of potentially preventable ED visits in the 12 months following release, per 1,000 MM (Measure 121)	
Numerator/Denominator	Numerator: Discharges, for patients in the denominator and meet numerator criteria for any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 COPD or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission 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 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges These PQIs must meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Denominator: MM among members in the reentry program, ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. The number of MM, divided by 1,000.
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified AHRQ
Measure Name	PQI-90
Data Source	• MMIS • Program participation data
Desired Direction	Lower is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of all-cause ED visits in the 12 months following release, per 1,000 MM (Measure 122)	
Numerator/Denominator	Numerator: Number of all-cause ED visits among members enrolled in the reentry program Denominator: Number of MM among those enrolled in the reentry program, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified NCQA
Measure Name	Ambulatory Care (AMB)
Data Source	• MMIS • Program participation data
Desired Direction	No desired direction
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of IP visits in the 12 months following release, per 1,000 MM (Measure 123)	
Numerator/Denominator	Numerator: Number of IP visits among members enrolled in the reentry program Denominator: Number of MM among those enrolled in the reentry program, divided by 1,000
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	Modified NCQA
Measure Name	IP Utilization—General Hospital/Acute Care (IPU)
Data Source	• MMIS • Program participation data
Desired Direction	No desired direction
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 7.6: Do members participating in the reentry program have reduced rates of mortality, overdose, and suicide?

All-cause mortality in the 12 months following release (Measure 124)	
Numerator/Denominator	Numerator: Number of all-cause deaths among denominator population Denominator: Number of members enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports
Desired Direction	Lower is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Rate of deaths due to overdose in the 12 months following release (Measure 125)	
Numerator/Denominator	Numerator: Number of all-cause deaths among the denominator population Denominator: Number of members enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports
Desired Direction	Lower is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Rate of suicide in the 12 months following release (Measure 126)	
Numerator/Denominator	Numerator: Number of suicide deaths among the denominator population Denominator: Number of members enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• MMIS • Program participation data • Vital statistics • DOH, overdose and mortality reports
Desired Direction	Lower is better
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 8: The reentry program will provide cost-effective care for members.

Research Question 8.1: Did the reentry program provide cost-effective care for members?

Total and PMPM cost (among members in the reentry program) (Measure 127)	
Numerator/Denominator	Numerator: Total cost of care among denominator members Denominator: Number of MM among members enrolled in the reentry program
Comparison Population	N/A
Stratification	Race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography
Measure Steward	N/A
Measure Name	N/A
Data Source	• Program participation data • MMIS
Desired Direction	No desired direction
Analytic Approach	• Descriptive time series • Subgroup analysis • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 9: Eligible members will access services covered under the traditional health care practices (THCP) initiative.

Research Question 9.1: What are barriers or facilitators of the THCP initiative?

Stakeholders' reported barriers and successes of the THCP initiative (Measure 128)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key Informant Interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Stakeholders' reported accessibility and quality of care provided through the THCP initiative (Measure 129)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key Informant Interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report and Summative Evaluation Report)

Research Question 9.2: Did members access services covered under the THCP initiative?

Number of providers enrolled in or offering Medicaid reimbursable THCP services (Measure 130)	
Numerator/Denominator	Numerator: Number of providers enrolled in or offering THCP Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually

Number of members receiving Medicaid reimbursable THCP services (Measure 131)	
Numerator/Denominator	Numerator: Number of members receiving services from a provider enrolled in or offering THCP Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually

Number and type of Medicaid reimbursable THCP services provided to eligible members (Measure 132)	
Numerator/Denominator	Numerator: Number and types of Medicaid reimbursable THCP services provided to eligible members Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Frequency	Annually

Hypothesis 10: The THCP initiative will provide cost-effective services.

Research Question 10.1: Did the THCP initiative provide cost-effective care for members?

Total and PMPM cost among members accessing services covered under the THCP initiative (Measure 133)	
Numerator/Denominator	Numerator: Total cost of care among members eligible for and receiving Medicaid reimbursable services from the THCP initiative Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	MMIS
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Frequency	Annually

ATTACHMENT F
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid members for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

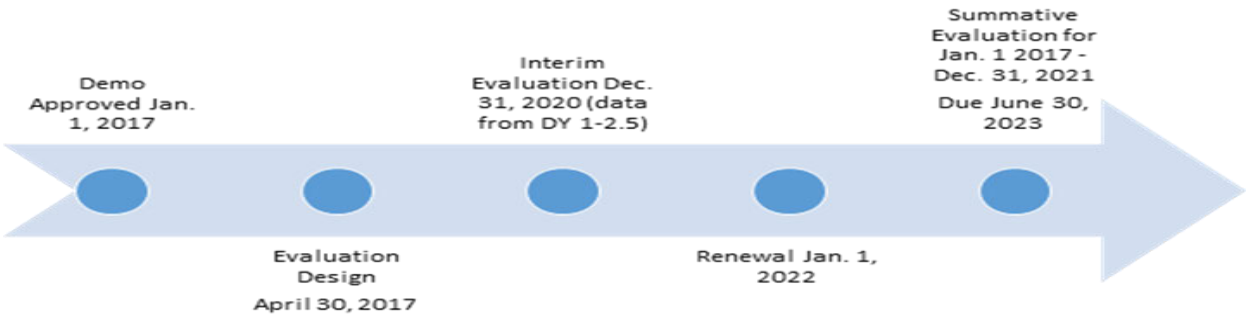
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports
The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve member health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the

objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.
    - **A. Methodological Limitations** - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.
    - **B. Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

    - **C. Conclusions** – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Attachment G
Monitoring Protocol (Reserved)

Attachment H
SUD Implementation Plan Protocol
Approved: May 21, 2019

Introduction

The prevalence of Substance Use Disorders (SUDs) in the United States occurs in 5-6 percent of the population (Ritchie, H. & Roser M, (2018), Substance Use, *Institute of Health Metrics and Evaluation*), with alcohol substantially outweighing other substances. In New Mexico, the statistics exceed those of the nation:

- Alcohol related injury deaths are 1.6 times the national average;
- In the reporting period 2012-2016, drug overdoses surpassed alcohol related motor vehicle traffic crashes;
- Unintentional drug overdoses account for almost 86% of drug overdose deaths with the most common drugs accounting for deaths in descending order being prescription opioids, benzodiazepines, cocaine, and methamphetamines;
- New Mexico records 1.9 times the national average for deaths from suicide;
- The negative consequences of excessive alcohol use in New Mexico are not limited to death but also include domestic violence, crime, poverty, and unemployment as well as chronic liver disease, motor vehicle crash and other injuries, mental illness, and a variety of other medical problems.

New Mexico has made significant advances in recent years in our services to both combat and treat OUD and SUD. We halted the increasing overdose trend from the highest rate among states to 13th. We must consider, however, that the upward trends of other states also impact this. However, New Mexico continues to be the top state in alcohol-related deaths and 3rd in suicides. We still have much work to do. The following link represents NM OUD/SUD statistics: https://www.nmpharmacy.org/resources/2018%2006%2023%20-%20NMPhA%20Law%20Update.pdf.

Research reported by Ritchie and Roser suggests that "the transition from intermittent or regular use toward addiction and relapse are most strongly influenced by a mixture of stress response, environmental factors, genetic predisposition to addiction and importantly the drug-induced effects which often create a cycle of addiction and relapse." The Ritchie/Rose article also relates mental health as a risk factor for SUD postulating that a person with a mental health condition is 1.1 to 6.3 times more likely to develop a SUD. ADHD, bipolar disorder, intermittent explosive disorder, and PTSD are among the top diagnoses signaling risk.

For these reasons New Mexico's continuum of SUD services and its implementation plan also includes:

- Treatment of co-occurring mental health conditions with a primary diagnosis of SUD;
- A focus on the integration of SUD screening in physical health provider locations;
- The introduction of behavioral health counselors in primary care agencies, and primary care practitioners in behavioral health agencies; and
- Interdisciplinary teaming with the Medicaid beneficiary and his/her natural supports to treat not only the person with the SUD, but also the family or natural support system.

New Mexico's 1115 demonstration application supports and focuses its SUD evaluation on the six goals developed by CMS:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUD;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

This implementation plan will describe services currently in place, and put forward our plans to implement new services, i.e. our gaps in service options. It is based upon American Society of Addiction Medicine (ASAM) levels of care for the continuum of care, and is organized by CMS's SUD milestones:

1. Access to critical levels of care for OUD and other SUDs
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Milestone 1: Access to critical levels of care for OUD and other SUDs

0.5 – Early Intervention: Screening & prevention

Current State:

Screening, Brief Intervention, and Referral for Treatment*:* New Mexico is in the final year of a SAMHSA grant to promulgate Screening, Brief Intervention and Referral for Treatment (SBIRT) for adults. NM SBIRT services are intended to identify individuals with risky alcohol and drug behavior and provide a brief intervention or a referral to treatment, if necessary. NM SBIRT has provided services to emergency rooms, health clinics, and primary care offices in targeted areas, and in an Indian Health clinic.

Both the NM Managed Care organizations and the CareLink New Mexico Health Homes (CLNM) promote prevention through their disease management programs to manage chronic illnesses and prevent risk factors such as SUD.

NM State Plan does not support all screening and prevention activities in the categorically needy:

Screening & prevention	3.1-A	Pg 5

Future State Implementation Plan:

Strategic importance: Early detection of SUD and concomitant behavioral health conditions in a physical health environment at which an individual is more likely to visit has not been a focus. Moving this service and a behavioral health practitioner into an environment that is more natural for an individual can offset what may be an escalating behavioral health condition.

1) Expand SBIRT to include adolescents.
2) Include SBIRT in other physical health settings beyond the targeted areas identified in the discretionary grant. This will include eligible providers and practitioners.
   A) Providers:
      - Primary care offices including FQHCs, IHS and 638 tribal facilities;
      - Patient centered medical homes;
      - Urgent care centers;
      - Hospital outpatient facilities;
      - Emergency departments;
      - Rural health clinics;
      - Specialty physical health clinics; and
      - School based health centers.

   B) Practitioners, who must be trained in SBIRT, may include:
      - Licensed nurse;
      - Licensed certified nurse practitioner or licensed clinical nurse specialist;
      - Behavioral health practitioner;
      - Certified peer support worker;
      - Certified family peer support worker;
      - Certified community health worker;
      - Licensed physician assistant;
      - Physician;
      - Medical assistant; and
      - Community health representative in tribal clinics.
3) Staff training and/or certification requirements for SBIRT approved practitioners:
   A) General requirements (can be in person or webinar based):
      - Attest to all agency/clinic mandatory trainings and clearances;
      - Evidence of current professional licensure;
      - Peer and family Peer Support Workers - evidence of current CPSW/CFPSW certification or enrollment in classes to receive certification; and
      - Evidence of annual HIPAA training.
      - Harm Reduction 101;
      - SBIRT 101 including a warm handoff process;
      - Training in the scoring of the screening tools utilized;
      - 42 CFR part 2; and
      - Naloxone/Overdose prevention.

   B) Specific training for the clinician delivering the BI (all required):
      - Motivational Interviewing (by a MINT trainer);
      - QPR (Suicide Prevention);

- Community Reinforcement Approach (CRA); and
- Reviews of Audit-10; GAD-7; PCL-C; PHQ-9 and DAST-10

C) Suggested for Behavioral Health Counselors/Therapists

- Seeking Safety
- IMPACT

Subject to Approval of 1115 Demonstration and State Plan Amendment Summary of Actions Needed – Early Intervention

Action	Timeline	Responsible entity
Submit to CMS the SUD State Plan Amendment including screening, prevention, and SBIRT services	3/1/19 – 3/31/19	MAD
Solicitation of interested providers for SBIRT	1/01/19 – 3/31/19 (ongoing)	BHSD
Provider Staff Training and University clinical student training for SBIRT	1/01/19 – 12/31/20 by groups	BHSD, LifeLink, UNM
Implementation of SBIRT in provider agencies	4/01/19 – 12/31/20 by groups	BHSD, UNM, LifeLink
Complete BH rule promulgation	1/01/19 – 12/31/19	Program Policy Bureau
Add SUD to beneficiary eligibility criteria for CLNM health homes through SPA and rule - which includes all OUD/ SUD screening	6/31/19 – 12/31/19	Medicaid BH Manager & BHSD HH Program Manager
Update and Publish CLNM policy Manual	7/01/19 – 12/31/19	HH Program Manager
Continue the statewide education of naloxone use and availability of the kits	1/01/19 – 12/31/20	HCA

1.0 – Outpatient Services: Less than 9 hours of services/week for adults, and less than 6 hours of services/week for youth.

Current State:
Outpatient Treatment: Medicaid enrolled providers currently deliver outpatient services to New Mexicans throughout each region of the State. Outpatient programs include individual, group and family counseling and provide services specific to elders, adolescents, youth, men and women both within managed care and fee-for-service which is primarily our Native American population. Tele-medicine is also available for many services to accommodate frontier regions with few resident practitioners.

Specialized OP services targeting SUD are available in some areas and are inclusive ~~comprised~~ of:

- Comprehensive Community Support Services to promote recovery, rehabilitation and resiliency for SUD, SED and SMI – all ages. This culturally sensitive service coordinates

and provides services and resources to an eligible recipient and his or her family necessary to promote recovery, rehabilitation and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the eligible recipient's community, as well as strengths that may aid the eligible recipient and family in the recovery or resiliency process

- Crisis intervention services for BH crises – all ages, beneficiaries
- Family Support Services to enhance the family's strengths, capacities and resources to promote recovery and resiliency, and the behavioral health goals of the beneficiary – all ages
- Medication assisted treatment (MAT) for opioid use disorders – any age with OUD: MAD pays for coverage for medication assisted treatment (MAT) for opioid use disorder to an eligible recipient as defined in the Drug Addiction Treatment Act of 2000 (DATA 2000) and subsequent Comprehensive Addiction and Recovery Act (CARA) 114-198. Services include 1) an assessment and diagnosis by the prescribing practitioner as to whether the recipient has an opioid abuse diagnosis and their readiness for change; 2) an assessment for concurrent medical or behavioral health illnesses; 3) an assessment for co-occurring substance abuse disorders; 4) educating the recipient as to differing treatment options prior to starting treatment; 5) a service plan that prescribes either in house counseling or therapy, or referral to outside services; and 6) skills building and recovery and resiliency support. Multi-systemic therapy for SED, SUD, justice involved, and at risk for out of home placement – 10 to 18 years of age
- Opioid Treatment Program in methadone clinics for withdrawal treatment - adults
- Recovery Services with peer-to-peer support to develop and enhance wellness and health care practices for chronic SUD, SMI and SED – all ages
- Legislation is in place to facilitate the use of telehealth to expand access to clinical services and telehealth is a reimbursable service through NM Medicaid.

<u>Recent initiatives currently in place:</u>

- Expanded access to counseling and therapy beyond normal business hours to include evening and weekend hours through rate differential.
- Expanded access to recovery services, peer and family support services through additional training and reimbursable codes.
- Updated NMAC regulation to cover peer support workers for individual and group skill building work, particularly for SUD beneficiaries.
- Added community-based crisis stabilization centers for less than 24 hours of triage, de-escalation, and stabilization services with trained behavioral health and physical health practitioners. This is available for ages 14 and over. It serves as an alternative to emergency department use, or incarceration, and will target overdose and threatened suicidal events.
- Added family peer support workers to the workforce to emphasize not only "person centered" service, but "family-centered" service, as recovery and resiliency rests on not only individual efficacy, but on a strong and educated support system.
- Increased rate for mobile crisis teams to incentivize more teams; particularly in frontier areas where there is limited access to services.

Opiate Treatment Program (OTP): Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use.

New Mexico has a system for development of OTPs and process for expanding throughout the state. The OTPs offer medication assisted treatment using methadone or buprenorphine and counseling. They are regulated and approved through the state opioid treatment authority (SOTA). Appendix M, Attachment A outlines the process for adding new OTPs.

NM State Plan supports OP and OTP services:

Crisis services	State Supplement A to attachment 3.1A	Page 21
Medication Assisted Treatment	State Supplement A to attachment 3.1A	Page 21d
CCSS	State Supplement A to attachment 3.1A	Page 21b
MST	State Supplement A to attachment 3.1A	Page 21c
OP hospital	State Supplement A to attachment 3.1A	Pages 1,2
FQHC, CMHC	State Supplement A to attachment 3.1A	Pages 5b, 5c
Behavioral Health	State Supplement A to attachment 3.1A	Pages 9 – 10a
EPSDT	State Supplement A to attachment 3.1A	Pages 5a – 5g

Implementation Plan for Future State of 1.0 Outpatient Medicaid covered services:

1) Include the ability to expand treatment services for OTPs. Previously, our methadone clinics did not provide many outpatient services except for the mandated one hour of counseling per month, and the initial physical exam and prescribing and administering methadone. We are now adding other forms of MAT, additional counseling and therapy, intensive outpatient services, recovery support services, and comprehensive community support services. This will facilitate a recipient receiving services in one location, particularly the one within which they are most comfortable. Additional medical treatments may also be added to serve the individuals in an integrated care model.

2) Add Behavioral Health Agencies to the provider types that can deliver Comprehensive Community Support Services (CCSS) to expand this highly needed service for SUD beneficiaries in more areas of the state. CCSS builds the skills necessary for an individual to live more successfully in the community, offers recovery and resiliency support, and links the recipient with other services to meet their needs such as housing, nutrition and employment supports. Most of the work is accomplished in the community rather than in a clinic with the certified peer support worker often accompanying the recipient until the recipient becomes more self-sufficient. Because the providers are most often peer support workers under supervision, they have demonstrated maximum effectiveness.

3) Add SUD as admission criteria for CCSS; it was previously restricted to those with a serious mental illness (adults) or severe emotional disturbance for children/adolescents. This service is focused on surrounding individuals/families with the services and resources necessary to promote recovery, rehabilitation and resiliency. Community support activities address goals specifically in the following functional domains: independent living, learning, working, socializing and recreation.

4) Further the "Treat First Clinical Model" which allows treatment of presenting conditions without requiring a full comprehensive assessment or diagnostic evaluation before attending to the reason for which the recipient presented. A provisional diagnosis is utilized for billing purposes. It also allows for immediate referral to CCSS services often rendered by a peer. This has already been shown to decrease the "no show" rate, particularly in the SUD and homeless population. Providers already certified in Treat First, have also significantly increased their open access hours to immediately capture individuals when their need presents without being placed on a "wait list" for an appointment.

5) Add coverage for interdisciplinary teaming to incentivize the collaboration of physical health, mental health, and social determinants of health, as many of the NM population with substance use disorders also have significant mental health and physical health disorders and navigating all concerns is difficult for these beneficiaries. Interdisciplinary teaming requires the recipient be present with the differing practitioner disciplines at significant times in their rehabilitative journey.

6) Expand training in best practices for substance use detoxification by UNM/CBHTR

7) Ambulatory withdrawal management: via administrative code add as a service in crisis stabilization centers

8) Add crisis intervention services that are community-based crisis intervention services which are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode or to prevent inpatient psychiatric hospitalization or medical detoxification. Services include four types of crisis services: telephone crisis services; face-to-face crisis intervention in a clinic setting; mobile crisis services; and outpatient crisis stabilization services. Crisis stabilization services are outpatient services for up to 24-hour stabilization of crisis conditions which may, but do not necessarily, include ASAM level two withdrawal management, and can also serve as an alternative to the emergency department or police department. Eligible population is 14 years and older or adult only.

9) BHSD has disseminated the HHS guidance for prescribing MAT via telehealth to all opioid treatment programs which is attached. This guidance is included in the NM Medicaid Behavioral Health Policy Manual.

All STR and SOR funded trainings related to Medication Assisted Treatment include specific information and guidance to attendees about the use of telehealth when setting up buprenorphine initiatives. This new guidance provides a hands-on mentorship experience for providers in rural areas who are considering applying their own DEA waiver to prescribe buprenorphine and is consistent with New Mexico's goal of increasing capacity for Medication Assisted Treatment throughout the state.

Summary of Actions Needed – LOC 1.0

Action	Timeline	Responsible entity

Schedule further trainings such as MAT, DATA waiver 2000, to expand access to buprenorphine.	Ongoing	HCA, UNM
Alert Behavioral Health providers to the additional benefits effective 1/01/19: additional counseling in an OTP, MAT through telehealth, crisis stabilization, additional access after-hours and weekends, reimbursable interdisciplinary teaming with the recipient; peer support; family peer support the use of non-independent practitioners in more agency types; and CADCs which are now reimbursable.	1/01/19 – 6/31/19	HCA, CYFD, Primary Care Assoc., NM Hospital Assoc., NM BH Provider Association
Complete promulgation of BH rule which adds the above listed benefits	1/01/19 – 12/31/19	MAD
Complete the publication of the BH Billing and Policy manual which clarifies many benefits intended to encourage provider participation: the reimbursement of masters level behavioral health interns, the addition of agency types that can utilize non-independent licensed practitioners and peer support workers, i.e. opioid treatment programs, behavioral health agencies, political subdivision of the state such as court systems, counties, cities once they are enrolled in Medicaid, and crisis stabilization and triage centers.	1/01/19 – 3/31/19	MAD
Expand the learning communities for the treat first model, and the Treat First University to continue exploring new initiatives to expand access to BH services;	On-going	BHSD
Explore collaborative opportunities with County organizations for crisis services.	4/01/19 – 12/31/22	HCA, NM Assoc. of Counties
Work with opioid treatment programs to expand services with additional counseling, peer support, and buprenorphine in addition to methadone.	4/01/19 – 12/31/19	BHSD

Process and add 2 new OTPs that have applied and are pending	1/01/19 – 6/31/19	BHSD
Process and add 4 new OTPs that are in process	7/01/19 – 12/31/19	BHSD
Process and add new OTPs as they apply	Ongoing	BHSD
Conduct an analysis for results on CY 1 activities related to availability of providers for OP services in all regions of the state, including MAT, tele-medicine, and after-hours access	10/01/19 – 12/31/19	HCA

2.1– Intensive Outpatient Services: Adult: 9 or more hours of services/week; youth: 6 or more hours of services per week to treat multi-dimensional instability

Current State:
Certified Medicaid enrolled providers offer intensive outpatient (IOP) services for SUD to New Mexicans throughout each region of the State. IOP programs offer treatment activities weekly based on individual needs and the evidence-based practice that the providers use. These activities consist of a combination of psycho-educational groups, individual, group, and/or family therapy sessions.

NM State Plan supports intensive outpatient services:

Behavioral Health	State Supplement A to attachment 3.1A	Pages 9 – 10a

Future State Implementation:

Strategic importance: IOP, through the weekly hours of engagement, offers the support for both recovery and developing the resiliency necessary to change the habits that have adversely affected an individual's life. Both through education based on the reasons why, and the effects on the brain, body and behaviors, and the support of group activities with individuals with similar struggles, positive changes are more likely to occur. In offering evidence-based models and groups specific to the range of ages of enrollees, success is more likely.

Expand this level of service to Opioid Treatment Programs. This will enhance the continuity of care and provide more access to this service in an environment in which the individuals are comfortable.

Continue to add more evidence-based models for specific ages or distinct groups, for example drug court individuals through moral reconation therapy to decrease recidivism.

There is no waiver request.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete the promulgation of the BH rule	1/01/19 -12/31/19	MAD
Support the OTPs in the application and training process for adding IOP as a service.	4/01/19 – 12/31/19	BHSD
Complete the publication of the BH Billing and Policy manual which clarifies many benefits intended to encourage provider participation: the reimbursement of licensed substance abuse associates for some services; the use of interns, the addition of agency types that can utilize non-independent licensed practitioners and peer support workers, i.e. for 2.1 level of care such as behavioral health agencies, political subdivision of the state such as court systems, counties, and cities once they are enrolled in Medicaid.	1/01/19 – 3/31/19	HCA
Continue to investigate and add more EBPs to the approved list of proven models for recovery	1/01/19 - ongoing	HCA
Conduct an analysis of available programs for all applicable age levels across the state.	10/01/19 – 12/31/19	HCA & CYFD

2.5 - Partial Hospitalization: 20 hours or more per week of clinically intensive programming with direct access to psychiatric, medical and lab services.

Current State:
Partial hospitalization is a covered service for youth as part of EPSTD in a psychiatric hospital.

NM State Plan supports partial hospitalization services:

OP hospital	State Supplement A to attachment 3.1A	Pages 1,2
EPSDT services	State Supplement A to attachment 3.1A	Page 5a

Future State Implementation:
No waiver request; through SPA and administrative code

Strategic importance: This service is particularly important because it is designed to stabilize deteriorating conditions in a supportive medical and behavioral environment and avert inpatient hospitalization. It can also be a step-down strategy for supportive transitions for individuals with SUD, SMI, or SED who have required inpatient hospitalization, and are not yet ready for complete community existence. It keeps them in a structured environment with intensive services, while preparing for community living by having them return home in the evening. The program works with the family as well as the individual to enhance success at home and avert additional hospitalizations.

1) Expand partial hospitalization to cover adults, youth and children with SMI/SED/SUD, and

2) Expand partial hospitalizations to acute care hospitals with a psychiatric unit.
3) Increase reimbursement rate for partial hospitalization to encourage greater service delivery.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete the promulgation of the BH rule which re-drafts regulation and reimbursement for partial hospitalization to encourage hospitals to add this service.	1/01/19 - 12/31/19	MAD
Include in State Plan Amendment for SUD continuum of care	1/01/19 – 3/31/19	MAD
Work with hospitals to add this service	1/01/19 – 12/31/19	HCA

2.0 withdrawal management: Ambulatory withdrawal management with exended on-site monitoring

3.1 Clinically managed low-intensity residential services: 24 hour structure; at least 5 hours of clinical service/week

3.2 withdrawal management (WM) – clinically managed residential withdrawal management: 24 hour structure

3.3 – Clinically managed population specific residential services: 24-hour structure, high intensity clinical services with a less intense milieu and group treatment for those with cognitive or other impairments

3.5 – Clinically managed high intensity residential services: 24 hour care, high intensity services for persons who cannot be treated in less intensive levels to stabilize mult-dimensional needs and/or safety issues

3.7 – Medically Monitored intensive residential services: 24 hour nursing care with physician availability for significant problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications with 16 hour/day counselor availability.

3.7 withdrawal management (WM) – medically monitored residential withdrawal management with 24 hour care with physician availability.

Current State:
Not currently available for adult Medicaid population

NM State Plan supports hospitalization and residential treatment for youth through EPSDT services:

EPSDT Services not otherwise in the State Plan	State Supplement A to attachment 3.1A	Page 5a

Future State Implementation subject to 1115 demonstration and State Plan Amendment approval:

Strategic importance: When a less restrictive setting is not sufficient to engender change, residential care is often medically necessary.

1) Include 2 WM, 3.2, 3.5, and 3.7 WM in crisis triage centers for adults and adolescents;
2) Include 3.1 in step down accredited residential treatment centers for SUD and co-occurring conditions to prepare beneficiaries for community-based services and living;
3) Include 3.2, 3.3, and 3.5 in adult accredited residential settings for individuals with SUD and co-occurring conditions; and
4) Include 3.7 and 3.7 WM in shorter term accredited residential settings with enhanced clinical support for beneficiaries with SUD.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Develop & submit State Plan Amendment which delineates new services at every level of care for both MCO members and fee-for-service recipients. The new services are SBIRT and other screening tools (ASAM 0.5); peer support and family peer support services, ambulatory withdrawal management in crisis stabilization centers (ASAM 1.0); IOP for SUD in an OTP (ASAM 2.1); partial hospitalization for SUD from ages 14 and over (ASAM 2.5); accredited residential treatment centers for adults with SUD (ASAM 3), and SUD treatment in an inpatient IMD (ASAM 3.7 & 4.0).	1/01/19 – 4/01/19	HCA
Align Department of Health standards for crisis triage centers with behavioral health certification and with BH rule;	1/01/19 – 6/31/19	HCA
Complete promulgation of the behavioral health rule that includes crisis triage centers;	1/01/19 – 12/31/19	HCA
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HCA
Schedule trainings on best practices for withdrawal management through UNM/CBHTR;	1/01/19 – 12/31/19	UNM

3.7 - Medically Monitored Inpatient Withdrawal Management: 24-hour nursing care with physician availability for significant problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications. 16 hour/day counselor availability.

4.0 - Medically Managed Intensive Inpatient: 24-hour nursing care and daily physician care for severe unstable problems with acute intoxication and/or withdrawal potential, biomedical conditions and complications, or emotional, behavioral, or cognitive conditions and complications. Counseling available to engage patient in detox treatment.

Current State:
New Mexico funds inpatient services through acute care hospitals. At present this service is underutilized for withdrawal management (de-toxification).

IMDs currently have a 15-day limit for ages 21 through 64 for MCO coverage only as an "in lieu of service" and restricts services to withdrawal management. There is no coverage for the over 65 age range.

NM State Plan supports IP services in acute care and limited IMD services:

Inpatient	Supplement A to attachment 3.1A	Page 1
EPSDT IP and residential for psychiatric/SUD	Supplement A to attachment 3.1A	Page 5a
IMD – over 65	Attachment 3.1A	Page 6
IMD – under 22	Attachment 3.1A	Page 7

Future State Implementation subject to 1115 demonstration and SPA approval:

Strategic importance: Emergency rescue education for overdose through naloxone must be made increasingly pervasive, and then follow-up de-toxification in a hospital if medically necessary must be available. There is much encouragement to hospitals still needed.

1) No regulatory changes are expected for acute care hospitals; continue educational opportunities.
2) Delete the 15-day time restriction in IMDs, and add coverage for over 65 age range, but continue SUD specificity.

Summary of Actions Needed:

Action	Date	Responsible entity
Schedule trainings for acute care hospitals on best practices for withdrawal management	10/01/19 – 12/31/19	UNM
Complete the promulgation of NM Administrative code for behavioral health;	1/01/19 – 12/31/19	MAD
Offer directive to MCOs and IMDs to re-negotiate contracts related to reimbursement for IMDs;	1/01/19 – 6/31/19	MAD
Develop and submit to CMS the State Plan Amendment for SUD which includes coverage for adults with SUD from ages 18 and above, and adults over 65 for SUD and mental illness.	1/01/19 – 4/01/19	MAD
Develop a report that shows the average length of stay for adult ARTCs across the state. LOS	7/01/19 – 12/31/19	HCA

will be specific for each of the 3 levels of care within an ARTC.		

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

Strategic importance: One size does not fit all. The medical necessity for residential care is very specific for differing stages and intensity of illness, and for different age groups, and for individuals with different cognitive abilities and readiness for change and are perfectly articulated through the ASAM placement criteria. That is why New Mexico's placement criteria will be based on ASAM criteria, and why we will require all accredited residential centers and MCOs that will be providing prior approval to have the same training so that consistency across all entities can be the expectation. To assure the most effective placement for the individual, we will also not require authorization until five days into a stay so that appropriate assessment as to level of care needed has been determined. Prior authorization will also be required between transitioning to a different level of residency and care.

Current state:
New Mexico relies on evidence-based practices and clinical practice guidelines for all aspects of provider development, treatment authorization and recovery. The State developed level of care guidelines for some services and will utilize ASAM level of care guidelines for SUD services. The NM Health Care Authority has created a BH policy manual that informs providers of expectations for specific placement, staffing and treatment guidelines for SUD treatment services.

Future State Implementation:

Schedule trainings on ASAM	1/01/19 – 12/31/19	CYFD, HCA
The state is developing the standards for prior authorization for the MCO and the review tools for appropriate placement and utilization, together the instruments will ensure proper placement aligned with ASAM criteria.	1/01/19 – 6/31/19	
Edit current report #41 (attached as C: Utilization Management Review Tool) to specify each ASAM level of care	7/01/19 – 9/30/19	HCA
Train and standardize prior authorization procedures for all MCO and FFS authorization staff in ASAM placement criteria to assure beneficiaries are placed in the correct LOC, i.e., extended partial hospitalization, accredited residential treatment centers, and inpatient admissions.	1/01/19 – 6/31/19	BHSD
Conduct an independent evaluation of placement criteria and utilization management for all levels of ARTCs	10/01/21 – 12/31/21	HCA

Milestone 3: Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications

Current State: NM Medicaid does not cover adult residential treatment centers.

Future State Implementation subject to 1115 demonstration and State Plan Amendment CMS approval:

- Standards: Because all residential treatment centers must be accredited by Joint Commission (JC), or Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) our regulation states that "all MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow up auditing is done by the accrediting agency per their standards". A composite of their standards includes:
- Leadership
- Governance
- Workforce Development and Management
- Financial Planning and Management
- Information Management
- Legal Requirements
- Rights of Persons Served
- National Patient Safety Goals
- Infection Prevention and Control
- Care, Treatment and Services including record keeping of same
- Screening and Access to Services
- Assessment
- Service Planning and Monitoring
- Emergency Management
- Risk Management
- Medication Management
- Medical Care and Clinical Support Team
- Detoxification Treatment
- Promoting Non-Violent Practices
- Transition/Discharge

- After Care and Follow-Up
- Performance Improvement

In addition, HCA will certify each ARTC before they are enrolled in Medicaid to assure compliance with ASAM standards of care for each level, staffing plans, and hours of service, and types of service. Below are the proposed sections of the HCA ARTC certification, to be completed in the first quarter.
Recommended requirements:

- Review of Policies and Procedures
    - Listing of specific policies and procedures to be submitted are in development.
- Documentation of staff ASAM training
- Copies of clinical staff licensure, also DEA# (for physician)
- Table of Organization demonstrating staffing appropriate to ASAM Level(s) of Care and appropriate oversight
- Copy of service schedule
- Attestation showing that required clinical staff are available at the required times per ASAM Level(s) of Care (attest to understanding of requirements and standards, bullet pointing the requirements for the specific ASAM Level of Care). Attestations shall be signed by the CEO/ED or designee and notarized.
- Copy of Assessment Template (including ASAM assessment for each domain, summary, and placement recommendations)
- Copy of Treatment Plan Template (to include ASAM
- Copy of Current Accreditation Certificate (JC, CARF, COA)
- Electronic submission of application materials is acceptable.
- Site visit: Chart review ASAM Risk matches ASAM Level of Care Provided, services provided match schedule provided and meet agencies chosen ASAM Level(s) of Care
    - Review Tool in development.
- Review all ARTCs for inclusion of MAT either on-site or through referral relationships.

Notes:

- No provisional certification.
- Cost Analysis/Rate Setting application submitted, reviewed, approved, and sent to MCO's (rate for each of the Levels of Care). Cost Analysis based on state fiscal year.
- Interim rate might be available through Myers and Stauffer through January 2019.
- If nationally recognized accreditation body (JC, CARF, COA) and ASAM develop a Level Three specific certification that exceeds these proposed review standards, BHSD may reconsider state deemed status for certified programs.

1) Train all current residential treatment centers that are not covered by Medicaid and not accredited in ASAM placement and treatment standards to prepare them for becoming accredited and, therefore, covered by Medicaid.
2) Train all potential crisis triage centers in ASAM standards of care

3) Assure JC or CARF or COA service and quality standards are incorporated into ARTC policy and procedures for NM tiered ARTCs: a) 3.1 in step down accredited residential treatment centers for SUD and co-occurring conditions; b) 3.2, 3.3, and 3.5 in adult accredited residential settings mid-level services, and c) 3.7 and 3.7 WM in shorter term accredited residential settings with enhanced clinical support for beneficiaries with SUD.

Summary of Actions Needed:

Action	Timetable	Responsible entity
Complete promulgation of the behavioral health rule that includes accredited residential treatment centers	1/01/19 – 12/31/19	HCA
Provide technical support to residential providers to become accredited;	1/01/19 – ongoing	HCA
Notify and educate providers and authorization centers on ASAM requirements;	1/01/19 – 6/31/19	HCACA
Schedule trainings on ASAM criteria	1/01/19 – 12/31/19	CYFD HSD
Research state and national staffing ratios and provider types; and include in BHSD's certification process for ARTCs	4/01/19 – 6/31/19	HCA
Compare to The Joint Commission, CARF and COA standards.	7/01/19 – 9/30/19	HCA
Set standards for NM ARTCs	10/01/19 – 12/31/19	HCA, CYFD, DOH
Work with accrediting agencies and ARTCs to access evaluation results of standards of care at each ASAM level, and institute corrective action if needed	4/01/20 – 6/30/20	HCA
Develop certification criteria for new ARTCs	1/01/19 – 6/31/19	BHSD
Develop on-site audit tool for ARTCs to assure placement, staffing, service standards, and placement criteria meet ASAM criteria. This will be conducted every two years	1/01/19 – 9/31/19	BHSD
Review all ARTCs for inclusion of MAT either on-site or through referral relationships.	annually	HCA

Milestone 4: Sufficient provider capacity at each level of care, including Medication Assisted Treatment

Strategic importance: Adequate workforce is the precursor to access of care throughout the state. Workforce is the primary issue within New Mexico as this is a frontier state where areas of the state are without behavioral health providers, and access is a problem. Also, the majority of the population are enrolled in Medicaid where reimbursement isn't adequate to afford competitive salaries.

Rates have been increased in several areas to assist providers in these efforts. Below is a summary of rate increases:

- Treatment foster care – 20% increase
- ARTC for youth from $270/day to $350/day
- Supportive housing - $450/month
- Preventive education in an OTP - $40.05/30 min or $32.50 for groups
- Interdisciplinary teaming from $70,00 to $280 dependent on # of participants
- SBIRT - $27.00 for screen; $54.00 for brief intervention
- BH screening $16.36
- BH brief intervention $22.79
- Partial hospitalization - $875 for full day
- Group homes for youth - $112/day to $150/day
- Peer support individual - $12.00/15 min – group $7.20

The New Mexico Behavioral Health Collaborative, which includes all State Departments, developed a strategic plan with one arm of it being devoted to workforce. The work of this group continues with the second CY summit having just occurred. It included students interested in health-related careers and accentuated the need to reach out to students through internship programs and relationships with existing providers.

The new Behavioral Health Gaps Analysis is attached as Appendix M, Attachment D Behavioral health system barriers begin on page 19 of the New Mexico Health Gaps Analysis. The conclusion and recommendations begin on page 30.

- A range of behavioral health evidence-based practices (EBPs) are available in agencies throughout New Mexico. These EBPs include Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI). However, counties are also lacking important services, such as detox services and crisis mobile outreach services. With the high rates of overdose related to substance use in New Mexico, funding for these types of services should be prioritized.
    - Through the STR and SOR grants the state has been able to increase provider training on EBPs such as Motivational Interviewing, Seeking Safety Community Reinforcement Approach, American Society of Addiction Medicine criteria, Nurtured Heart, Medication Assisted Treatment, multiple trainings regarding opioid use disorder through the ECHO model.
- Given the racial and ethnic diversity of our state, it was encouraging to learn that many behavioral health agencies in NM have adapted or created behavioral health services for Hispanic and Native American populations. However, with this being the case for less than 50% of the agencies, more work needs to be done with respect to developing culturally appropriate services. Noteworthy is the need to extend this work to other cultures, including LGBTQ and people with developmental disabilities.
    - The state is currently offering LGBTQ 101 to all community BH providers (8-10) trainings across the state and delivered the same amount last FY.

- Less than 30% of behavioral health agencies consistently develop psychiatric advance directives. Psychiatric advance directives promote autonomy and empowerment, enhance communications between providers and consumers, and help prevent crisis situations. Training should be provided to agencies to encourage the use of this recovery-oriented practice.
    - BHSD has been in on-going communications to develop an electronic platform for Advanced Directives with Trilogy. Trilogy designs the state's Network of Care on-line resource and information site for BHSD.
- More agencies in urban counties (33%), compared to those in rural counties (22%) utilize telehealth/telemedicine to ensure consumers have access to treatment services. While this is a growth area for agencies throughout NM, this is especially true for those in rural counties.
    - BHSD has disseminated the HHS guidance for prescribing MAT via telehealth to all opioid treatment programs which is attached. This guidance is included in the NM Medicaid Behavioral Health Policy Manual.
    - All STR and SOR funded trainings related to Medication Assisted Treatment include specific information and guidance to attendees about the use of telehealth when setting up buprenorphine initiatives. This new guidance provides a hands-on mentorship experience for providers in rural areas who are considering applying their own DEA waiver to prescribe buprenorphine and is consistent with New Mexico's goal of increasing capacity for Medication Assisted Treatment throughout the state. Current research from UNM led by Dr. Salvador confirms that clinicians are looking for opportunities to observe experienced clinicians when prescribing buprenorphine including induction. The presence of a clinician at the originating site with a patient who is receiving buprenorphine by telehealth is an important component of learning new skills.
    - New Mexico already legislation in place to facilitate the use of telehealth to expand access to clinical services and telehealth is a reimbursable service through NM Medicaid.
- Another area of growth is the integration of electronic health systems into an information exchange to increase the sharing of information between providers. This integration of information is only available in about 26% of agencies in urban counties and 20% of agencies in rural counties.
- With only 50% of agencies having a process for using data to impact services, training and possibly even incentives need to be provided to agencies to make this a standard practice.
- While we know access to medication assisted treatment (MAT) has increased throughout NM since these data were collected, especially through initiatives such as the SAMHSA-funded State Targeted Response (STR) grants, the number of MAT providers needs to increase throughout NM. At the time these data were collected approximately 30% of agencies had providers who could prescribe and manage medications used to treat substance use disorders. For agencies where this is not possible, agreements or relationships with agencies who can provide these necessary services need to be developed.

- Through efforts established in NM's Hub and Spoke model and the use of ECHO.
- In addition, the State's Opioid Treatment Authority works to expand the opioid treatment programs (OTP). Currently there are three new providers working on completing the numerous licensing steps through SAMHSA, accreditation, the Drug Enforcement agency and the Board of Pharmacy. The state will offer CARF 101 training and ASAM training open to all potential OTPs. In addition, there are monies in the SOR to give OTP financial assistance for accreditation.

- Lack of reimbursement for trainees/interns was the most commonly cited barrier to independent licensure for both rural and urban clinical directors. In order to alleviate this barrier, funds should be made available to compensate a higher number of supervised trainees in NM. Funds should also be made available to compensate the clinical supervision of master's level social work and counseling professionals to facilitate independent licensure either through stipends/salaries or changes to existing Medicaid reimbursement laws. In response to this feedback from providers,
    - NM Medicaid issued a new proposed rule change that allows community behavioral health agencies to bill Medicaid for services provided by trainees as long as supervisory requirements are met. This new rule change takes effect January 1, 2019.

Summary of Actions Needed:

Action	Date	Responsible entity
Expand allowable agencies to include political subdivisions and other behavioral health agencies	1/01/19 – 3/31/19	HCA
Expand practitioners who can deliver SUD services, e.g., trainees under supervision, certified peer support workers, certified family support workers, and other qualified paraprofessionals	1/01/19 – 3/31/19	HCA, CYFD
Develop trainings focused on SUD for certified peer support workers, licensed clinicians, and prescribers	10/01/19 – 12/31/19	HCA, UNM and CYFD
Schedule further trainings such as MAT, DATA waiver 2000, to expand access to buprenorphine.	On-going	HCA, UNM
Expand statewide behavioral health workforce coalition	On-going	HCA, UNM, CYFD
Collaborate with professional licensing boards to review scopes of practice for all licensed professionals	1/01/2021 – 3/31/2021	HCA, CYFD
Edit the HSD network adequacy report to include BH services for all ASAM levels and incorporate composite into annual CMS reporting - identifying the types of services	4/01/19 – 6/31/19	HCA

that are challenging to access and also identifying where in the state there are access challenges for those types of services.		

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Current State:

Recovery Supports:
New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD.

In addition, Medicaid covers the following recovery services:

- Comprehensive Community Support Services;
- Behavioral Management Skills Development;
- Adaptive Skills Building;
- Psychosocial Rehabilitation;
- Family Support Services;
- Recovery Services; and
- BH Respite Services.

PAX Good Behavior Game
PAX Good Behavior Game® is a powerful evidence-based practice, consisting of proven instructional and behavioral health strategies used daily by teachers and students in the classroom. This universal preventive approach provides lifetime of benefits for every child by improving self-regulation and co-regulation with peers.

Prescription Monitoring Program (PMP):
16.19.29 NMAC, the rule regulating the PMP recently underwent a major rewrite addressing issues such as registration requirements to the PMP, restrictions on the disclosure of PMP information and mandatory reporting to one (1) business day.

State legislation and each healthcare professional licensing board enacted legislation/rules that mandate PMP utilization. The NM Board of Pharmacy has partnered with the NM Department of Health to analyze practitioner utilization compared to the controlled substances that were dispensed using their credentials. This analysis is then disseminated by the NM Board of Pharmacy to each of those healthcare licensing boards who have oversight of their licensees, and the licensing board can use this information to develop communication or initiate an investigation.

To help practitioners and pharmacists query PMP patient reports, medical staff (licensed and unlicensed) have the ability to query PMP patient reports for their supervising practitioners, and licensed pharmacy technicians and pharmacy interns also have the ability to query PMP patient reports on behalf of their pharmacists. Although a practitioner or pharmacist can only have four (4) delegates, a delegate can act in this role for an unlimited number of practitioners and pharmacists. As previously mentioned, the delegate usage and association to the practitioner's profile allows for the data analysis to link the delegate's query to the practitioner's PMP utilization.

The NM Board of Pharmacy is now requiring dispensers (i.e., pharmacies and dispensing physicians) to report both prescription records or zero reports (i.e. no prescription-controlled substances dispensed during the reporting period) within one business day. While the PMP Director sends courtesy reminders and will work with data submitters experiencing temporary issues with reporting, 16.19.29 NMAC states very clearly that this is a requirement of dispensers dispensing controlled substances. If necessary, the NM Board of Pharmacy will open a case on those pharmacies who do not meet compliance needs. Ensuring that dispensers report daily ensures that the PMP is a valuable clinical tool to all authorized users with the most up-to-date prescription record data.

The NM Board of Pharmacy and the NM Department of Health developed a feature called a Prescriber Feedback Report (PFR), which provides a summary to the individual practitioner regarding the controlled substance dispensed using their credentials as reflected in the PMP. This report is informational which includes a comparison of prescribing measures to the average prescriber in the practitioner's specialty and graphical representation. It also includes information on several factors shown to increase the risk of overdose death involving prescription-controlled substances.

This link shows the NM statistics published at the 2018 Pharmacy Convention:
https://www.nmpharmacy.org/resources/2018%2006%2023%20-%20NMPhA%20Law%20Update.pdf

Future State Implementation:

Strategic importance: Treatment of existing SUD has been part of New Mexico's array of services; however, prevention has not had enough focus. SUD is often a means of self-medication for those with serious mental illness (SMI) or severe emotional disturbances (SED) for adolescents. If this risk factor becomes part of the consciousness of all providers, the individual, and the natural support systems for individuals with a SMI or SED, and psycho-education and other preventive measures become common practice we can, hopefully, diminish the on-set of SUD.

There are no planned enhancements to the PMP at this time.

Opioid Prescribing Guidelines

The state has developed best practice protocols for opioid prescribing that are in keeping with the CDC guidelines. DOH and STR have contracted with Dr. Robert Rhyne to deliver trainings and follow up on these guidelines.

NM Medicaid ensures that best practices are followed by limiting the following opioid prescriptions through a soft edit process within the MCOs and FFS:

- Total daily doses above 90 MME of opioids
- Maximum of 7 days for all new opioid prescriptions for all patients who are new to opioids
- Refill threshold of 90% before opioid prescriptions can be filled

1) Centennial Care MCOs will monitor the use of controlled substances retrospectively to detect potential abuse or overuse and to assure the appropriate use of the drugs items with diversion potential. In addition, the Centennial Care MCOs will work together on the drug utilization review committee (DUR) to develop a standard monitoring program for controlled substance utilization. The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for the DUR oversight group to report regularly to HCA and the Behavioral Health Collaborative, as requested. The MCOs shall notify the appropriate providers in their networks regarding this initiative and shall inform providers that utilization and prescribing patterns will be monitored.

2) Continue and expand PAX Good Behavior Games in early childhood education through the New Mexico public school system for early development of self-regulation and co-regulation with peers.

3) Add SUD to the admission criteria for individuals with SMI or SED in the NM CareLink health home program and enhance the risk factor education for SUD with all SMI/SED participants. The Health Home Steering committee will oversee the CLNM community providers in creating and implementing a health education program that informs participants with SMI/SED about the increased risk factors for SUD.

4) Overdose Prevention Education Coordinator (OPEC) whose task is to implement and coordinate trainings, technical assistance, and distribution of naloxone. The OPEC implements a Train the Trainer model, prioritized based on local need, local capacity, and overdose data, focused on increasing training access throughout 29 of the 33 New Mexico counties. This model focuses on providing overdose education and naloxone distribution (OEND) training to local individuals to serve as a county-based trainer for all OEND training needs. In addition, the SOR OPEC utilizes stipends as a mechanism to support the establishment of local trainers within the community. This will increase the ability of local providers to allot the necessary time needed to become trainers within their counties. The SOR OPEC also provides training and naloxone to special populations who are often underserved and at high risk of overdosing. These populations include adults age 55 and older, lesbian, gay, bisexual, and transgender community members, and youth under age 18. To assist with statewide capacity building, special population trainings, and fidelity checks with new trainers, the OPEC subcontracts with two statewide Overdose Prevention Educators and one Tribal Liaison. These individuals work regionally to orchestrate trainings, fidelity checks, and other local community needs identified by the SOR OPEC.

A continued commitment must be established in order to effectively serve special and high need populations and the agencies that serve these populations. For example, law enforcement often serves as the first professional on the scene of an overdose. Due to turnover with law enforcement officers, there must be a continued emphasis on training and educating law enforcement agencies to be best equipped to recognize and respond in cases of an overdose. For entities like corrections and treatment programs or homeless shelters, these individuals also experience turnover at the staff level as well as turnover with clientele. This requires a focus on a continuous relationship around training and distribution to these populations and encourages OSAP to coordinate activities across grants.

- To date, the STR OPEC has distributed 6,009 kits with 1,975 people being trained.
- To date, the Community-based Organizations funded through STR have distributed 953 kits with 814 people being trained.
- The Santa Fe Mountain Center (SFMC), who will expand opioid overdose prevention education/outreach and naloxone distribution specifically targeting youth, outpatient programs, LGBT, and community agencies, is anticipated to conduct 15 trainings reaching approximately 225 people.
- 32 reversals have been reported to date.
- An upcoming February 2019 purchase of Narcan will provide approximately 5,300 additional kits for distribution.
- The SOR OPEC is anticipated to conduct 120 trainings over the next 12-month period.
- The Law Enforcement Training Institute (LETI), who trains law enforcement agencies throughout the state, is anticipated to conduct 150 trainings to approximately 3000-5000 law enforcement officers over the next 12-month period.
- OSAP will purchase approximately 6,000 additional kits for distribution in 2020.

5) New Mexico has invested a great deal to implement and sustain a health IT infrastructure that supports Medicaid recipients. Like many states, substance use disorders (SUD) plague the health care system in New Mexico. The state will pull together stakeholders across the health care system to refine existing health IT plans or to develop a new plan that will detail the necessary health IT capabilities that will be implemented to support Medicaid recipient health outcomes to address the SUD goals of the demonstration. Stakeholder engagement and plan development will occur in first year of the demonstration. Applicable standards and best practices will be incorporated into the plan. During the first year of the demonstration, New Mexico will look for opportunities to leverage the Medicaid Management Information System (MMIS) replacement project to achieve the goals that will be developed in the plan.

   In years 2 and 3 of the demonstration, New Mexico will enhance its existing master client index (MCI) to support the state's MMIS replacement. The enhanced MCI is part of a broader master data management strategy and will function as a shared service to a variety of stakeholders within the health care system in New Mexico.

   Years two through five of the demonstration will see execution and monitoring of the plan. New Mexico will utilize existing governance structures and processes in place to monitor the execution and success of the plan.

Summary of Actions Needed:

Action	Timetable	Responsible Entity
Expand reimbursable services under home visiting initiatives to improve early identification and engagement in treatment for parents with SUD	4/01/19 - ongoing	HCA, DOH, CYFD, UNM
Continue and expand PAX Good Behavior Game	ongoing	HCA
Add SUD to CLNM admission criteria and expand risk factor education for members with SMI, SED	1/01/21 – 4/01/21	HCA
Drug utilization review committee to continually adjust monitoring guidelines (see IT Plan – Appendix M, Attachment F)	Ongoing	HCA & MCOs
Leverage the Medicaid Management Information System (MMIS) replacement project to achieve the SUD goals that will be developed in the plan.	1/01/19 – 12/31/19	HCA
Enhance the existing master client index (MCI) to support the state's MMIS replacement.	1/01/20 – 12/31/22	HCA
Execution and monitoring of the MMIS replacement plan	1/01/20 – 12/31/24	HCA

Milestone 6: Improved care coordination and transitions between levels of care

Current state:

Care coordination is currently provided by the four MCOs and is inclusive of transitions between levels of care, including a new transition between correctional facilities and the community. Care Coordination can include face to face contact during transitions, warm hand-offs to appropriate community providers such as the CLNM health homes, and/or information and referral to community resources.

In addition, they have delegated care coordination to the existing 9 health homes for our highest need chronically ill recipients with behavioral health conditions categorized as serious mental illness (SMI) or severe emotional disturbances (SED) for children. These recipients most often have multiple co-morbidities. They must agree to becoming a CLNM health home member (opt-in). The 9 health homes, in 11 counties, are providing services to individuals with SMI/SED and all co-occurring conditions. There will be 13 counties

targeted across the state for expansion. Approximately 1/3 of the counties are currently open for health homes, and the rest will be implemented in 2 future phases. In Appendix M, Attachment E on page 3 the potential population is calculated. However, it should be understood that these numbers are not unique to the diagnosis, meaning that a person that has an SMI/SED diagnosis and a SUD could potentially be counted in both.

Six services include:

1) Comprehensive care management
2) Care coordination
3) Health promotion
4) Comprehensive transitional care and follow-up
5) Individual and family support
6) Referral to community and social support services

NM State Plan supports CLNM Health Homes and transitions between levels of care:

CareLink NM Health Home	NM-15-0014 Attachment 3.1 - H	
CareLink NM Health Home	NM-18-0002 6A.1	
Discharge Planning & QA Review	Attachment 3.1-C	Page 1F

Future state implementation:

Strategic importance: For this high need population, comprehensive care coordination has proven to be more effective in the community in which the recipient lives, and in the behavioral health agency where he or she can receive multiple behavioral health or integrated services. Support of an individual between levels of care, which is one of the six core services, particularly from IP or residential or correctional facilities to the community, is most frequently the time for relapse and eventual recidivism. This is a crucial time for support to ensure the individual is well situated with the care and social determinants needed for a successful life.

1) Move some care coordination services to the beneficiaries' community through:
   a. The expansion of health homes into more counties;
   b. Expansion of delegated or partially delegated care coordination to other providers such as: PCMHs, FQHCs, etc. These will usually operate under value-based purchasing agreements with targeted populations.
2) Develop transition protocols for most at-risk populations;
3) Under State Plan Amendment authority, CLNM expansion for health homes will incorporate the addition of SUD to the eligible population. It has been the intention to add moderate to severe substance use disorder to the qualifying conditions for Health Homes, and this intention was included in the first SPA. SUD can be added to the existing HHs and will be

included in the new SPA for the 2020 roll out. Table one of Appendix M, Attachment E identifies the number of Medicaid beneficiaries with this diagnosis. In addition to having the highest numbers of beneficiaries with SMI, SED, and SUD claims, the recommended counties also have several providers that could serve as Health Homes or participate as part of the provider network. Please see Appendix M, Attachment E for an executive summary of plans.

Summary of actions needed:

Action	Date	Responsible entity
MCOs delegate care coordination to community agencies	1/01/19 - ongoing	HCA, MCOs
CLNM Steering committee to establish new requirements for SUD addition to CLNM HHs	1/01/19 – 6/31/19	HCA, CYFD, MCOs
Submit health home SPA to CMS	7/01/19 – 7/01/20	HCA
Solicit potential providers in 13 targeted counties (see Appendix M, Attachment E for the targeted expansion counties)	TBD	HCA
Evaluate potential health home applications	TBD	HCA, CYFD, MCOs,
Educate applicants on health home requirements and provision of additional services expected.	TBD	HCA, CYFD, MCOs
Develop reimbursement per facility	TBD	HCA
Activate HH in 13 counties	1/01/2021	HCA, CYFD
Repeat above steps and activate all remaining counties for Health Homes	1/01/2022	HCA, CYFD

Attachment A: Opioid Treatment Program Initiation Process

Attachment B: Best practices for substance use detoxification by UNM/CBHTR

Attachment C: Utilization Management Review Tool

Attachment D: New Mexico Gaps Analysis

Attachment E: CareLink New Mexico Health Home Expansion Plan

Attachment F: Information Technology Plan

Attachment F: Information Technology Plan

Attachment F

Information Technology Plan

Treatment of existing SUD has been part of New Mexico's array of services, and the prevention through early screening, education, and prescription monitoring practices are now demanding greater focus. New Mexico, through the Human Services Department and the managed care organizations, the NM Board of Pharmacy (NM BOP), and the NM Department of Health (NM DOH) is implementing multiple programs through information technology to both prevent and support opioid and substance use disorders. The initiatives described below highlight current processes and future plans.

Criteria	Current State	Future State	Summary of Actions & timeline Needed
Enhanced interstate data sharing in order to better track patient-specific prescription data	Prescription Monitoring Program Interconnect (PMPI) is being utilized to share NM Prescription Monitoring Program (PMP) data with 30 other states, territories and programs, including all contiguous states. Practitioners are mandated to query the NM PMP prior to initially prescribing a control substance in schedules II-V and every three months thereafter if the prescription is being renewed, pursuant to the licensee's healthcare licensing board rules. PMP utilization is reported by the NM BOPPMP Director to the licensee's healthcare licensing board quarterly.	100% of prescribers will utilize PMP and check prescriptions across NM and all contiguous states, if available.	Determine rate of prescribers utilizing the PMP from a State-level aggregate level and develop a plan for 100% of prescribers to utilize PMP – 3rd quarter 2019

	The State tracks utilization for each individual prescriber, but at this time the rate of prescribers utilizing the PMP from a State-level aggregate rate is not available. Even though querying the NM PMP prior to prescribing a control substance is mandated by statute and healthcare licensing board rules, we are not yet 100% PMP utilization.		
Enhanced ease of use for prescribers and other state and federal stakeholders	To help practitioners query PMP patient reports, medical staff (licensed and unlicensed) have the ability to query PMP patient reports for their supervising practitioners. Certified pharmacy technicians and registered interns also have the ability to query PMP patient reports on behalf of their pharmacists. Although a practitioner or pharmacist can only have four (4) delegates, a delegate can act in this role for an unlimited number of practitioners and pharmacists. The delegate usage and association to the practitioner's profile	Will explore other enhancements as funding allows	• Develop a team from the NM BOP, the Medicaid Systems Bureau, and the Behavioral Health Services Division of Medicaid, to explore funding options through the Support Act • Explore use of NarxCare for enhanced request reporting (if funding is procured) • Explore funding opportunities to integrate

	allows for the data analysis to link the delegate's query to the practitioner's PMP utilization. The NM PMP is engaging with electronic health records (EHR) and pharmacist dispensing systems (PDS) throughout the state to integrate their healthcare system with the NM PMP. This will allow for one click access within the EHR/PDS for the practitioner/pharmacist to query the NM PMP (and other states if allowed).		EHRs/PDSs with the NM PMP. 2020
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	Emergency Department Information Exchange (EDIE) has been established with most emergency departments (ED) in NM to present a patient's PMP report to the attending physician. It also sends a real time notification of admission to the MCOs and CLNM health homes. The HIE is integrated with the NM PMP.	Complete implementation of EDIE in remaining EDs	Complete implementation of EDIE in remaining EDs and new health homes as they are opened– 12/31/19
Enhanced identification of	1. NM includes OUD to list of conditions	1. Automatically transmit notice of	1. Complete the implementatio

long-term opioid use directly correlated to clinician prescribing patterns	that qualify as a notifiable condition. Pilot in two hospitals. 2. The NM BOP and the NM DOH developed a feature called a Prescriber Feedback Report (PFR), which provides a summary to the individual practitioner regarding the controlled substance dispensed using their credentials as reflected in the PMP. This report includes a comparison of prescribing measures to the average prescriber in the practitioner's specialty and graphical representation. It also includes information on several factors shown to increase the risk of overdose death involving prescription-controlled substances. 3. State legislation and each healthcare professional	presentation of overdose in ED to DOH for follow-up clinical support to individual and family. No human interaction required. 2. Any new query functions dependent on dedicated funding stream	n in remaining hospitals in State for statewide compliance – only 3 hospitals remaining to implement - 2nd quarter 2019 2. Exploration of any additive query functions to be designed by collaborative IT committee – 3rd quarter 2019 3. Continue ECHO learning modules on a quarterly basis.

	licensing board enacted legislation/rules that mandate PMP utilization. The NM BOP partnered with the NM DOH to analyze practitioner utilization compared to the controlled substances that were dispensed using their credentials. This analysis is then disseminated by the NM Board of Pharmacy to each of those healthcare licensing boards who have oversight of their licensees, and the licensing board can use this information to develop communication or initiate an investigation 4. MCO Pain and Addiction ECHO on line learning module: MCO collaboration with primary care (PCMH) includes access to quarterly on-line trainings. Training also		

	available to all NM hospitals.		
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PMP	1. The state has developed best practice protocols for opioid prescribing that are in keeping with the CDC guidelines. DOH and UNM have contracted with academic detailers to deliver trainings and follow up on these guidelines. 2. NM Medicaid ensures that best practices are followed by limiting the following opioid prescriptions through a soft edit process within the MCOs and fee for service: - Total daily doses above 90 morphine milligram equivalents (MME) of opioids - Maximum of 7 days for all new opioid prescriptions for all patients who are new to opioids	The Centennial Care MCOs will work together on the drug utilization review (DUR) committee to develop a standard monitoring program for controlled substance utilization. The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for the DUR oversight group to report regularly to HSD and the Behavioral Health Collaborative, as requested. The MCOs shall notify the appropriate providers in their networks regarding this initiative and shall inform providers that utilization and prescribing patterns will be monitored.	• DUR to convene quarterly to accomplish monitoring parameters, and receive input requiring action from the MCOs – Through the duration of the demonstration

	- Refill threshold of 90% before opioid prescriptions can be filled 3. Centennial Care MCOs monitor the use of controlled substances retrospectively to detect potential abuse or overuse and to assure the appropriate use of the drugs items with diversion potential.		
Enhanced provider workflow/business process to better support clinician in accessing the PMP prior to prescribing	All authorized PMP users have access to a web-based portal, PMP AWARxE. The state HIE is integrated with the NM PMP. EDs have integrated NM PMP data within the EDIE platform. Several EHRs and PDSs throughout the state are expressing interest or already have integrated their healthcare system with the NM PMP that allows for one click access to NM PMP data.	HSD will work with the NM PMP to foster integration with more EHRs technology (CEHRT) to allow practitioners to have one click access to the patient's NM PMP information directly within their healthcare system.	Dependent on funding, additional EHR interoperability targeted for 2020
Develop enhanced supports for clinician review of the patients'	Developed DUR edits in the claim adjudication system based upon CMS guidance and CDC	• Develop a system enhancement to identify DUR PPS code submissions on prior claims to	• Develop system enhancements • Work with DUR

history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	guidelines with review and approval by the MCO Pharmacy and Therapeutics Committee. Currently the functionality requires submission of the point of sale DUR prospective payment system codes on each claim that soft rejects.	automatically override future soft rejects as applicable. • The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for the DUR oversight group to report regularly to HSD and the Behavioral Health Collaborative, as requested.	Committee to establish a standard monitoring program across all MCOs. • Maintain edits as to supply limitations, therapeutic dose checks, duplicate therapy of long acting opioids, and opioid refill utilization threshold as CDC guidelines are updated. • 3rd quarter 2019
Enhance the master patient index (MPI) or master data management service (MDMS) in support of SUD care delivery.	Component parts of the new Medicaid Management Information System (MMIS) are under early planning or contract negotiations or out for proposal	• Stakeholder engagement and plan development will occur in first year of the demonstration. App licable standards and best practices will be incorporated into the plan • Enhanced MCI across multiple health care departments and providers	• Yr 1: Identify opportunities to leverage the new MMIS to achieve the SUD goals • Yrs 2 & 3: Enhance the master client index (MCI) to function as a shared service to a variety of stakeholders within NM.

			• Yrs 2 – 5: Execution and monitoring of the plan.
Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.	See above drug utilization committee work and system edits		Place peer support workers in EDs for patient education & support – 4th quarter 2019

Part 2:

Demonstration Goal	Milestone	Health IT Considerations	Timeframe & responsible party
Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs	Access to critical levels of care for OUD and other SUDs	Telehealth is available through any video technology that has a business associates' agreement to ensure security and HIPAA compliance; Master client index is our identity management system which will be expanded to a hub and spoke model in our new MMIS which will	HSD and vendors for the new MMIS will be designing and implementing enhanced data analytics targeted for 2022.

Demonstration Goal	Milestone	Health IT Considerations	Timeframe & responsible party
		include all Health and Human Services Departments. Care team attribution is managed by the MCOs.	
Increased adherence to and retention in treatment for OUD and other SUDs	Widespread use of evidence-based, SUD-specific patient placement criteria	Use of standardized and electronic assessments and care plans are through the MCOs and Health Homes; closed-loop referral systems are specific to provider EHR systems; and Smart phone apps are being considered as part of our new MMIS.	Smart phone apps are part of the MMIS unified portal interface (UPI). HSD and vendors for the new MMIS will be designing and implementing smart phone capabilities (UPI) in 2022.
Reductions in overdose deaths, particularly those due to opioids	Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications	A central registry system for all opioid treatment, which is a federal DEA requirement, is managed for both Medicaid and non-Medicaid populations. Interoperability between the central registry and the PMP for advanced alignment is under consideration. Data analytics for population health and clinical decision	HSD, administrative services organization (ASO), and the NM Board of Pharmacy will be responsible for determining if interoperability is feasible – 2020. HSD and vendors for the new MMIS will be designing and implementing data services to

Demonstration Goal	Milestone	Health IT Considerations	Timeframe & responsible party
		support is part of our new MMIS design.	provide analytics for public health and clinical support for providers - targeted for 2022.
Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to another continuum of care services	Sufficient provider capacity at each level of care, including prioritized Medicated-Assisted Treatment (MAT).	Better utilization of the central registry program allows us to better align OUD and SUD treatment across various treatment systems including criminal justice, emergency departments, medical de-toxification in crisis triage centers and accredited residential treatment centers which will help to achieve over-utilization of the EDs and IP hospitalization. Identity management and central registry is the IT tracking mechanism which is essential.	
Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for	Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	Under consideration is a client assessment record (CAR) which would capture any changes in treatment levels across provider systems with all HIPAA SUD	HSD and their ASO will be enhancing the CAR to capture mandated data for the Medicaid population

Demonstration Goal	Milestone	Health IT Considerations	Timeframe & responsible party
OUD and another SUD		considerations from 42 CFR Part 2. Transitions in level of care is an enhanced priority in the 1115 waiver.	targeted for 2021.
Improved access to care for all health conditions among beneficiaries with OUD or other SUDs	Improved care coordination and transitions between levels of care. A key consideration relates to an individual's current level of care, so treatment teams can refer individuals for assistance to higher levels of care.	MCOs and health homes utilize a standard care plan. MMIS tracks levels of care and health homes are adding SUD as criterion for admission which will be tracked.	HSD will add SUD to health homes in 2020. HSD and vendors for the new MMIS will be designing and implementing enhanced data analytics targeted for 2022.

Statement 2: The State is in a requirement gathering phase to align Medicaid and Behavioral Health IT plans to be incorporated into the Health and Human Services (HHS 2020) platform.

Part 3: Advancing Interoperability using Health IT Standards

The MMISR and HHS220 are being built to MITA level 3 standards. As we are in the requirements phase, we are considering specificity for SUD/OUD.

Statement 3: The state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) https://www.healthit.gov/isa/ and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/ Health Care Plan re-procurements.

ATTACHMENT I
Pre-Tenancy/Tenancy Services
Approved on: July 18, 2025

Pre-Tenancy Services
• Assisting the member with identifying preferences and barriers related to housing and successful tenancy (e.g., type, location, living along or with someone else, identifying a roommate, accommodations needed, or other important preferences). • Assisting the member to develop a housing support plan based on the functional needs assessment, including establishing measurable goals(s) as part of the overall person-centered plan. • Developing a crisis plan, which must identify prevention and early intervention services if housing is jeopardized. • Assisting the member with housing application and selection process, including filling out housing applications and obtaining and submitting appropriate documentation. • The CPSW, Community Support Worker, Case Manager, or Supportive Housing Coordinator will provide members tenancy orientation training including assistance in budgeting for housing/living expenses, assistance in establishing credit and in understanding, assistance in the process of securing necessary household supplies, ensuring a safe living environment, and meeting obligations of tenancy. • Supporting members in the development of independent living skills, such as skills coaching, financial counseling, and communication. • Assisting the member by building property owner/property manager relationships and communication.
Tenancy Services
• Assisting the member with early identification of issues that undermine housing stability, including member behaviors and housing safety. • Coaching to the member about relationship with neighbors and property owners/property managers and tenancy compliance. • Connecting the member to education and training on tenant roles, rights and responsibilities and property owner/property manager roles, rights and responsibilities. • Assisting the member in resolving tenancy issues that help the member improve his or her conflict resolution skills, coaching, role-playing communication strategies targeted towards resolving disputes with property owners/property managers and neighbors, address biopsychosocial behaviors that put housing at risk, and provide ongoing eviction prevention support with activities related to household management. • Assisting the member to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. • Assisting the member in linking to available community resources responsible for maintaining housing.

New Mexico Turquoise Care Pre-Tenancy and Tenancy Needs-Based Criteria **Eligibility: Members must meet the Part 1 targeting criteria, Part 2 needs-based criteria, and Part 3 risk factors outlined below.**		
	Linkages	**Set-aside Housing Program (SAHP)**
Part 1: Targeting Criteria	Individuals must be an adult of 18 years of age or older with a Serious Mental Illness (SMI).	Except for (d) below, individuals must be an adult of 18 years of age or older and must have one of the following: a. Individuals with SMIs; b. Individuals with Substance Use Disorders (SUDs); c. Individuals with intellectual/developmental disabilities; d. Individuals with physical, sensory, or cognitive disability occurring after the age of 22; e. Individuals with a disability caused by chronic illness (as determined by a physician or similarly qualified practitioner); or f. Individuals with an age-related disability (as determined by a physician or similarly qualified practitioner).

Part 2: Needs-based Eligibility Criteria	Individuals must, at minimum, need supervision with one of the following IADLs due to a disability: • Preparing and planning meals. • Performing ordinary housework. • Getting around in the community (transportation). • Using the telephone or computer. • Shopping for groceries and other necessities. • Exploring employment opportunities • Managing finances. • Following lease and property expectations, including maintaining healthy relationships with neighbors and the Property Manager. • Caring for pets. • Managing medication, including assisting with setting up medication administration mechanisms (e.g. pill jars) and ensuring that individuals have the supports necessary to take medications in a timely manner.	Individuals must, at minimum, need supervision with one of the following IADLs due to a disability: • Preparing and planning meals. • Performing ordinary housework. • Getting around in the community (transportation). • Using the telephone or computer. • Shopping for groceries and other necessities. • Exploring employment opportunities • Managing finances. • Following lease and property expectations, including maintaining healthy relationships with neighbors and the Property Manager. • Caring for pets. • Managing medication, including assisting with setting up medication administration mechanisms (e.g. pill jars) and ensuring that individuals have the supports necessary to take medications in a timely manner.
Part 3: Risk Factors	In addition to meeting the needs-based criteria above in Part 2, a. Individuals must also meet the risk factor of homelessness or precariously housed* AND b. Meet one or more of the following risk-factors, as determined by a physician, licensed behavioral health practitioner, or similarly qualified practitioner, in the SMI checklist): 1. Is a significant danger to self or others within the last year; 2. Has repeated use of acute care, defined as three or more emergency room visits or at least one psychiatric hospitalization within the last year; 3. Experiences trauma symptoms related to sexual assault, domestic violence or other traumatic event; OR	Must meet a risk factor of homelessness or precariously housed.*

	4. Due to a substance use disorder, experiences complications with SMI that have resulted in worsened intoxicated/withdrawal symptoms, bio medical conditions, and/or emotional/behavior/cognitive conditions.	
	* For both Linkages and SAHP, homelessness or precariously housed is defined as: People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing or after discharge from an institution where they temporarily resided for up to 90 days and were in shelter or a place not meant for human habitation prior to entering that institution. • People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled- up situation, within 14 days, and lack resources or support networks to remain in housing. • Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. • Living situations that include excessive occupancy in a unit. Excessive occupancy is occupancy in excess of the lease and/or local regulations. An Excessive Occupancy Declaration must be included with the Certificate of Eligibility. Excessive occupancy applies to those with their own lease and is different than "doubled-up situation[s]" noted above. • The following subcategories apply to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.[1] [From "Changes in the HUD Definition of Homelessness." January 18, 2012, Federal Policy Brief.] • Homeless or precariously housed families with children may be considered eligible only by an adult (18 years or older) being diagnosed with SMI (minor children with Severe Emotional Disturbance are not a qualifying situation). • Unaccompanied Youth must be 18 years of age and able to legally sign a Lease and diagnosed with a Serious Mental Illness.	

Attachment J
SMI/SED Demonstration Implementation Plan

Approved: July 10, 2025

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Dana Flannery, NM Medicaid Director
Dana.Flannery@HCA.nm.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	New Mexico
Demonstration name	Turquoise Care
Approval date	3/28/2023
Approval period	*03/28/2023-12/31/2029*
Implementation date	8/1/2025
SMI/SED demonstration goals and objectives	During the demonstration period, the state seeks to achieve the following SMI/SED goals: 1. Reduced utilization and lengths of stay in emergency departments (Eds) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings; 2. Reduced preventable readmissions to acute care hospitals and residential settings; 3. Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the state; 4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including

	through increased integration of primary and behavioral health care; and 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	

1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current State:** Adult Residential New Mexico currently has no Medicaid eligible adult accredited residential treatment centers (AARTC) licensed to primarily treat mental illnesses. NM does have adult accredited residential treatment centers that are certified to provide treatment for individuals with substance use disorder (SUD) and co-occurring mental health conditions. NM does not have regulatory language in place to allow for licensing and certification for adult residential facilities providing mental health treatment primarily. Hospitals Hospitals that provide treatment for mental illness must have licensure from the Department of Health (DOH). They are also in compliance with Medicare Conditions for Participation (CoPs). Hospitals must be accredited by the joint commission, (JC), the council on accreditation of services for families and children (COA), or the commission on accreditation of rehabilitation facilities (CARF). There are currently five institutions for mental disease (IMDs) that are psychiatric hospitals. They are licensed by the DOH and are accredited by the Joint Commission (JC). The State Behavioral Health Institute is operated and licensed by the DOH. The DOH licensing rule requires that, according to the NM Administrative Code (NMAC) 7.7.2.19, hospitals must be in compliance with CMS's patient rights conditions of participation. Furthermore, the objectives of 7.7.2.6 NMAC are to: A. Establish standards for licensing hospitals in order to ensure that hospital patients receive adequate care and treatment and that the health and safety of patients and hospital employees are protected. B. Establish standards for the construction, maintenance and operation of hospitals. C. Regulate such hospitals in providing the appropriate level of care for patients. D. Provide for hospital compliance with these requirements through surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the patients and staff. Residential Treatment Facilities for Youth NM has 4 Accredited Residential Treatment Centers (ARTCs) for Youth that are not participating in the 1115 demonstration. ARTCs for youth must have licensure and certification from CYFD/LCA. 8.321.2.11 NMAC requires ARTCs for Youth to be accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

Future State:

NM will put infrastructure in place to facilitate AARTC level of care with a primary diagnosis of serious mental illness (SMI). This will involve updating NMAC, updating the Behavioral Health (BH) Policy and Billing Manual, updating the certification process and reviewing the rate setting process for AARTCs. Through the course of the waiver period, we anticipate that we can facilitate up to 3 new AARTCs for the treatment of SMI. NM will:

- Investigate the clinical need and necessary infrastructure for AARTC level of care with a primary diagnosis of SMI.
- Clarify Medicaid reimbursement and enrollment processes for acute care in hospital based IMDs for SMI
- Promulgate regulation and policy for SMI AARTCs
- Ensure that the single point of entry system conforms to the State Plan that HCA shall submit to CMS Health Care Finance Administration

Future State and Implementation:

Date	Activity	Responsible
August 2023 - ongoing	Work with all SMI AARTC applicants to assure CARF accreditation and BHSD certification	Behavioral Health Services Division (BHSD)
August 2023 - ongoing	Clarify Medicaid reimbursement and enrollment processes for acute care in hospital based IMDs for SMI	BHSD, Medical Assistance Division (MAD)
June 2024	Develop and disseminate a survey to all existing AARTCs, and IOP, programs to determine interest and capacity to open new facilities to primarily provide treatment for SMI.	BHSD
July 2024	Review and determine what necessary regulatory changes will be made to NMAC accreditation requirements to add AARTC facilities providing SMI treatment	BHSD & MAD
August 2024		BHSD & MAD

		August 2024	Work with actuarial firm, to develop criteria for reimbursement of SMI AARTCs	MAD & BHSD	
		August 2024	Develop and distribute a request for applications for SMI AARTCs	BHSD	
		August 2023 - ongoing	Work with all SMI AARTC applicants to assure CARF accreditation and BHSD certification	BHSD	
		December 2025	Update NMAC regulations to include SMI AARTC. Incorporate SMI AARTC into the BH Policy and Billing Manual.	MAD, BHSD	
		Ongoing as prospective providers are identified	Train all prospective provider ARTCs (serving youth) on trauma responsive care, nursing staff requirements, family participation, improved documentation, family-based after-care, detailed assessment, case planning, documentation, judicial determinations and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive title IV-E FCMPs for the placement.	CYFD	

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current State:** There are currently no Adult Accredited Residential Treatment Centers (AARTCs) for SMI. Managed care organizations (MCOs) currently do clinical oversight for acute care IMDs. The DOH current process for issuing and renewing annual licenses for psychiatric hospitals (IMDs) is as follows: • For new facilities, once application packet, policy and procedure manual and program narrative have been approved, and the building construction has been completed, an on-site Life Safety Code Inspection will be scheduled to determine if the facility is in compliance with the applicable DOH requirements, and able to accept residents or treat patients. If needed the life safety code surveyor will issue a letter of deficiencies that require correction before the facility license can be issued. • Upon successful completion of this Life Safety Code Inspection, the facility will be issued a temporary license. Facilities may then begin providing services to a limited number of patients/residents. • When the facility is in full operation and has served a sufficient number of patients/residents to implement their full range of services, they must make a written request to the district office for the initial health survey. • At the time of your initial health survey, the facility must have available Purified Protein Derivative (PPD) skin test certificates or chest x-rays results, for all staff who have any resident contact, and current licenses for all staff who are required to be licensed by the State of NM. Upon successful completion of your initial health survey, an annual license will be issued. • NOTE: The application, P&P and plan review are good for one-year, which begins from the date of receipt of application fee. At the end of the one-year period if a license has not been issued, the provider may be required to submit a new application and begin the process from the start. If providers must begin the process over, this will push their survey to the end of the schedule list. Joint Commission (JC) accreditation renewal occurs every three years and the Commission on Accreditation of Rehabilitation Facilities (CARF) issues initial accreditations in the terms of one-and three-year time spans, therefore, would be renewed based on the approval of the initial accreditation date. Additionally, BHSD conducts at least one unannounced site visit to each facility annually to ensure facilities are adhering to DOH State Licensing regulations, in addition to JC and CARF requirements.
	Future State The CYFD/LCA process described above will continue for child and adolescent ARTCs.

<table>
<tr><td></td><td>BHSD will certify adult AARTCs for SMI each year that are primarily certified to treat mental illness. They will make bi-annual site visits, and unannounced visits if issues are suspected. The agency produces their accreditation either annually or every 3 years, depending on the requirements of the accrediting body. HCA will transition to the Health Care Authority (HCA) on July 1, 2024. The Division of Health Improvement (DHI), previously a division of DOH, will transition to the HCA. DHI will be responsible for licensing AARTCs as residential psychiatric treatment facilities. The DHI offers facility licensing while BHSD certifies programs. The DHI will be an integral part of approving AARTCs.

Future State and Implementation

<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>October 2024</td><td>Develop criteria for adult AARTC SMI oversight</td><td>BHSD</td></tr>
<tr><td>December 2025</td><td>Incorporate AARTC SMI oversight policies into BH Policy & Billing Manual</td><td>BHSD, MAD</td></tr>
<tr><td>December 2026 & ongoing</td><td>Conduct annual audits for AARTCs for SMI</td><td>BHSD</td></tr>
</table>
</td></tr>
<tr><td>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</td><td>Current State

Utilization reviews for mental health services and substance use services are conducted through the MCOs for managed care recipients and the Department’s contracted third-party assessor (TPA) for fee-for-service (FFS) recipients.

8.308.21.17 UTILIZATION MANAGEMENT: A utilization management (UM) program is an organization-wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCOs have a UM program as described in the Medicaid managed care agreement services or the managed care policy manual.</td></tr>
<tr><td></td><td>Future State

The prior authorization and continued stay requirements for both psychiatric hospitals and AARTCs will be updated through the Clinical Policy Group, which is comprised of representatives from BHSD, MAD, CYFD, University of NM(UNM) and consulting services. They will incorporate use of the Level of Care Utilization System (LOCUS) and Child/Adolescent Level of Care utilization System (CALOCUS) for the assessment of Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) diagnoses and severity requiring acute care or residential care as well as the risk level for suicidality and medical necessity for either residential or hospital admissions. Once developed this will be used by the TPA for FFS beneficiaries, and the MCOs for both admitting and utilization review purposes.

The MCOs, and third-party assessor will monitor continued stay and discharge criteria to assure all beneficiaries are</td></tr>
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<tr><td></td><td>receiving the right level of care. NM contracts with a third-party assessor to ensure quality of care for FFS Medicaid recipients.

Additionally, CYFD is developing the Individual Planning Process to create a team-based approach for all CYFD involved youth when transitioning from congregate settings to community-based services.

CYFD will work in collaboration with BHSD to develop processes to include active family engagement in post-discharge services for children in or to ensure Family First Prevention Services Act requirements are met.

Please see table below for the proposed changes to RTC and ARTCs.</td></tr>
<tr><td></td><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>April-August 2025</td><td>Develop level of care criteria for admitting, continued stay, and discharge criteria for AARTCs, ARTCs and psychiatric hospitals based on age appropriate, Medicaid approved assessment tools</td><td>BHSD, CYFD</td></tr>
<tr><td>September 2025</td><td>Update prior authorization and continued stay requirements for both psychiatric hospitalizations and AARTCs and ARTCs and program in the Medicaid Management Information System (MMIS)</td><td>BHSD, CYFD, MAD</td></tr>
<tr><td>November 2025</td><td>Train the third-party assessor and MCOs on updated criteria.</td><td>BHSD, MAD, CYFD</td></tr>
<tr><td>December 2025</td><td>Complete SMI AARTC NMAC regulation and incorporate into the BH Policy and Billing Manual</td><td>BHSD, MAD</td></tr>
<tr><td>January 2026 – December 2029</td><td>Use new criteria for prior authorization for admitting, changing levels of care, and discharging from IMDs</td><td>MAD</td></tr>
</table></td></tr>
<tr><td>1.d Compliance with program integrity requirements and state compliance assurance process</td><td>Current State

Risk-based screening of newly enrolling providers is in accordance with the Employee Abuse Registry Act, 27-7A-3 NMSA 1978, the NM Caregivers Criminal History Screening Act, 2-17-2 et seq., NMSA 1978 and 7.1.9 NMAC, the NM Children’s and Juvenile Facility Criminal Records Screening Act, 32A-15-1 to 32A-15-4 NMSA 1978, Patient Protection and Affordable Care Act (PPACA), and ensures that all subcontracted and contracted providers are screened against the federal “list of excluded individuals or entities” (LEIE) and the federal “excluded parties list system” (EPLS)</td></tr>
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<tr><td></td><td>(now known as the system for award management (SAM)) and any other databases that may be required through federal or state regulation. CYFD LCA does not allow for any chemical restraint.

In accordance with 8.308.2 NMAC, participating providers must meet applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

In order to become approved with HCA to deliver these services, providers must have entered into Medicaid provider agreements pursuant to 42 CFR 431.107.</td></tr>
<tr><td></td><td>Future State

SMI/SED will be based upon the comprehensive assessment which is conducted or supervised by an independently licensed behavioral health practitioner and where clinical judgement is used for developing the plans. International Quality System Registrars (IQSR) reviews paired with, or in lieu of, regulatory compliance reviews will be conducted bi-annually.</td></tr>
<tr><td></td><td>Future State and Implementation

<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>August 2024</td><td>Review and edit current program integrity requirements for SMI/SED</td><td>CYFD & DOH</td></tr>
<tr><td>October 2024 - December 2029</td><td>Conduct site visits for review of compliance with developed standards and all relevant federal laws</td><td>CYFD & DOH</td></tr>
</table>
</td></tr>
<tr><td>1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</td><td>Current State
Currently, the state requires a full biopsychosocial assessment on admission to residential settings and hospitals that includes screening for physical health conditions, SUDs and suicidal ideation. When residential facilities apply for state certification, they must demonstrate that this screening takes place. BHSD conducts bi-annual site visits to AARTCs and reviews whether this screening takes place and whether AARTC staff require a co-occurring disorder assessment, both physical and psychiatric, as part of the admissions process in an IMD and a youth based residential treatment facility. If the IMD does not offer treatment for any of these conditions, they must render a referral to the appropriate provider. CYFD conducts annual site visits to youth ARTCs to ensure compliance with these processes.

All psychiatric hospitals conduct a full physical and psychiatric examination upon admitting which includes screening for physical health conditions, SUDs and suicidal ideation. The completeness of this process is monitored through</td></tr>
</table>

regular Joint Commission surveys and visits.

Future State

BHSD will conduct an initial visit and subsequent bi-annual visits for all new ARTCs that are licensed to treat mental illness to ensure compliance with screening and coordination of care for detected conditions. DOH will conduct annual health and safety site visits to psychiatric hospitals to ensure compliance with screening expectations.

BHSD will also require participating facilities to facilitate access to treatment for those conditions which cannot be treated at that facility through on-site staff, by either connecting beneficiaries to telemedicine and/or through partnerships with local physical health providers. BHSD will ensure these partnerships are in place through annual site reviews of new adult ARTCs. DOH will conduct site visits to psychiatric hospitals to ensure compliance with screening expectations.

Future State and Implementation

Date	Activity	Responsible
July 2023 - ongoing	On-site reviews of care plans and chart reviews to assess quality of care and to assure co-morbidities are being assessed and treated	BHSD, CYFD
December 2024	Develop training for all facilities for use and implementation of age appropriate, Medicaid approved assessment tools	BHSD
December 2025	Update NMAC and BH Policy and Billing Manual to clarify screening and referral requirements	BHSD, MAD, & CYFD

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current State** The BH Policy and Billing Manual covers beneficiaries of all ages and supplements the NMAC. It is developed by the Clinical Policy Group, which is comprised of BHSD, CYFD, MAD, UNM, and consulting services. This is a critical component related to quality of care because it outlines expectations of care, accepted practices, and billing mechanisms for each service. This document goes into greater detail than the NMAC. The DOH licensing rule 7.7.2.19 NMAC requires hospitals comply with CMS's patient rights condition of participation. Furthermore, the objectives of NMAC 7.7.2.6 state: E. Establish standards for licensing hospitals in order to ensure that hospital patients receive adequate care and treatment and that the health and safety of patients and hospital employees are protected. F. Establish standards for the construction, maintenance and operation of hospitals. G. Regulate such hospitals in providing the appropriate level of care for patients. H. Provide for hospital compliance with these requirements through surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the patients and staff. Adult AARTC's adhere to 8.321.2.11 NMAC and the BH Policy and Billing Manual. An ASAM based assessment must be conducted for all adult admissions for mental health treatment. If there is no history or reported current substance use the remainder of the assessment need not be executed. If there is substance use, admission criteria specific to each ASAM level must be utilized for both prior authorization purposes, and development of the treatment plan Program requirements: • Must be accredited as an adult (18 and older) residential treatment facility by the Joint Commission (JC), The Commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA) as an adult (18 and older) residential treatment facility. DOH licensure for AARTCs is pending. Until such time, certification from BHSD is a requirement before enrolling in Medicaid. Also required is correspondence with BHSD related to determining the reimbursement rate for the differing levels which are specific to an agency. BHSD will conduct bi-annual site visits.

<table>
<tr><td></td><td>Future State
Update NMAC and BH Policy and Billing to accommodate all changes. The state will updated licensing requirements for AARTC to include AARTC specific to SMI, updated discharge planning for IMDs, Division of Health Improvement (DHI) policy and procedure for facility oversight and monitoring of seclusion and restraints for adult services. CYFD LCA monitors use of seclusion and/or restraint if used by youth facilities.</td></tr>
<tr><td></td><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>December 2025</td><td>Update NMAC and BH Policy and Billing Manual to accommodate all changes relative to an SMI or SED primary condition</td><td>BHSD, CYFD, MAD</td></tr>
</table></td></tr>
<tr><td colspan="2">SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</td></tr>
<tr><td colspan="2">Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs must focus on improving care coordination and transitions to community-based care by taking the following actions.</td></tr>
<tr><td colspan="2">Improving Care Coordination and Transitions to Community-based Care</td></tr>
<tr><td>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</td><td>Current State
Pre-discharge planning begins at intake and continues through an episode of care. This planning must include community-based providers and the MCO care coordinators or the CareLink NM (CLNM) Health Home care coordinators.

MCO policies state that care coordinators (CC) must be knowledgeable of non-Medicaid behavioral health and physical programs and services statewide available to its members in order to facilitate referrals, coordinate care, and ensure transition to community-based services. Furthermore, care coordinators are required to participate in the discharge planning for beneficiaries transitioning from inpatient or residential to community-based care. Community based providers are included in the collaboration of care planning with the beneficiary, family members and child's guardian (including CYFD workers when children are in state custody), care coordinators and residential program or psychiatric hospitals to ensure appropriate placement of services.

NM has behavioral health homes in 10 counties for beneficiaries with SMI and SED, both children and adults. These CLNM Health Homes are available to FFS beneficiaries as well as MCO members. This is the only opportunity for the FFS beneficiaries to receive care coordination. One of the core services is comprehensive transitional care, i.e. taking a lead role in transitioning patients from differing levels of care. The CLNM Health Home policy manual states comprehensive transitional care activities include, but are not limited to:
• Participating in all discharge and transitional planning activities.</td></tr>
</table>

	• Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS), Tribal programs, and others to continue implementing or modifying the service plan as needed. • Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports. • Sharing critical planning and transition documents with all providers involved with an individual's care via web-based tools, secure email or hard copy. Both the MCOs and the CLNM Health Homes utilize Collective Medical's Emergency Department Information Exchange (EDIE) system which notifies the care coordinator of either an inpatient or emergency department admission so immediate action can be taken. Currently, NM implemented a statewide platform for adult behavioral health referrals called OpenBeds. This platform allows agencies, including psychiatric hospitals and residential settings, to update their information about real time capacity to accept new referrals.
	Future State The State has received a planning grant for development of Certified Community Behavioral Health Clinics (CCBHC) and was awarded the CCBHC Demonstration opportunity, which will support additional opportunities for FFS beneficiaries to receive care coordination for transitional services. Through the course of the waiver, the state will work with tribal liaisons through the Health Care Authority (HCA) to assess care coordination needs for FFS recipients. NM will help facilitate connections with existing CLNM Health Homes and CCBHCs to support care coordination. Additionally, tribal liaisons can work with local social workers and public health nurses employed through 638 tribal behavioral health entities to explore care coordination options for FFS members. The State will increase training for care coordinators: to assess clinical risk management and increase Comprehensive Community Support Services (CCSS) during transitions of care by providing ongoing training in CCSS across the state, continuing to revise and improve access to CCSS through 8.321.2 NMAC changes. The state will update the BH Policy and Billing Manual to describe expectations for all IMDs to conduct intensive pre-discharge planning and include community-based providers in care transitions. These activities will be reviewed during annual site reviews by the state. CYFD is creating the Individual Planning Process to develop a team-based approach for all CYFD involved youth when transitioning from congregate settings to community-based services. BHSD will continue to review and evaluate the OpenBeds platform that is currently in use.

Future State and Implementation

Date	Activity	Responsible
December 2024	Assess care coordination processes at IMDs during site reviews	BHSD & MAD
December 2024-ongoing	Work with tribal liaisons to facilitate connections with existing CLNM Health Homes and future CCBHCs to support care coordination for FFS recipients	BHSD & MAD
October - November 2025	Train all MCOs and CLNM Health Home care coordinators on new IMD discharge policies	BHSD & MAD
December 2025	Update NMAC and BH Policy and Billing Manual with language to clarify new expectations for care coordination to community-based care for all IMDs	BHSD & MAD
December 2025	IPP policies will be in place for CYFD involved youth when transitioning from congregate settings to community-based services	CYFD
December 2025	Track all 7-day follow-up metrics and develop CQI procedures to improve results	BHSD

2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.

Current State

Coordination with housing services is part of care coordinators' responsibility which includes both MCO care coordinators and CLNM Health Home care coordinators. NM does provide supportive housing for SMI beneficiaries. Care coordinators assess housing status for all Medicaid managed care recipients at time of intake and re-assess this status of members upon discharge from an IMD. This assessment is done through the Care Needs Assessment (CNA). This assessment is conducted annually and individuals are re-assessed at times of transition from higher levels of care. When someone is identified to be precariously housed, care coordinators work with state network of provider agencies associated with the Linkages Supportive Housing Program to identify options for supported housing. Additionally, housing status is assessed by all IMDs upon intake through the biopsychosocial assessment. There is no current care coordination for FFS beneficiaries, except in CLNM Health Homes. The Health Homes coordinate housing for their members as needed. As described above, they assess housing status as part of the CNA and work with the state network of Linkages providers to address identified housing needs.

Future State

We will leverage Certified Peer Support Workers (CPSWs) with housing certifications (housing credential) to ensure that psychiatric hospitals, residential settings, and CCBHCs assess beneficiaries housing situation and

coordinate housing services. Currently 117 CPSWs hold a housing certification. The State intends to offer ongoing training opportunities for CPSWs to obtain the housing certification.

HCA will update NMAC and the BH Policy and Billing Manual to clarify expectations that IMD facility staff will coordinate with CCBHCs and housing service providers who have SSI/SSDI Outreach, Access, and Recovery (SOAR) workers and connect them with FFS beneficiaries who are experiencing, or are at risk of, homelessness. If a SOAR worker is not available, coordination will be conducted between facility and housing service provider to ensure a Vulnerability Index - Service Prioritization Decision Assistance Tool (VISPDAT) assessment is completed to ensure beneficiary is entered into the Homelessness Management Information System (HMIS) which is used across the state by numerous agencies. The VISPDAT is a survey administered to both individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons; training is offered to social service agency workers, housing service providers and any other provider who is interested in becoming trained to conduct assessments. The effectiveness of these coordination efforts will be assessed through annual site visits to IMDs.

Future State and Implementation

Date	Activity	Responsible
January 2025 - ongoing	Train SMI/SED facilities on working with CPSWs based on the requirements in the BH Policy and Billing Manual	BHSD, Office of Peer Recovery and Engagement & Contract Agency
December 2025	Update NMAC and BH Policy and Billing Manual to clarify requirement that IMDs must coordinate with local housing providers	MAD & BHSD
December 2025	Communicate new expectations that IMDs coordinate with housing providers through multiple channels including through the NM Hospital Association, Provider Alerts and through Managed Care	MAD & BHSD
July 2026	Commence annual site visits to IMDs to assess coordination with housing providers	BHSD

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	**Current State** There is no regulation for the hospitals or residential settings to this effect. However, MCO policy dictates: "Transitions of Care for Members Moving from a Higher LOC to a Lower LOC. The MCO shall develop and implement policies and procedures for ensuring that members transition successfully from higher levels of care (e.g., acute inpatient, residential treatment centers, social detoxification programs, treatment foster care, etc.) to the most appropriate lower LOC. Transitions from inpatient and BH residential treatment facilities for both children and adults must be addressed. At a minimum, the following must be addressed: • Maintain on-going communication, enlist the involvement of and coordinate with state-run facilities to monitor and support their participation in the member's care. • Care Coordinators must be knowledgeable of non-Medicaid BH and PH programs/services, statewide, available to its members in order to facilitate referrals, coordinate care, and ensure transition to community-based services. • Ensure members receive follow-up care within seven 72 hours after discharge" CLNM Health Home policy manual for SMI/SED states: "Comprehensive transitional care activities include, but are not limited to: • Supporting the use of proactive health promotion and self-management; • Participating in all discharge and transitional planning activities; • Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services, Tribal programs and others to continue implementing or modifying the service plan as needed; • Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports; and • Sharing critical planning and transition documents with all providers involved with an individual's care via web-based tools, secure email or hard copy."
	Future State CYFD will work with BHSD on development of processes to include active family engagement in post-discharge services for children in order to meet Family First Prevention Services Act requirements.
	NM will implement a requirement that mandates staff from the facility who is discharging the beneficiary, follow up with FFS beneficiaries and to the community-based provider(s) they were referred to, within 72 hours post discharge, through most effective means possible. HCA will update the BH Policy and Billing Manual with these expectations. Furthermore, if the discharging facility is registered in OpenBeds, they will be required to utilize that system to make and follow up on behavioral health referrals. Currently all adult behavioral health and SUD providers certified through BHSD are required to use OpenBeds, however, medical facilities and health clinics are

<table>
<tr><td></td><td>not included in that system and therefore would require follow up through phone, email or other secure communication means.

Future State and Implementation

<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>December 2025</td><td>Clarify in BH Policy and Billing Manual that IMDs must follow up with FFS beneficiaries and the community-based provider(s) they were referred to within 72 hours of discharge</td><td>BHSD, MAD</td></tr>
<tr><td>December 2025</td><td>Train all MCOs and agencies on use of certified and credentialed BH professionals during transition</td><td>BHSD</td></tr>
<tr><td>July 2027</td><td>Commence site visits to ensure that IMDs are following up with FFS beneficiaries within 72 hours of discharge</td><td>MAD & BHSD</td></tr>
</table>
</td></tr>
<tr><td>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</td><td>Current State
CLNM Health Homes promote self-management of members' chronic conditions and encourage them to call their care coordinator if they believe they need emergent help. They also utilize the PRISM system to alert CLNM providers to high utilizers of the emergency department (ED) so that they can work with these members. MCO care coordinators also reach out to members who have high utilization of ED and inpatient hospitalization to identify health needs and available community-based resources that can provide more support. At this time, the state does not have access to local electronic health records to identify high utilizers of ED/ hospital services.

The integration of CPSWs in the ED helps facilitate transfer to community-based services or IMDs when indicated. NM is in process of exploring the feasibility of adding more CPSWs to ED settings.

We currently have 3 approved crisis triage centers (CTCs) aimed at diverting beneficiaries from ED, hospital stays and incarceration. There are several others in the pipeline.

Alongside the launch of 988, the new crisis hotline, the State of NM has also begun implementation of the Crisis Now model to build out the state's crisis response care system. BHSD is currently working closely with four providers in various locations throughout the state to support their efforts in developing Mobile Crisis Teams (MCT), led by behavioral health professionals to aid in jail and ED diversion, and incorporating the use of peers on teams.

Furthermore, BHSD is developing the crisis care infrastructure based on the National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit created by SAMHSA. NM's Crisis Now Continuum of Care currently offers support to anyone experiencing a mental, emotional or substance use related crisis whether they are a beneficiary or FFS and crisis services will be available to anyone in need, despite insurance status.</td></tr>
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Future State

NM is in the process of enhancing its system of care for mental health crises. NM will be expanding mobile crisis teams and crisis triage centers which will provide alternatives to the ED for individuals with psychiatric emergencies and potentially reduce ED volume. Additionally, NM has implemented the 988 hotline for behavioral health crises which includes follow up and referral to treatment for callers.

CYFD is developing Mobile Response and Stabilization Services (MRSS) to meet youth & family needs. MRSS will be integrated with 988 Hotline services in NM.

NM continues to work towards implementing MCTs and CTCs which will provide alternatives to the ED for individuals with psychiatric emergencies. BHSD released a statewide Request for Applications (RFA) for MCTs and will be working with the four sites as they launch their MCTs. MCTs are dispatched through the State's 988 crisis call center in real time through an electronic tool utilized by both the crisis call center and participating MCTs.

In October 2022, BHSD released a statewide RFA for Alternative CTC models aimed to serve rural and frontier communities. This was a rolling RFA and one agency has recently applied for consideration. Planning and service delivery funding is available for agencies to apply for and develop one of the two models below:

- The Community Crisis Partner (CCP) model is a behavioral health pathway embedded in an ED. If after being screened by medical personnel that it is determined the beneficiary is experiencing a mental, emotional or substance use crisis, and their physical health is stable, a BH professional would be called to assess the individual to determine the most appropriate next steps to deescalate the crisis. One frontier community is already in the implementation phase of this Alternative model.

- The second model in the RFA is the Community Calming Center (CCC), which would be a 23-hour time limited stay at a facility which provides the beneficiary a quiet, safe and secure place to deescalate from their crisis and other appropriate supports to assist in stabilization.

Future State and Implementation

Date	Activity	Responsible
December 2023-	Continue to add CTCs regionally for a goal of six with alternative crisis support in between those centers, such as MCT and MRSS.	BHSD, CYFD

		December 2027			
		2023-2029	OPRE will prepare a situation report regarding the cost and feasibility of placing more CPSWs in ED settings	OPRE	
		April 2023-December 31, 2029	Create and expand MCTs as part of the 988 initiative	BHSD	
2.e Other State requirements/policies to improve care coordination and connections to community-based care	**Current State** All state initiatives have been discussed in other sections.				
	Future State N/A				
	Future State and Implementation N/A				

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions. CYFD is developing MRSS to meet youth & family needs. MRSS will be integrated with 988/Crisis Now services in NM.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and	**Current State** In 2011, NM passed the NM Health Care Work Force Data Collection, Analysis and Policy Act which requires all health professional licensing boards to collect a core essential data set and establishes a state healthcare workforce committee which oversees annual analysis of this data and develops recommendations to the legislature to improve access to health professionals. The annual NM Healthcare Workforce report includes a chapter analyzing behavioral health professionals across the state which includes psychiatry, psychology, psychiatric nursing, social work, and counselors as well as practice locations including community mental health centers and FQHCs. **Future State** Submit an annual assessment and report on Medicaid utilization across the system of care (outpatient, inpatient, residential, crisis, etc.) using the required CMS reporting template.

<table>
<tr>
<td>FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.</td>
<td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>June 2025</td><td>UNM will submit an annual assessment and report on Medicaid utilization across the system of care (outpatient, inpatient, residential, crisis, etc.).</td><td>UNM</td></tr>
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<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">3.b Financing plan</td><td>Current State
The Budget Planning and Reporting Bureau of the Medical Assistance Division (MAD) of the Healthcare Authority (HCA) maintains projected budgets and actual expenses for each service type. They also maintain budget neutrality for the 1115 demonstration. Please see Milestone 5.</td></tr>
<tr><td>Future State
Incorporate all new initiatives into the budget.</td></tr>
<tr><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>December 2023-December 2029</td><td>Incorporate all new initiatives into the budget</td><td>HCA</td></tr>
</table></td></tr>
<tr><td rowspan="3">3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds</td><td>Current State
The State is currently contracted with OpenBeds to maintain a website that tracks availability of adult inpatient and crisis stabilization beds in real time. NM has three CTCs, five psychiatric hospitals, and nine psychiatric units in acute hospitals. All providers in the state have access to OpenBeds and 74 agencies are accepting referrals.

Additionally, OpenBeds has been included in all contract deliverables with all behavioral health providers who are contracted with BHSD, and continuous support is being offered to providers to assist them with overcoming any challenges they may be facing while utilizing the system.</td></tr>
<tr><td>Future State
Add additional residential and non-residential CTCs as well as implement real-time tracking of in-patient and crisis stabilization bed availability through OpenBeds.</td></tr>
<tr><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>December 2023 and ongoing</td><td>Add additional residential and non-residential CTCs</td><td>BHSD, CYFD, DOH</td></tr>
<tr><td>December 2025</td><td>Implement real-time tracking of psychiatric bed availability through OpenBeds</td><td>BHSD</td></tr>
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<table>
<tr>
<td rowspan="3">3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</td>
<td>Current State
IMDs must conduct all necessary psychological tests and assessments to determine appropriate care.</td>
</tr>
<tr>
<td>Future State
Development of NM standardized tool for assessment of SMI/SED: NM will develop an aligned version of Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) for SMI and Child and Adolescent/LOCUS for SED individuals.

BHSD will update provider certification criteria in the BH Policy and Billing Manual to include required use of age appropriate, Medicaid approved assessment tools such as LOCUS assessment for adults, Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS) for youth under the age of 18,

The LOCUS is a tool that can be used in a wide variety of settings, to include both mental health and addictions, and is able to distinguish appropriate needs and services in a sensitive manner. Some key areas that the assessment covers include: Risk of Harm, Functional Status and Medical, Addictive and Psychiatric Co-Morbidity, which makes it an ideal assessment while working with beneficiaries who may be receiving treatment in psychiatric hospitals or residential settings.</td>
</tr>
<tr>
<td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>August-December 2024</td><td>Implement provider training on use of the of LOCUS and CALOCUS</td><td>BHSD, CYFD</td></tr>
<tr><td>August 2025</td><td>Finalize rate development for Level of Care Assessments</td><td>BHSD, MAD</td></tr>
<tr><td>December 2025</td><td>Integrate utilization of LOCUS and CALOCUS into the BH Policy and Billing Manual as required.</td><td>BHSD, MAD</td></tr>
<tr><td>December 2025</td><td>Release provider instructions and a Letter of Direction to MCOs with new assessment expectations and rates.</td><td>BHSD, MAD</td></tr>
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Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	**Current State** All state initiatives have been discussed in other sections.
	N/A
	N/A
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported education programs	**Current State** NM Medicaid pays for coverage for permanent supportive housing pre-tenancy and tenancy support services (PSH-TSS) to an eligible recipient enrolled in a MCO to facilitate community integration and contribute to a holistic focus on improved health outcomes, to reduce the negative health impact of precarious housing and homelessness, and to reduce costly inpatient health care utilization. Services include, but are not limited to, pre-tenancy services including individual housing support and crisis planning, tenancy orientation and landlord relationship services as well as tenancy support services to identify issues that undermine housing stability and coaching, education and assistance in resolving tenancy issues for an eligible recipient who has a serious mental illness and is enrolled in a Medicaid MCO. Supportive housing programs provide services for those who are homeless, therefore identifying and engaging beneficiaries early on. Early identification in the supportive housing program improves overall health and reduces the costs of other publicly funded services such as crisis services, shelters, hospitals, jails, prisons, etc. MAD and BHSD are participating in a national learning collaborative hosted by CMS to improve access to housing related supports for individuals with substance use disorders. NM also has a school-based health center program run through the DOH. Students who receive physical or behavioral health care through these settings receive an extensive standardized assessment to identify their risk of behavioral health conditions. When students are assessed to be at risk for a behavioral health condition, they are referred to School Based Health Center therapists by the School Based Health Center Coordinator. NM does not have a supported employment program through Medicaid although supported employment activities are included in Psychosocial Rehabilitation programs and through the Coordinated Specialty Care model for First Episode Psychosis (FEP) which is funded through the state block grant. At this time, there are no other supported education/ employment programs funded by other agencies or through other funding sources.

NM SBIRT, which includes screening for mental health symptoms, can be implemented in pediatric care office. and NM Medicaid provides coverage for a warm hand off to a local behavioral health provider for children who are assessed to need behavioral health treatment. It is at the practitioner's discretion to administer SBIRT.

CYFD has developed a Certified Youth Peer Support Worker (CYPSW) initiative– CYPSWs must be 18 or older and have personal experience navigating any of the child/family-serving systems prior to the age of 18 years. They must also understand how the systems mentioned above in the current section operate in NM and have received certification as a CYPSW.

CYFD has finalized the training and certification process for CYPSW who will assist youth under 18 in navigating the child/family-serving systems.

NM is also implementing the CCBHC model, which went live on 1/1/25. CCBHCs must provide screening and psychiatric rehabilitation. Screening assists with the early identification of SMI and SED and the psychiatric rehabilitation efforts include a focus on the development of supported employment and education efforts. Finally, NM currently reimburses for mental health screening to facilitate early identification of SMI/SED with validated instruments. These screenings can be conducted in a range of settings and by non-physicians. However, the implementation of this screening has been varied. NM will prioritize clarifying the use of screening in the BH Policy and Billing Manual.

Future State
As explained in Milestone 2., section a, NM certified five CCBHCs across the state through the CCBHC Demonstration program which went live on 1/1/25. CCBHC certification includes expectations for provision of screening, supported employment, and supported education. Five CCBHC have been certified by HCA and CYFD and began providing services to their respective communities January 1, 2025.

Screening for individuals at risk for SMI/SED will be required by all CCBHCs.

Future State and Implementation

Date	Activity	Responsible

<table>
<tr><td></td><td></td><td>December 2025</td><td>Update NMAC and BH Policy and Billing Manual to implement CCBHC clarify expectations for screening for SMI/SED.</td><td>BHSD and MAD</td><td></td></tr>
<tr><td>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</td><td colspan="5">Current State

The NM Screening Brief Intervention and Referral to Treatment (SBIRT) model uses the Health Lifestyle Questionnaire which includes screening for anxiety, depression and trauma in addition for SUD. It is delivered in physical health settings, and a positive result yields a brief intervention by a trained clinician and, when more serious illness is suspected, a referral to a behavioral health professional. At this point a diagnostic psychiatric evaluation is conducted which would indicate if a SMI or SED is present. The NM SBIRT model does provide coverage for the physical health care provider to conduct a warm hand off to a local behavioral health provider for individuals who are assessed to need ongoing behavioral health treatment. NM incorporated interdisciplinary teaming, as a reimbursable service, into the NMAC and BH Policy and Billing Manual. Interdisciplinary teaming encourages collaboration between clinicians including primary care and behavioral health clinicians. NM does not currently have coverage for Collaborative Care models.

Many of the State's FQHCs have incorporated multiple behavioral health specialties into their agency which were previously focused primarily on physical health. The same is true of many of our Medical Homes and our Tribal 638 clinics. According to the NM Primary Care Association, NM has 125 community health clinics that provided integrated behavioral health and provided care of 141,808 behavioral health patients in 2021. At this time, NM does not have specific plans to expand these clinics.

Future State
BHSD will contract with a trainer to provide training to physical health care providers in the use and implementation of SBIRT.
HCA will analyze projected utilization and budget impact to determine if the state will submit a SPA to incorporate Collaborative Care Following SPA approval HCA will prepare policies and update the BH Policy and Billing Manual regarding the use of Collaborative Care in primary care settings.

Future State and Implementation

<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>2025</td><td>Provide training and technical assistance in SBIRT</td><td>BHSD</td></tr>
<tr><td>2025</td><td>Complete situation report regarding the implementation of the Collaborative Care model in NM</td><td>BHSD/ MAD</td></tr>
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Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current State** NM has developed Community Crisis Services which can be delivered in any outpatient setting for beneficiaries of all ages. Services that are covered are: • A crisis assessment (immediate and ongoing); • Peer support as navigation services or self-help support; • Nursing behavioral health assessment; • Skilled services of an RN for observation & assessment of a patient's condition; • Psychiatric diagnostic evaluation; • Psychotherapy for crisis; and • Oral medication administration and direct observation for suboxone. • NM provides Coordinated Specialty Care for individuals with First Episode Psychosis through a partnership with the University of NM which provides services through in person and telehealth We have also developed regulations, policies and a financial structure for our three CTCs which are licensed by DOH and reimbursed by Medicaid. They can be either outpatient only or outpatient and residential with no more than 15 beds. BHSD is hosting a learning collaborative for CTCs to improve their clinical practices. Currently, there are no CTCs that focus on crisis stabilization for young people experiencing SMI/SED. CYFD developed High Fidelity Wraparound (HFW) for children with SED. These have either been stand-alone or incorporated into NM's CLNM Health Homes. There are currently 10 HFW providers one agency in each county listed below, aside from Bernalillo county, which has two. The counties are Bernalillo, Chaves, Dona Ana, Lea, McKinley, Roosevelt, San Juan, Sandoval, and Valencia. There were ten provider sites providing HFW services prior to July 1 (through varying funding). Six of the ten sites have transitioned to Medicaid and bill Medicaid. NM has also launched a website to provide information about HFW. NM does have an extensive network of school-based health centers which offer behavioral health services. CLNM Health Homes are required to serve the lifespan and are located in community-based agencies that provide behavioral health services for youth with SED. NM has updated 8.321.2 NMAC to incorporate evidence-based practices. NM has updated the BH Policy and Billing Manual to incorporate evidence-based practices.

	Future State CYFD has developed a plan to allow reimbursement for HFW which will allow expansion to further sites. Over the course of the demonstration, New Mexico will have HFW available in all counties. Four HFW sites are still to transition to Medicaid and working with the State on requirement adherence. Seven new provider sites will be set up in Curry County, Quay County, De Baca County, San Miguel, Mora Counties, Valencia, and Socorro Counties. After these providers are active and receiving monitoring and oversight, the State will continue to assess network needs for the covered services to ensure coverage statewide. The State continues provider outreach to engage in HFW. The State will work through MCOs and FFS to ensure monitoring and oversight of this Medicaid covered service. HCA and CYFD are expanding training for evidence-based programs for all children with SED, including those in State custody. The SPA was approved by CMS on February 5, 2024. These programs are: • Dialectical Behavior Therapy; • Multisystemic Therapy; • Eye-Movement De-sensitization and Re-processing; • Functional Family Therapy; and • Trauma-informed Cognitive Behavioral Therapy. NM will offer enhanced reimbursement to providers who meet fidelity requirements for the delivery of these evidence-based practices. NM will develop certification standards for providers who meet these enhanced fidelity requirements. NM submitted the SPA to request permission to provide enhanced reimbursement to providers delivering these EBPs to fidelity and is in the final stages of approval. The state will update 8.321.2 NMAC to incorporate the evidence-based practices above with an effective date of August 2024. Then, NM will update the BH Policy and Billing Manual to provide guidance on the fidelity expectations when delivering this array of evidence-based practices for youth. NM will provide training in these evidence-based practices. NM has certified five CCBHCs and will certify additional CCBHCs (in alignment with CCBHC Demonstration requirements), who are required to deliver community-based services to youth with SED and young adults with SMI. This includes the provision of crisis stabilization services, mobile response services, respite, IOP, among the other required CCBHC services. One of NM's CCBHCs is a traditionally youth-serving organizations. A second traditionally youth-serving organization is currently seeking CCBHC certification. CYFD will participate in monthly CTC Learning Communities where they will provide education and support to agencies seeking to launch youth focused CTCs. Further, CYFD and HCA will continue to outreach to providers to build additional capacity for this service.

<table>
<tr><td></td><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>July 2025 and ongoing</td><td>Conduct provider outreach and training to continue to expand the HFW program.</td><td>CYFD</td></tr>
<tr><td>June 2026</td><td>Transition all 10 HFW sites to Medicaid billing</td><td>CYFD and MAD</td></tr>
<tr><td>June 2026</td><td>Coordinate training for providers in evidenced-based practices for youth with SED</td><td>CYFD</td></tr>
<tr><td>2025-2027</td><td>Explore interest among CTC providers in developing CTC with focus on youth with SED. Aim to develop at least one CTC with a focus on youth with SED during this period.</td><td>CYFD</td></tr>
<tr><td>2025-2027</td><td>Include CYFD in ongoing Learning Community for CTCs to provide education on adaptations needed for youth</td><td>BHSD</td></tr>
</table></td></tr>
<tr><td rowspan="3">4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</td><td>Current State

All state initiatives have been discussed in other sections.</td></tr>
<tr><td>N/A</td></tr>
<tr><td>N/A</td></tr>
</table>

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**Current State** No coordinated, collaborative state-wide crisis response currently exists. We have 988 and a NM crisis line which has many referral agencies. There are also regional collaborative services. Alongside the launch of 988, the State of NM has also begun implementation of the Crisis Now model to build out the state's crisis response care system. BHSD is currently working closely with four providers in various locations throughout the state to support their efforts in developing MCT, which will be led by behavioral health professionals to aid in jail and ED diversion, and incorporate the use of peers on teams. MCTs will be dispatched through the State's 988 crisis call center in real time through an electronic tool utilized by both the crisis call center and participating MCTs. BHSD is developing the crisis care infrastructure based on the National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit created by SAMHSA. NM's Crisis Now Continuum of Care currently offers support to anyone experiencing a mental, emotional or substance use related crisis whether they are a beneficiary or FFS and crisis services will be available to anyone in need, despite insurance status. Through the 988/Crisis Now initiative, NM is focusing on the adoption of the Crisis Now model and has developed workgroups to support the implementation of CTCs, MCTs, and streamlining processes to crisis call centers. NM received a congressional directed spending allocation to support new implementation of mobile crisis teams and CTCs that are consistent with the Crisis Now model. BHSD staff have released RFAs for these awards. NM also received the 988 Call Center grant from SAMHSA to support workforce development and streamlining processes to crisis call centers. BHSD has oversight of the SAMHSA call center grant and is meeting these deliverables. BHSD has also contracted with an external consultant to develop a strategic plan to support statewide transition to Crisis Now model. The State of NM also has three active CTC operating which offer an alternative to ED use for people in crisis in those locations and will also work in conjunction with the 988 crisis call center and participating MCTs. There are 6 sites implementing the Law Enforcement Assisted Diversion model (LEAD) in tribal and non-tribal jurisdictions LEAD is a public safety program that provides a tool for police officers to divert individuals suspected of low-level non-violent crimes rooted in substance use disorder and other unmet behavioral health needs to community-based services and treatment in lieu of arrest, prosecution, and incarceration. We also have a grant from the Federal Emergency Management Agency to address the increasing behavioral health

	needs of New Mexican's homeless/justice involved populations impacted by the COVID-19 pandemic. Many of these individuals suffer from SED or SMI. The crisis counselors help to calm the individual's fears and concerns due to the pandemic and coordinate the transfer of care to behavioral health resources and treatment providers. NM has updated 8.321.2 NMAC and the BH Policy and Billing Manual to incorporate mobile crisis services. Additionally, BHSD has approved four Medicaid-enrolled mobile crisis team providers.
	Future State The state continues to implement the 988 hotline, MCTs, and CTCs. CYFD is developing MRSS to meet youth & family needs. MRSS will be integrated with 988/Crisis Now services in NM. The 988 initiative will be critical in helping to advance the crisis system of care in NM. NM continues to work towards expanding MCTs and CTCs which will provide alternatives to the ED and jails for individuals with psychiatric emergencies. Two agencies are working with BHSD to launch MCTs. One MCT is operational in a rural community. Two additional urban MCTs are anticipated to be operational in December 2024. A 4th rural community is in the planning stages and will be considered for funding in CY 2025. All CCBHC sites will have MCTs in operation as part of CCBHC implementation. In late 2022, BHSD released statewide RFAs which would provide planning and service delivery funds for behavioral health led MCTs and Alternative CTC models aimed to serve rural and frontier communities. The RFA for Alternative CTC models include planning and service delivery funds for one of the two models below: • The Community Crisis Partner (CCP) model is a behavioral health pathway embedded in an ED. If after being screened by medical personnel that it is determined the beneficiary is experiencing a mental, emotional or substance use crisis, and their physical health is stable, a BH professional would be called to assess the individual to determine the most appropriate next steps to deescalate the crisis. One frontier community received funding through BHSD and is implementing of this Alternative model. NM has an additional rural community who is contemplating this model and is in the planning phase and hopes to make one additional award in 2025. • The second model in the RFA is the Community Calming Center (CCC), which would be a 23-hour time limited stay at a facility which provides the beneficiary a quiet, safe and secure place to deescalate from their crisis and other appropriate supports to assist in stabilization. NM does not currently have a calming center in operation and has not identified potential sites. In conjunction with the national consultant, NM will continue to provide support and education around the 988 system of care and will recruit CCC sites over the next 4 years.

<table>
<tr><td></td><td>Additionally, CYFD is developing MRSS to meet youth & family needs and are developing plans for pilot sites to launch in 2024-2025. MRSS will be integrated with 988 Hotline services in NM. This implementation has been delayed and has engaged with a national consultant to assist with the implementation of MRSS and the crisis continuum. The number of new MRSS teams will be determined after consultation with the consultant. The Medicaid rate and service definitions for this service has been developed.

The state will update 8.321.2 NMAC and the BH Policy and Billing Manual to incorporate mobile crisis services.</td></tr>
<tr><td></td><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>October 2025</td><td>CYFD will deploy 1 MRSS team at each of its 3 federal grant sites.</td><td>CYFD</td></tr>
<tr><td>2025 through July 2029</td><td>Implementation of crisis stabilization centers, including CTCs. There are three current centers, with a need of a minimum of 6 for one in every public health region.</td><td>BHSD</td></tr>
</table></td></tr>
<tr><td>F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</td><td>Current State
NM has FQHCs throughout the state that provide behavioral health services in 125 locations to youth and adults. Primarily the FQHCs provide outpatient therapy and medication management. Many of the FQHC sites integrate physical and behavioral health. NM also has 19 community mental health centers that deliver community-based behavioral health care. These services include outpatient behavioral health, recovery services such as peer support and comprehensive community support services (CCSS) as well as intermediate levels of care such as Intensive Outpatient Treatment (IOP). There are currently 7 ACT teams in NM that deliver care to individuals with SMI. We also have 10 CLNM Health Homes for SMI/SED. We currently have no partial hospitalization programs. We are exploring expansion of CLNM Health Homes and have developed criteria for CCBHCs. We are also exploring the benefits and costs of adopting the Collaborative Care reimbursement codes to expand behavioral health services in integrated care settings. NM received a CCBHC planning grant from SAMHSA and submitted a CCBHC Demonstration grant application in March 2024. NM’s CCBHC Demonstration program went live January 1, 2025 with five CCBHCs. NM has developed CCBHC NMAC regulations.</td></tr>
<tr><td></td><td>NM will focus on the expansion of CCBHCs to provide comprehensive community based behavioral health services to individuals with SMI and SED. As stated above, NM submitted a proposal to SAMHSA in March 2024 and HCA received notice of New Mexico’s successful entry to the CCBHC Demonstration program. NM has certified 5 CCBHCs and successfully implemented the model on 1/1/25. NM looks forward to enrolling additional sites/locations in future demonstration years.</td></tr>
<tr><td></td><td>Future State and Implementation
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>December 2025</td><td>Assess the potential costs and benefits of adopting collaborative care codes</td><td>BHSD/MAD/CYFD</td></tr>
</table></td></tr>
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		September - November 2025	Review and re-certify Demonstration Year 1 sites. Enroll and certify new CCBHC sites for Demonstration Year 2 implementation (1/1/2026)	BHSD/MAD/CYFD	

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
The state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan describes, among other items, the: 1. Interoperability, build and maintain interfaces to connect health care facilities and providers as data sharing organizations with the HIE, 2. Clinical Portal – Secure online access to the longitudinal CDR to share encounters, diagnose, clinical notes, laboratory results, imaging reports and diagnostic quality images, medications, Advanced Directives and M.O.S.T forms and access to the National eHealth Exchange. 3. Maintain and manage an Enterprise Master Patient Index (EMPI) to identify individuals across systems, settings, and populations sharing data with the HIE to create a single, unified CDR. 4. Insights for Substance Use Disorder, Hepatitis C, Mental Health Insights, and other priorities. 5. Alerts and notifications for hospitalization, 6. Access to population health, data analytics and National eHealth Exchange. Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	**Current State** NM has an established health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives. The state's health-IT infrastructure includes, but is not limited to: 1. Development of new use cases and to operate and maintain the infrastructure of the state designated Health Information Exchange (HIE) that supports the administration of the Medicaid Program, Medical providers and Medicaid Managed Care Organizations (MCOs). 2. HIE will securely exchange digital data from medical, behavioral, and social service providers to create a longitudinal clinical data record (CDR) for individual patients. In addition to CDR, 3. HIE offers core solutions to provide health information at the Point of Care, solutions to improve Population Health and Quality; and a blend of health records, claims data, and Social Determinants of Health (SDOH) to inform Policy and Strategic Planning. 4. HIE will develop annual strategic priorities aligned with HCA goals. 5. HIE will provide the Agency with the project list and schedule to meet its annual strategic priorities. 6. HIE will develop software, security and attribution modifications, ETL and Export Modification, and deploy the visualization of CCBHC Measures in a custom dashboard.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	**Future State** The state of NM is currently working to implement an enterprise solution for our MMIS and other systems as part of our HHS 2020 project. This process includes alignment of our SUD HIT plan with our larger State HIT plan. NM is on target to comply with the implementation of the PDMP as part of the enterprise solution with the anticipated completion date prior to January, 2026. As the data collection components of the CCBHC program are integrated into the HHS 2020 project, however additional work is ongoing. NM is working with its Board of Pharmacy to implement a web-based electronic database that aids in the reporting of dispensed controlled substance prescriptions Prescription Monitoring Program (PMP). This will allow practitioners, pharmacists, and other authorized users the ability to review a patient's-controlled substance prescriptions history and assist in the prevention of diversion, abuse, misuse, and drug overdose deaths associated with controlled substance prescriptions. The State Medicaid HIT Plan (SMHP) is currently being updated and the state is ensuring that there is alignment among the HIE Plan, the SMHP, and this demonstration application.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	**Future State and Implementation** NM's interoperability efforts adhere to and/or are in direct alignment with federal guidance. As illustrated in the state-wide strategic HIE Plan, NM continues to demonstrate success in all strategic planning on architecture and standards set forth by CMS and the Office of the National Coordinator. NM has received approved HITECH funds to support an assessment to: • Upgrade and enhance the state HIE, NM Health Information Collaborative (NMHIC); • Build infrastructure and capacity for Federally Qualified Health Center (FQHC) data exchange and integration to the HIE (FQHC Connectivity); • Piloting telemedicine infrastructure that integrates with the HIE for data-sharing; • Support NM Department of Health involvement in HIE development to support public health activities; • Continued access to patient data and coordination of care in emergencies; • Support Public Health registry reporting through enhancements to the immunization registry and the development of electronic case reporting (eCR) capability; and • Support for an Enterprise HITECH project management office within HCA. The HIE Plan, currently being updated, to integrate the PDMP and Health Information Exchange data.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	**Current State** Closed loop referrals and e-referrals are not currently supported.
	Future State The objective is to drive awareness and enable better care coordination for individual's holistic mental health needs across acute and ambulatory settings. With a goal of providing a process to ensure there is continual collaboration and transparency around patient-consented sensitive information and assist with the clinical and administrative protocol across diverse stakeholders to drive better patient outcomes. Additionally, the goal would be to increase follow up visit compliance after a hospitalization for mental/behavioral health and drive awareness of associated comorbidities. The initial stakeholders identified include, but may not be limited to, acute care (ED), social workers, case managers, behavioral health clinics and social services, which would have platform access. Some of the data elements which may be needed include diagnosis, prescription and CPT information. Access to behavioral health scheduling is a plus but not required. Consent models and platforms to support 42 CFR Part 2 logic and compliance with NM specific consent regulations are needed as well as access to behavioral health crisis plans and notes. Emergency department dashboards and alerting and access by behavioral health providers to the prescription drug monitoring program. This will allow a Closed loop and e-referral system to be supported and sustained.
	Future State and Implementation With funding through this collaborative HIE partnership, Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as Closed loop and e-referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.

Date	Activity	Responsible

		2025-2029	Expand to at least ten other health conditions of high value to New Mexico; these will be selected and prioritized from a stakeholder-generated list. In some cases, these data will blend with Collective's Mental Health and Substance Use Disorder use cases to identify and target unaddressed and under-addressed physical health needs of high-risk behavioral health patients.	BHSD/MAD	
		2025	Define and develop tool requirements	HCA	
		2026	Solicit input from CYFD regarding youth related metrics	HCA	

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider</td><td>Current State
Closed loop referrals and e-referrals are not currently supported.</td></tr>
<tr><td>Future State
The objective is to drive security and improved decision-making in the ED to enable focus on patients truly in need of emergency care, to enable primary care to patient connections, and to facilitate better coordination with first responders. This will be solved by delivering ED providers with relevant patient-specific alerts and information, reducing avoidable services provided in the ED as well as reducing workplace violence for ED staff. This will drive awareness of frequent ED utilizers and result in faster diagnosis and triage as well as lower costs.
Stakeholders for this improvement include acute care providers, social workers, security personnel, imaging and diagnostic staff, and payers. Proposed functionality includes encounter history, prescription claims history, security alerting, alerting of recent imaging and lab results, and improved continuity of care documents (CCDs) for ED discharge. Anticipated necessary data elements include ADT encounter feeds, prescription claims, and lab results. This will allow a Closed loop and e-referral system to be supported and sustained.</td></tr>
<tr><td>Future State and Implementation
With funding through this collaborative HIE partnership, Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as Closed Loop and e-referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.
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<tr><td>2025</td><td>Define and develop tool requirements</td><td>BHSD/MAD</td></tr>
<tr><td>2026</td><td>Solicit input from CYFD related to youth metrics</td><td>HCA</td></tr>
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</td></tr>
</table>

<table>
<tr>
<td rowspan="3">1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports</td>
<td>Current State

Closed loop referrals and e-referrals are not currently supported.</td>
</tr>
<tr>
<td>Future State

The objective is to drive awareness and enable better care coordination for individual's holistic mental health needs across acute and ambulatory settings. With a goal of providing a process to ensure there is continual collaboration and transparency around patient-consented sensitive information and assist with the clinical and administrative protocol across diverse stakeholders to drive better patient outcomes. Additionally, the goal would be to increase follow up visit compliance after a hospitalization for mental/behavioral health and drive awareness of associated comorbidities.

The initial stakeholders identified include, but may not be limited to, acute care (ED), social workers, case managers, behavioral health clinics and social services, which would have platform access.

Some of the data elements which may be needed include diagnosis, prescription and CPT information. Access to behavioral health scheduling is a plus but not required. Consent models and platforms to support 42 CFR Part 2 logic and compliance with NM specific consent regulations are needed as well as access to behavioral health crisis plans and notes. Emergency department dashboards and alerting and access by behavioral health providers to the prescription drug monitoring program. This will allow a Closed loop and e-referral system to be supported and sustained.</td>
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<td>Future State and Implementation

With funding through this collaborative HIE partnership, Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as Closed Loop and e-referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.

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			physical health needs of high-risk behavioral health patients.		
		2025	Define and develop tool requirements	BHSD/MAD	
		2026	Solicit CYFD input related to youth metrics	HCA	

Electronic Care Plans and Medical Records (Section 2)

2.1 The state and its providers can create and use an electronic care plan

Current State

The NM Healthcare Authority, through the Medical Assistance Division (HCA/MAD) is the State Medicaid Agency (SMA) that administers the NM Medicaid Program. HCA/MAD has developed a plan for administering the EHR incentives through its Medicaid Incentive Provider Payment (MIPP) Program aka the NM Medicaid Electronic Health Records (EHR) Incentive Program or Promoting Interoperability Program (PI).

Future State

With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.

Future State and Implementation

Date	Activity	Responsible
2025-2029	Increase provider adoption and utilization of EHRs and participation in health information exchange (HIE) activities	BHSD/MAD
2025-2029	Perform business and technology research to recommend solutions, with a design focus on workflow automation and actionable information to tie together disparate EHRs	BHSD/MAD
2025-2029	Solicit CYFD input related to youth related metrics	HCA

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</td><td>Current State
The NM Healthcare Authority, through the Medical Assistance Division (HCA/MAD) is the State Medicaid Agency (SMA) that administers the NM Medicaid Program. HCA/MAD has developed a plan for administering the EHR incentives through its Medicaid Incentive Provider Payment (MIPP) Program aka the NM Medicaid Electronic Health Records (EHR) Incentive Program or Promoting Interoperability Program (PI).</td></tr>
<tr><td>Future State
Orion Health Coordinate, enables best practice care coordination across a community on top of this robust longitudinal record. With Coordinate's tools, users can build forms and care pathways; create, assign, manage and complete patient specific tasks; individualize care plan goals and actions; view and manage relationships and support networks for a patient; and monitor a cohort of patients using a variety of worklists.

Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as clinical referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.</td></tr>
<tr><td>Future State and Implementation
Coordinate works in concert with Orion Health Engage for easy and effective patient engagement. Patients can collaborate with their care team by reviewing and documenting their care plan goals, completing tasks forms and questionnaires, accessing educational content, and managing their Circle of Care.
<table>
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<tr><td>2025-2029</td><td>Perform business and technology research to recommend solutions, with a design focus on workflow automation and actionable information to tie together disparate EHRs</td><td>BHSD/MAD</td></tr>
<tr><td>2025-2029</td><td>Solicit CYFD input related to youth metrics</td><td>HCA</td></tr>
</table></td></tr>
<tr><td rowspan="2">2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</td><td>Current State
The NM Healthcare Authority, through the Medical Assistance Division (HCA/MAD) is the State Medicaid Agency (SMA) that administers the NM Medicaid Program. HCA/MAD has developed a plan for administering the EHR incentives through its Medicaid Incentive Provider Payment (MIPP) Program aka the NM Medicaid Electronic Health Records (EHR) Incentive Program or Promoting Interoperability Program (PI).</td></tr>
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<tr><td></td><td>and stages of a lifecycle.

Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as clinical referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.</td></tr>
<tr><td></td><td>Future State
With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.
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<tr><td>2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</td><td>Current State
The NM Healthcare Authority, through the Medical Assistance Division (HCA/MAD) is the State Medicaid Agency (SMA) that administers the NM Medicaid Program. HCA/MAD has developed a plan for administering the EHR incentives through its Medicaid Incentive Provider Payment (MIPP) Program aka the NM Medicaid Electronic Health Records (EHR) Incentive Program or Promoting Interoperability Program (PI).</td></tr>
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Orion Health Coordinate is an integrated solution designed to support the management of all patients with long term conditions in a region by multi-disciplinary teams. It is capable of supporting a wide range of related programs such as clinical referrals, disease registries, well childcare, the implementation of evidence-based clinical pathways and supports community programs in areas including mental health and social services.</td></tr>
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Future State and Implementation

With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.

Date	Activity	Responsible
2025-2029	Perform business and technology research to recommend solutions, with a design focus on workflow automation and actionable information to tie together disparate EHRs	BHSD/MAD
2025-2029	Solicit CYFD input related to youth metrics	CYFD

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">2.5 Transitions of care and other community supports are accessed and supported through electronic communications</td><td>Current State
Collective Medical Technologies is presently deployed across every non- federal hospital in the State of New Mexico, is in use by every NM Medicaid MCO as well as other risk-bearing entities and has been adopted by many additional providers across the State. It has demonstrated an ability to clinically operationalize shared data to address specific problems which require community-level collaboration. Collective's software helps care teams collaborate by enabling real-time point-of-care awareness and collaboration tools though the build out of technical capability to support use cases. Example use-cases include high-utilizer emergency department utilization, transitions of care and avoidable readmissions, substance use disorder, workplace safety, behavioral health, and value-based care. These services assist providers in reducing unnecessary utilization by leveraging all points of care appropriately through the use of real-time patient risk identification, back-end stakeholder identification, and last-mile routing technologies in order to deliver actionable insights at the point of care.</td></tr>
<tr><td>Future State
The objective is to decrease resource requirements, reduce complication rates through smoother care transitions, reduce length of stay and reduce inpatient admission rates. This will be solved by using information from the HIE and participating provider organizations to provide a comprehensive view of a patient's utilization through integration with acute care, post-acute care, primary care, and criminal justice provider workflows. This will reduce unnecessary inpatient admissions/readmissions, reduce friction in knowledge transfer between care groups, and drive population level insight around patient transitions.</td></tr>
<tr><td>Future State and Implementation
With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.
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<tr><td colspan="2">Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)</td></tr>
</table>

<table>
<tr><td rowspan="3">3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)</td><td>Current State
Collective Medical Technologies is presently deployed across every non- federal hospital in the State of New Mexico, is in use by every NM Medicaid MCO as well as other risk-bearing entities and has been adopted by many additional providers across the State. It has demonstrated an ability to clinically operationalize shared data to address specific problems which require community-level collaboration. Collective’s software helps care teams collaborate by enabling real-time point-of-care awareness and collaboration tools though the build out of technical capability to support use cases. Example use-cases include high-utilizer emergency department utilization, transitions of care and avoidable readmissions, substance use disorder, workplace safety, behavioral health, and value-based care. These services assist providers in reducing unnecessary utilization by leveraging all points of care appropriately through the use of real-time patient risk identification, back-end stakeholder identification, and last-mile routing technologies in order to deliver actionable insights at the point of care.</td></tr>
<tr><td>Future State
Collective’s software helps care teams collaborate by enabling real-time point-of-care awareness and collaboration tools though the build out of technical capability to support use cases to include electronic individual consent and ensure accessibility to patients and all members of the care team. Support a seamless sharing of sensitive health care information to all relevant parties and to become consistent with applicable law and regulations.</td></tr>
<tr><td>Future State and Implementation
Begin to build future state use case/workflow diagrams based on process options. Also consider developing and providing guidance materials to providers/health care facilities on best practice workflows.
<table>
<tr><th>Date</th><th>Activity</th><th>Responsible</th></tr>
<tr><td>2025-2029</td><td>Define and develop tool requirements</td><td>BHSD/MAD</td></tr>
<tr><td>2025-2029</td><td>Solicit CYFD input related to youth metrics</td><td>HCA</td></tr>
</table></td></tr>
<tr><td colspan="2">Interoperability in Assessment Data (Section 4)</td></tr>
<tr><td rowspan="2">4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem</td><td>Current State
Collective Medical Technologies is presently deployed across every non-federal hospital in the State of New Mexico, is in use by every NM Medicaid MCO as well as other risk-bearing entities and continues to be adopted by many additional providers across the State. It has demonstrated an ability to clinically operationalize shared data to address specific problems which require community-level collaboration. Collective’s software helps care teams collaborate by enabling real-time point-of-care awareness and collaboration tools though use cases. Example use-cases include high-utilizer emergency department utilization, transitions of care and avoidable readmissions, substance use disorder, workplace safety, behavioral health, and value-based care. These services assist providers in reducing unnecessary utilization by leveraging all points of care appropriately through the use of real-time patient risk identification, back-end stakeholder identification. Collective also provides “last-mile” routing technologies in order to deliver actionable insights at the point of care.</td></tr>
<tr><td>Future State
In accord with the CMS vision to enhance, utilize and share technology in place in the ecosystem, the proposed activities</td></tr>
</table>

are designed to build an integrated infrastructure and organization using the expertise, technology, and relationships these bring to the HIE. The framework will provide the right actionable data at the right time and at the right place. This integration will allow participants to make the best-informed decisions while bringing high-quality care to NM Medicaid recipients and meeting Stage 3 Promoting Interoperability requirements.

Future State and Implementation

Begin the collaboration of these players to provide enhancements (and in some cases, replacement of legacy systems) to result in state-of-the-art systems and services desired and needed by NM providers and people. This includes the process of intake, assessment and developed screening tools. As NM moves forward with CCBHC implementation, BHSD, MAD and the IT Division of HCA will collaborate to ensure that required CCBHC screenings and metrics are included in the HIT framework.

Date	Activity	Responsible
2025-2029	Define and develop tool requirements	BHSD/MAD
2025-2025	Alignment of CCBHC and BHSD metrics into HHS 2020	BHSD/MAD
2025-2029	Solicit CYFD input into youth metrics	HCA

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State** NM expanded telehealth services in 2021 through revisions to 8.310.2 New Mexico Administrative Code (NMAC). These revisions leverage the use of telehealth to support a variety of telemedicine services including integrated care and consultative services.
	Future State N/A – milestone requirement is already met.
	Future State and Implementation N/A – milestone requirement is already met.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	**Current State** NM currently does not have the capability to identify risk for discontinuing engagement in treatment. Through claim data, we can review if a patient has discontinued services.
	Future State To drive awareness and enable better care coordination for individual's holistic mental health needs across acute and ambulatory settings. With a goal of providing a process to ensure there is continual collaboration and transparency around patient-consented sensitive information and assist with the clinical and administrative protocol across diverse stakeholders to drive better patient outcomes and continued services reducing risk. Additionally, the goal would be to increase follow up visit compliance after a hospitalization for mental/behavioral health and drive awareness of associated comorbidities. The initial stakeholders identified include, but may not be limited to, acute care (ED), social workers, case managers, behavioral health clinics and social services, which would have platform access. Some of the data elements which may be needed include diagnosis, prescription and CPT information. Access to behavioral health scheduling is a plus but not required. Consent models and platforms to support 42 CFR Part 2 logic and compliance with NM specific consent regulations are needed as well as access to behavioral health crisis plans and notes. Emergency department dashboards and alerting and access by behavioral health providers to the prescription drug monitoring program.

Future State and Implementation

With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.

Date	Activity	Responsible
2025-2029	Perform business and technology research to recommend solutions, with a design focus on workflow automation and actionable information to tie together disparate EHRs	BHSD/MAD
2025-2029	Define and develop tool requirements	BHSD/MAD
2025-2029	Solicit CYFD input related to youth metrics	HCA

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td rowspan="3">6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</td><td>Currently, the NMEARLY program provides clinical consultation and coordinated specialty care for individuals with first episode psychosis. There are no dedicated care coordination activities for this group and there are no targeted efforts to incorporate Health IT.</td></tr>
<tr><td>The trigger event is the patient presenting in the ED. When a patient is admitted in the ED, an admit and discharge ADT is sent to NMHIC. When NMHIC receives this admit ADT, NMHIC first matches this patient against the MPI and sends the patient's clinical data along with this ADT to Collective. Collective then triggers an admit and discharge alert to the patient's Primary Care Physician based on the patient provider attribution file. Collective will also analyze this patient data to determine if the patient frequently uses the ED based on metrics. Collective then goes through the process of analyzing and determining the provider and determining if the alert should be delivered based on the patient provider attribution file. If the data matches the provider attribution file an alert is delivered to the Collective end user. Three different alerts can be triggered:
1. ED Admit Alert
2. ED Discharge Alert
3. Frequent User Alert</td></tr>
<tr><td>With the successful ongoing implementation of certified EHR technology by providers across the state, NM is striving toward its ultimate vision for HCA's future HIT landscape — the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and, ultimately, the development of a fully patient-centric health care delivery system. HCA/MAD continues to engage in highly collaborative processes, seeking input into policy development and leveraging existing partnerships to further reach its goals.
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<tr><td>2025-2029</td><td>Solicit CYFD input related to youth metrics</td><td>HCA</td></tr>
</table></td></tr>
<tr><td colspan="2">Identity Management (Section 7)</td></tr>
</table>

7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	At this time, New Mexico's ongoing HIE endeavors include technical efforts to support care teams' abilities to tag or link children's EMR with their respective parent/caretaker EMR as appropriate.
	N/A
	N/A
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	At this time, New Mexico's ongoing HIE endeavors include technical efforts to capture all episodes of care correctly linked to the correct patient.
	N/A
	N/A

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

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.

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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.

ATTACHMENT L
Turquoise Care Reentry Demonstration Initiative Reinvestment Plan
Approved: May 27, 2026

Introduction

According to the Turquoise Care Special Terms and Conditions (STCs) section 9.11, New Mexico must reinvest federal dollars linked to existing carceral health services provided under its Reentry Demonstration Initiative. This Reentry Demonstration Initiative Reinvestment Plan identifies the existing services that necessitate reinvestment, the total amount of reinvestment required, and the new services that will be funded by the planned reinvestment.

New Mexico is seeking approval of this reinvestment plan for New Mexico Corrections Department (NMCD) facilities and County Detention Centers (CDCs). Please note that future phase-in of facilities is dependent on state budget availability and facility readiness. The reinvestment calculations are subject to change based on actual implementation.

Reinvestment Required

1. Service Categorization

CMS and the Health Care authority (HCA) have identified two categories of Reentry Initiative services for determining whether and how much reinvestment may be required:

a. ***"Existing services"*** are services that have been previously provided by carceral settings prior to the demonstration and will be newly matched by Medicaid under the demonstration. Reinvestment is required in an amount equivalent to the amount of Federal Financial Participation (FFP) invested in "existing services."
b. ***"New services"*** are services or support that are entirely new and portions of those classified as enhanced, meaning these services/support that had not previously been provided or had not been provided consistently and at the same level of care by carceral settings prior to the demonstration. FFP invested in "new services" does not prompt the need for reinvestment, as these services would not have otherwise been provided through Medicaid.

The amount of reinvestment required is equivalent to the amount of FFP invested in "existing services."

2. Services Requiring Reinvestment

HCA is only authorizing Service Level 2[1] for the current phase of facility implementation in this demonstration period. Based on an assessment of services provided or paid for by carceral settings prior to implementation of the Reentry Initiative, HCA identified several Service Level 2 services that were previously provided by carceral facilities prior to the demonstration. The degree of implementation prior to the demonstration varies by facility. HCA collected data[2] from each group

[1] Consistent with the approved implementation plan, Service Level 2 represents the three mandatory services: 1) Case management, 2) 30-day supply of medications upon release, and 3) MAT; and three additional services: 1) Treatment for Hepatitis C, 2) Peer support services, and 3) Community Health Worker (CHW) services. This reinvestment plan assumes implementation of Service Level 2, but does not assume an expansion to include additional services (e.g., Service Level 3) due to current state appropriation limits. This reinvestment plan will be updated in the event New Mexico implements additional services.

[2] CDC pre-demonstration baseline cost data was provided for the first cohort comprised of five counties (Q1 2026 CDC Baseline Data Survey). This data was used to establish pre-demonstration costs for the remaining counties and is subject to refinement as additional counties engage in implementation.

of facilities to determine the level of investment in each service prior to the demonstration. This facility-level data was used to calculate the amount of FFP associated with services funded prior to the demonstration. Where ramp up or service enhancements are projected under the demonstration, the service costs beyond the pre-demonstration baseline are treated as new costs and only the pre-demonstration costs are recognized as existing costs. This means most services contribute in part to the calculation of existing costs and in part to the calculation of new costs for the purpose of calculating required and planned reinvestment.

- **Case Management:** CDCs provided minimal case management services prior to the demonstration, and NMCD did not provide case management services prior to the demonstration. NMCD staff are limited to "classification officer" functions that are focused on carceral protocols and fundamental discharge planning. NMCD does not employ case managers or other individuals who perform the responsibilities of Medicaid case management.
- **Treatment for Hepatitis C:** NMCD facilities consistently provided diagnostic and treatment services for Hepatitis C prior to demonstration approval. CDCs provided minimal diagnostic and treatment services for Hepatitis C prior to the demonstration.
- **Medication-Assisted Treatment (MAT) Services:** MAT services were provided in a limited capacity prior to demonstration approval with the vast majority of implementation planned post-demonstration approval. This applies across NMCD and CDC facilities.[3]
- **30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release, consistent with approved Medicaid state plan coverage authority and policy**: NMCD facilities consistently provided a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate) prior to the demonstration approval. CDCs did not provide a 30-day supply of medications in-hand prior to the demonstration and typically only provided a script or referral to community providers. The state will provide this service under the demonstration, not the state plan.

Beyond the new service expansion and enhancements noted above, new services also include remaining authorized pre-release services under the demonstration:

Services provided by Community Health Workers (CHWs) and Peer Support Services: Prior to the demonstration, facilities did not pay for CHW services or Peer Support Services. HCA only reimburses for certified CHW and certified Peer services. Services prior to the demonstration were limited to peer services provided by incarcerated individuals to their peers within facilities. These individuals are not certified (not eligible for Medicaid reimbursement) and these programs will continue without any impact or reimbursement.

3. Amount of Reinvestment Required

To determine the amount of reinvestment required, HCA applied pre-demonstration expenditure data from NMCD and CDC Cohort 1. In line with requirements in the STCs, New Mexico must

[3] In 2023, the New Mexico legislature passed Senate Bill 425 mandating the expansion of services to include FDA-approved MAT. While MAT is currently offered in some state and county facilities, full implementation on a statewide basis will occur under this demonstration. Implementation will expand and enhance MAT based on higher level of participation across facilities and further alignment with FDA-approved MAT guidelines and inclusion of counseling/behavioral therapies.

reinvest a projected amount of $14,895,552, which is the total amount of projected FFP for existing services over the course of the demonstration based on facilities implementing Service Level 2. This required reinvestment projection assumes the following phase-in of member months by DY as outlined in the table below:

	DY 13	**DY 14**	**DY 15**	**DY 16**	**DY 17**
	CY 2025	CY 2026	CY 2027	CY 2028	CY 2029
NMCD	30%	100%	100%	100%	100%
CDCs	0%	20%	50%	75%	100%

Projected Reinvestment

1. Amount of Reinvestment Planned

New Mexico projects up to $27 million in reinvestment over the course of the demonstration to improve health care for incarcerated individuals. The reinvestment projection exceeds the required amount of reinvestment as summarized in the table at the end of this attachment. This projected reinvestment amount includes:

- The projected state share of expenditures for new, enhanced or expanded pre-release services approved under the demonstration;.
- The projected state share for Reentry Demonstration Initiative Planning and Implementation expenditures; and
- State appropriated reinvestment initiatives outside of the demonstration authorized services and non-services.

2. Types of Reinvestment Planned

a. New Services

According to STC 9.11, the state's share of funding associated with new services covered under the demonstration qualifies as reinvestment. As noted above, HCA identified the following Service Level 2 services as either new or enhanced services to be implemented under the demonstration. Only the projected new state costs beyond the pre-demonstration baseline are considered as part of reinvestment.

- Treatment for Hepatitis C
- Case management to assess and address physical and behavioral health needs, and health-related social needs;
- Expansion of MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/ behavioral therapies;
- 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release;
- Services provided by CHWs; and
- Peer support services.

For the demonstration, the planned reinvestment amount is based on Service Level 2 service costs below the budget neutrality per member per month limit in accordance with the phase-in schedule (outlined above) under the Reinvestment Required section.

b. Planning and Implementation Expenditures

According to STC 9.11, New Mexico may also reinvest in a range of allowable initiatives that benefit the justice-involved population broadly. These investments may include health information technology and data sharing and increased community-based provider capacity to better service justice-involved individuals or individuals at risk of justice involvement. New Mexico will use funding from the 1115 demonstration to reinvest in planning and implementation expenditures. New Mexico's planned reinvestment in the Reentry Demonstration Initiative Planning and Implementation is consistent with these goals. The Reentry Demonstration Initiative Planning and Implementation funding will support planning, IT investments, and facility readiness to enable implementation of Medicaid policies, service expansion, and reimbursement. This planned reinvestment is consistent with the approved budget neutrality limit for Reentry Demonstration Initiative Planning and Implementation expenditures.

In addition, New Mexico is committing to reinvest funds in allowable programs and capacity under state appropriated initiatives outside of the demonstration authorized services and non-services. These state investments are consistent with allowable reinvestment under STC 9.11. For example, the New Mexico legislature appropriated funding from 2026 through 2029 to support youth mentoring services for high risk youth within juvenile justice facilities, piloting universal screening and other pre-trial behavioral health services, diversion pilots, etc.

c. Privately Owned or Operated Carceral Facilities

There are three privately operated carceral facilities in New Mexico, one prison and two jails. New Mexico started implementation on July 1, 2025 with three prison facilities, and the privately operated prison is *not* included in this cohort. These privately operated facilities and their populations are included in the reinvestment calculations in the event these populations are covered by JUST Health Plus in the future. The population within the one remaining privately operated prison is relatively small. NMCD plans to transfer eligible members to one or more of the NMCD operated facilities for services during the 90-day pre-release eligibility period to facilitate JUST Health Plus service delivery. The state of New Mexico has made it a priority to minimize the number of private carceral facilities and has taken over several of these facilities over the last few years. The state will continue to focus on phasing out privately operated facilities as is feasible. If any privately operated facility participates in future years, appropriate safeguards and requirements will be established as a condition of participation.

To receive capacity funding, facilities must first apply for the funds and clearly describe the proposed funding needs related to readiness requirements. Once approved, contracts will be constructed so that facilities are reimbursed for funding actually spent on allowable categories. These contracts will also include stipulations regarding non-supplantation of planning and implementation funding related to prior investments and commitment to utilize planning and

implementation funds on allowable activities that are new and necessary to support implementation.

Regarding Planning and Implementation funding, New Mexico is implementing an application process that will outline allowable uses of funding and will include justification by facilities as to why the funding amounts and categories requested are necessary to support readiness for implementation of the Reentry Demonstration and applicable requirements. As a condition of eligibility for funding, facilities will be required to attest to an understanding of allowable and non-allowable uses, and that funding will be used specifically for the purpose of readiness milestones and requirements. In addition, the funding distribution process is built upon the readiness milestones and will require facilities to demonstrate progress from one milestone to the next in order to receive funding associated with each milestone. These same requirements will apply to privately operated facilities in the event they are included in future phases of implementation.

Regarding services funding, New Mexico intends to implement Certified Public Expenditure (CPE) claiming for NMCD's state prison facilities. This CPE will allow New Mexico to certify and claim NMCD's health care service costs that correspond with the services authorized under the Reentry Demonstration. These costs represent NMCD's actual costs of providing carceral health care services through a statewide carceral health care vendor, and implementing a CPE will allow HCA to ensure that FFP is reinvested into new services or planning and implementation funding.

ATTACHMENT L
Turquoise Care Reentry Demonstration Initiative Reinvestment Plan
Approved: May 27, 2026

Summary of Required and Planned Reinvestment for DY13 – DY17

Existing			
Services	Projected Total Computable for Existing Services	Projected FFP for Existing Services	A. Total FFP for Existing Services
HepC	$ 328,556	$ 279,273	$ 14,895,552
MAT	$ 11,140,287	$ 9,469,244	
30-days of medications upon release	$ 279,936	$ 237,946	
Case Management	$ 5,775,399	$ 4,909,089	
CHW	$ -	$ -	
Peer Support Services	$ -	$ -	
New			
Services	Projected Total Computable for New Services	Projected State Share for New Services	B. Total State Share for New Services
HepC	$ 10,678,145	$ 1,601,721	$ 12,628,351
MAT	$ 24,201,578	$ 3,630,238	
30-days of medications upon release	$ 3,099,787	$ 464,967	
Case Management	$ 8,666,021	$ 1,299,903	
CHW	$ 18,771,740	$ 2,815,761	
Peer Support Services	$ 18,771,740	$ 2,815,761	
Capacity Building	Projected Total Computable for Non-Services	Projected State Share for Non-Services	C. Total State Share for Non-Services
Planning and Implementation (Non-Services)	$ 9,946,800	$ 4,973,400	$ 15,188,800
Other State-Only Reinvestment	N/A	$ 10,215,400	
Reinvestment Calculation			
State Share on New (B+C)			$ 27,817,151
FFP on Existing (A)			$ 14,895,552
Excess Reinvestment Projected (C+B-A)			**$ 12,921,599**

ATTACHMENT L
Turquoise Care Reentry Demonstration Initiative Reinvestment Plan
Approved: May 27, 2026

FFP and State Share for Each Service by DY

Summary of FFP For Existing Services by DY						
Existing	**DY13 CY 2025**	**DY14 CY 2026**	**DY15 CY 2027**	**DY16 CY 2028**	**DY17 CY 2029**	**Total FFP**
HepC	$ 10,498	$ 38,366	$ 60,922	$ 82,635	$ 86,852	$ 279,273
MAT	$ 3,353	$ 777,972	$ 1,933,753	$ 2,897,836	$ 3,856,330	$ 9,469,244
30-day Supply	$ 10,498	$ 34,992	$ 52,488	$ 69,984	$ 69,984	$ 237,946
Case Management	$ -	$ 400,742	$ 1,001,855	$ 1,502,782	$ 2,003,710	$ 4,909,089
CHW	$ -	$ -	$ -	$ -	$ -	$ -
Peer Support Services	$ -	$ -	$ -	$ -	$ -	$ -
Summary of State Share for New Services by DY						
New	**DY13**	**DY14**	**DY15**	**DY16**	**DY17**	**Total State**
HepC	$ -	$ 118,230	$ 310,354	$ 488,807	$ 684,330	$ 1,601,721
MAT	$ 20,775	$ 301,062	$ 713,936	$ 1,104,409	$ 1,490,056	$ 3,630,238
30-day Supply	$ -	$ 34,321	$ 90,093	$ 141,897	$ 198,656	$ 464,967
Case Management	$ -	$ 111,829	$ 258,547	$ 398,023	$ 531,504	$ 1,299,903
CHW	$ -	$ 233,479	$ 556,366	$ 861,440	$ 1,164,476	$ 2,815,761
Peer Support Services	$ -	$ 233,479	$ 556,366	$ 861,440	$ 1,164,476	$ 2,815,761

Attachment M
Health-Related Social Needs Implementation Plan
Approved: January 14, 2025

In accordance with New Mexico's Section 1115 Demonstration and Special Terms and Conditions (STCs), the Health-Related Social Needs (HRSN) Implementation Plan (Plan) provides additional detail on the strategic approach, timelines, system changes, partnerships, and other elements necessary to implement Turquoise Care HRSN Initiatives. This Plan is in alignment with the HRSN Services Protocol, submitted to CMS on October 23, 2024 and updated for CMS on December 13, 2024.
Through the Turquoise Care 1115 Demonstration extension, the New Mexico Health Care Authority (HCA) received approval for new HRSN services:

- **Housing Interventions:**
  - **Short-term post-hospitalization housing** (Medical Respite) with room and board for up to six months per year, only where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing is limited to a clinically appropriate amount of time.
- **Nutrition Interventions:**
  - **Home delivered meals (medically-tailored meals),** tailored to health risk, or pantry stocking for pregnant individuals who meet risk and needs-based criteria. Additional meal support is permitted when provided to the household of a pregnant individual, as defined in the risk and needs-based criteria.
  - **Nutrition prescriptions**, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers for pregnant individuals as defined in the risk and needs-based criteria.

This HRSN Implementation Plan has been organized into five sections, aligned with the requirements in STC 10.18:

Section 1: HRSN Services Strategic Approach, Timeline and Evaluation Considerations

Section 2: Key Partnerships and Capacity Building

Section 3: Launching and Operationalizing HRSN Services

Section 4: Technology, Data Sharing, and Monitoring

Section 5: Rate Methodology and Maintenance of Effort

Attachment M
Health-Related Social Needs Implementation Plan

Section 1: HRSN Services Strategic Approach, Timeline and Evaluation Considerations (STC 10.18.b. and 10.18.b.1.v)

Medical Respite services and medically-tailored meals for pregnant members will be delivered to both managed care and fee-for-service (FFS) members[1]. For managed care members, medical respite will be paid for via a non-risk arrangement and medically-tailored meals will be included in capitation rates. Implementation of these services will leverage existing service delivery infrastructure where possible, and foster connections to other supportive resources and interventions. HCA will phase-in the implementation of initiatives beginning in the first year of the demonstration extension. Information for each initiative as required in the STCs is included below.

Housing Interventions (Medical Respite): Approach and Timeline

Medical Respite services are intended for unstably housed or homeless members who are discharging from a hospital setting and need a safe place to recuperate. For additional information on the Medical Respite program, please see the HRSN Protocols for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications: Medical Respite (Attachment N), submitted to CMS on October 23, 2024 and updated on December 13, 2024.

HCA will begin delivering Medical Respite services at one 50-bed site, operated by Albuquerque Healthcare for the Homeless (AHCH) a Federally Qualified Health Center, by February 1, 2025. This brand-new site in Albuquerque has been under development and will act as a pilot site for implementation, ensuring eligibility screening and referral, care delivery, billing, and oversight and monitoring processes are taking place effectively before expansion of the program to additional sites. HCA intends to expand Medical Respite services to nine additional sites over the course of the demonstration, with sites and phase-in schedule to be determined as provider capacity is developed and physical space is secured. We anticipate that the first site will be ready to accept Medicaid members in demonstration year (DY) 13 and beginning in DY14 an additional two to three sites per DY will be implemented.

HCA will require Medical Respite providers to maintain and report on key data elements related to Medical Respite service delivery, including data to support evaluation of the Medical Respite program. HCA anticipates including up to four Medical Respite sites in the 1115 evaluation.

Nutrition Interventions for Pregnant Members: Approval and Timeline

Medically-tailored meals and nutrition prescriptions for pregnant members are targeted interventions aimed at supporting the nutritional needs of pregnant members and improving health outcomes for their babies. For additional information on these services, please see the HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications: Nutrition Interventions (Attachment N), submitted to CMS on October 23, 2024, and updated on December 13, 2024.

HCA will phase-in the nutrition interventions by implementing a medically-tailored meals benefit for pregnant members with diabetes. Subject to state budget availability, HCA will begin providing these meals (or the food box equivalent) statewide through managed care and FFS by July 1, 2025. Subject to state budget availability, HCA will expand services based on several priorities:

- Inclusion of family members of pregnant members with diabetes.
- Addition of other qualifying clinical risk factors conditions for pregnant members.
- Addition of nutrition prescriptions.

- Expansion of services to all pregnant members to include their pregnancy period of 9 months and postpartum period of 12-months.

This expansion of services will be phased in over the course of the demonstration, with these additional clinical risk factors and any family size adjustments determined and phased in according to priority and budget availability. In DY13, HCA will implement medically-tailored meals to pregnant members with diabetes with an amendment to the managed care organization (MCO) contracts by July 1, 2025. In subsequent DYs, HCA anticipates expanding to additional clinical risk factors and/or family size adjustments each year thereafter in accordance with the managed care contract rating period. Subject to state budget availability, it is HCA's intent to expand to all pregnant members by the end of the demonstration period.

MCO members will receive these nutrition supports through their MCO. Native American members who opt out of managed care will receive these nutrition supports through FFS. HCA will enroll nutrition supports vendors in Medicaid that can deliver nutrition supports that meet generally accepted dietary guidelines for pregnant members and the clinical risk factors selected by HCA[2].

HCA will require providers of nutrition interventions, including Turquoise Care MCOs, to maintain and report on key data elements related to nutrition services, including data to support evaluation of the nutrition interventions program.

Section 2: Key Partnerships and Capacity Building (STC 10.16, STC 10.18.b.1.ii, and STC 10.18.b.1.viii)

Medical Respite

To design and plan the first medical respite site in New Mexico, tremendous partnerships were established in Albuquerque to develop clinical criteria and standards, find and convert a physical site, determine budgetary and financing needs, and engage hard-to-reach members from disenfranchised populations who would benefit most from these services. Key partners who committed time and resources to this partnership effort include AHCH leadership, First Nations Community Healthsource, the City of Albuquerque, and the University of New Mexico Hospital. This level of partnership is strategic and requires resources to be able to sustain. These partners have documented their roles, responsibilities, and contributions through a joint memo of understanding (MOU), setting a model for future sites to use. Moving forward, HCA's strategy is to continue to engage these and other key partners as the Medical Respite program expands to up to 10 sites. HCA plans to release capacity building funds to support necessary engagement and planning. Each site will be different, not only geographically but also in terms of the local partners, population served, scope of services and referral partnerships. Each site will require capacity building and collaboration among state and local partners to support readiness and successful implementation. For example, the City of Albuquerque has committed to reserving 40 housing vouchers per year for members exiting Medical Respite, a direct outcome of this partnership.

[2] In accordance with the CMS November 20, 2024 Dear State Medicaid Director letter on nutrition interventions.

Nutrition

For medically-tailored meals, key partners include primary care providers, Obstetricians, midwives, birth workers (including Doulas, lactation consultants, and others), community-based organizations, food banks, rural food providers, farms, farmer's markets, and commercial nutrition vendors. For all HRSN initiatives, additional foundational partners include managed care plans, Tribes, Nations, and Pueblos, other state agencies, and advocacy groups.

Additionally, in accordance with STC 10.16, New Mexico will work to have in place the appropriate partnerships with other state and local entities to assist members in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs. New Mexico has robust resources in place to connect residents with federal, state, and local support programs. Yes New Mexico is a web-based resource that acts as a single site to find, apply for, and manage health and human services programs and services, including SNAP and TANF, and local field offices managed and staffed by the Income Support Division. Additionally, housing programs, WIC, and other resources will be offered to support members transition from waiver supported benefits. As the medically-tailored meals program is implemented, all participating entities will be required to facilitate enrollment in other needed services and programs, and track referrals to these programs for reporting and monitoring purposes.

Timeline for Medical Respite Partnerships

DY12:

- MOU between AHCH and Medical Respite partners, including City of Albuquerque, is finalized (December 2024).

DY13:

- AHCH Medical Respite provider site opens and begins providing care, including case management for connecting and referral to non-Medicaid resources such as the Linkages supportive housing program.
- HCA works with partners to develop processes and address technology needs for tracking and monitoring of referrals and enrollment in these programs.

DYs 14–17:

- Identify, engage, and phase in additional sites for Medical Respite in New Mexico.
- Leverage capacity building funds to engage partners in planning and implementation, including developing local referral partnerships to support members' ongoing social needs.
- Review data collected for evaluation purposes to determine program success and effectiveness, and make changes as needed to maximize member engagement, support and health outcomes.

Timeline for Nutrition Partnerships

DY12:

- Host two Food as Medicine stakeholder engagement sessions, including a Food as Medicine Summit.
- Continue to design and develop nutrition programs in alignment with New Mexico's Food as Medicine program, communicating and sharing progress with key partners.

DY13:

- Medically-tailored meals for pregnant members with diabetes begins (July 2025).
- Coordination with Yes New Mexico and WIC is initiated.
- HCA continues stakeholder engagement and outreach as part of Food is Medicine Initiative. This includes engagement with state and local entities such as counties, associations, food vendors, government agencies, and other partners.
- HCA works with partners to develop processes and address technology needs for tracking and monitoring of referrals and enrollment in these programs.

DYs 14–17:

- Leverage capacity building funds to engage partners in planning and implementation, including developing local referral partnerships to support members' ongoing social needs.
- Continue rollout of medically-tailored meals program, including assessment of additional conditions and/or family members to be included in program eligibility criteria.
- Assess effectiveness of referral patterns and monitoring and tracking of enrollment into non-waiver social needs programs.
- Review data collected for evaluation purposes to determine program success and effectiveness, and make changes as needed to maximize member engagement, support and health outcomes.

Capacity Building for Community Partners

Funding for HRSN infrastructure investments was approved in the Turquoise Care extension. For additional information on infrastructure investment strategies and planning, please refer to the HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (Attachment N), which is currently pending with CMS.

Medical Respite*:*

This benefit includes onsite case management and care coordination support provided by community health workers, community support workers, engagement specialists, and other similarly qualified staff. Via a case management process, these workers will support members in making these longer lasting connections to critical social supports beyond the scope of Medicaid.

Nutrition:

HCA envisions every Medicaid member having a primary care provider, a core value of Turquoise Care. In this case, the provider may be a midwife, obstetrician, or a family medicine provider who will coordinate care for all of the member's needs, including their food insecurity needs, through this benefit. It is through this structure that pregnant members receiving nutrition interventions will be connected to more permanent non-Medicaid avenues for nutrition supports and other social service needs.

Section 3: Launching and Operationalizing HRSN

Outreach

HCA will partner with hospitals and Medical Respite sites to ensure hospitalized members are informed about the availability and benefits of Medical Respite services. As additional Medical Respite provider capacity grows in New Mexico, HCA will increase efforts to educate and outreach to members.

A key activity in implementation of nutrition services will be broad outreach and education around nutrition interventions to maximize participation of pregnant members in need of these services. Through our "Food as Medicine" initiative, HCA will work with state, local and community partners to increase awareness, screenings and referrals to Medicaid-funded nutrition interventions. These partners include primary care providers, care coordinators, MCOs, the New Mexico Department of Health's WIC Program, the New Mexico Farmers' Marketing Association, the Food Depot, New Mexico Aging and Long-term Service Department, Fresh Rx, the New Mexico Food and Agriculture Policy Council, Roadrunner Food Bank, Meals on Wheels, counties, Tribal partners, and the New Mexico Public Health Association.

In the first two years of the demonstration, New Mexico will focus on capacity building for foundational partners to deliver HRSN services effectively. HCA will leverage capacity building funds for partners in allowed areas for necessary activities, including the domains of:

- Technology
- Workforce development
- Development of business or operational practices
- Stakeholder engagement and outreach

For a full description of anticipated activities eligible entities can use infrastructure investments for, please see the New Mexico Turquoise Care 1115 Demonstration HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications.

Readiness Assessment

HCA will ensure MCOs and providers are ready to implement HRSN services before go-live. At a minimum, the readiness criteria services will include:

- Provider ability to deliver services according to the approved HRSN Protocol.
- Appropriate screening and referral processes.
- Ability of providers to develop person-centered care plans according to member need and state Medicaid requirements.
- Provider ability to meet privacy and other member protection standards.
- Ability to track and report encounter and other pertinent data as required by the Demonstration Extension STCs.
- The ability to bill according to the rate methodologies approved by CMS.

Section 4: Technology, Administrative Services, and Monitoring (STC 10.18.b.1.i and iii)

Technology and Data Sharing

Technology infrastructure and data sharing are key areas of focus for successful HRSN implementation in New Mexico. HCA will work with MCOs, providers, and community partners on an approach to data sharing that meets entities where they are today and supports them toward uptake and the use of shared systems.

New Mexico is currently implementing a statewide Closed Loop Referral System (FindHelp CLRS) with funding allocated to HCA in the 2023 Legislative session through House Bill 2. The CLRS will operate to

address the social needs of individuals and communities to improve the health and well-being of New Mexicans, including supporting resource and referral capabilities for Medical Respite and Nutrition interventions. Community Based Organizations (CBOs), health care organizations, and State agencies will use the CLRS to efficiently and easily communicate and coordinate these referrals and ensure the needs of members are met. As of DY12, the FindHelp system is operational as a local referral resource, with implementation occurring on the back end to ensure MCOs and providers have access to licenses for the purpose of documenting referrals and member uptake of services.

To successfully promote health information exchange and integration of HRSN services into electronic medical records, HCA intends to award infrastructure funding to entities for a range of technology needs. This includes interoperability with the New Mexico FindHelp CLRS, participation in health information exchange, and new or upgraded electronic medical records that include plans of care. Additionally, training and technical assistance on best practices for the use of technology to support HRSN will be offered to providers via publications and training tools.

HCA will also ensure appropriate updates to existing IT infrastructure to support and promote the successful delivery and monitoring of HRSN services. This includes updates to the MMIS-R system, eligibility systems, and other pertinent IT systems.

Additional data sharing between key entities may also include general social needs screenings, person-centered care plans, and HRSN service referral and service delivery status. The State will work with these entities to phase in the use of closed loop referral technology based on readiness and appropriateness, over the course of the demonstration.

Monitoring, Reporting, and Evaluation

HCA will require MCOs to partner with HRSN providers to maintain data and report on key data elements related to HRSN service delivery. The State, in collaboration with HRSN partners, will be required to track and report on the following key data elements, at a minimum:

1. Number of members who have been screened for HRSN services (i.e., the number of members who have had an HRSN service requested).
2. Number of members currently referred and authorized to receive an HRSN service (listed by service).
3. Number of members denied for HRSN services (listed by service).
4. Number of members who have received an HRSN service (listed by service).
5. Data to support evaluation of HRSN program, including, for example:
    a. Data on improvements in member health-related resource needs.
    b. Data on member health outcomes, if applicable.
6. Other data required by the State and the demonstration's STCs.

This information will inform implementation needs and provide data to monitor service uptake and utilization, parity across populations (for example, FFS vs managed care), and effectiveness of service delivery. Additionally, data collected via this monitoring process will allow for timely and accurate reporting of HRSN implementation to CMS as well as data collection for demonstration evaluation activities.

Tracking and Maximizing Enrollment in Other HRSN Programs

Medicaid funded HRSN services are meant to be a temporary bridge to other, more permanent social supports. As such, HCA is designing policies and procedures to ensure members are connected to housing and nutrition services that meet their longer-term needs. For Medical Respite, members will have access to case management services as part of the care model, and tracking data on connecting members to other federal, state, and local programs to support their housing and other HRSN needs will

be collected and kept for monitoring and reporting purposes. Pregnant members will be connected with programs to support nutritional needs after delivery, including SNAP and WIC, with enrollment data also collected for monitoring and reporting purposes. New Mexico also has many local programs that provide needed community and social supports for members, and case management and care coordination processes will help connect members to these resources in order to address social needs long term.

Several specific strategies and processes will be developed and implemented to ensure members receiving HRSN services are also applying for and maintaining other key benefits for which they may be eligible, and ensuring enrollment in other federal, state, and local program is maximized. These include:

- Initiating applications, referrals, and enrollment processes upon assessment for HRSN services.
- Requiring these referral and enrollment steps be completed as part of the person-centered care planning process.
- Offering hands-on assistance with application processes and benefit interview appointments (e.g., WIC enrollment that requires an appointment).
- Providing training and technical assistance to care coordinators and other individuals involved in the HRSN assessment, referral, or service delivery process.

Section 5: Rate Methodologies and Maintenance of Effort (STC.10.18.b.1.vi and vii, STCs 10.14 and 10.15.)

Rate Methodologies

In accordance with STC 10.14, HCA submitted a rate methodology for Medical Respite services to CMS on December 2, 2024. The rate methodology is currently under review by CMS.

Maintenance of Effort for HRSN Services

According to STC 10.15 Maintenance of Effort (MOE), the State must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports. New Mexico's plan for determining this baseline spending was submitted to CMS and is pending approval. The document as submitted is also included on the following page.

Introduction

According to the STCs section 10.15 Maintenance of Effort (MOE), the State must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports comparable to those authorized under this demonstration, for the populations authorized under this demonstration, and for the duration of this demonstration, not including one time or non-recurring funding. This submission outlines New Mexico's plan for determining baseline spending on these services so the State can monitor and report annual MOE within the Annual Monitoring Report.

Program Inclusion Criteria

For program inclusion, the State will use the following criteria:

1. Programs that provide Medical Respite or nutrition support in the State, comparable to program descriptions in the HRSN Implementation Plan;
2. For the same targeted populations described in the HRSN Implementation Plan;
3. Does not depend on continuing federal funding;[3] and
4. For a duration that is not considered time-limited, i.e., there is no known end date for program funding.

Federally funded programs will not be included in the baseline due to federal funding uncertainties that are outside of the State's control and beyond the intent of the MOE requirement.

Baseline Calculation Methodology

Below are the parameters for the baseline calculation:

1. The State will use the most recent historical expenditures.
2. If any programs are identified in the inclusion criteria:
    a. The historical annual expenditures will be used to establish an average for the baseline.
    b. This approach will allow the State to establish an average annual expenditure amount to be included in the baseline while reducing the potential for the baseline to reflect any anomalies in the amount of State general fund appropriations.
    c. The average baseline and annual MOE will be reported in the Annual Monitoring Report with a summary of the inclusion criteria and MOE calculation approach.
3. If no programs are identified for one or both program categories according to the inclusion criteria above, the MOE section in the Annual Monitoring Report will include a summary of the criteria used and the outcome of the analysis.

[3] Federally funded programs will not be included in the baseline due to federal funding uncertainties that are outside of the State's control and beyond the intent of the MOE requirement.

HRSN Baseline MOE

Nutrition Support Program	FY25	
Double Up Food Bucks		$633,000
Summer Food and Supper Enhancement	$	400,000
SNAP 200% FPL Enhancement	$	382,000
Healthy Food Financing Initiative	$	450,000
Baseline	**$**	**1,865,000**

Medical Respite Program	FY25	
None identified	$	-
Baseline	**$**	**-**

Notes and assumptions
Source: https://www.nmdfa.state.nm.us/dfa-dashboards/food-initiative-dashboard/
Reviewed FY24 and FY25 funding for nutrition supports. Did not include any FY24 funding in the calculation as FY24 only included non-recurring funding for the applicable programs. Included programs identified in FY25 as recurring programs, even if newly established in FY25.
Included only the FY25 programs with eligibility crossover to the applicable pregnant member population, i.e., excluding initiatives focused on school-aged children and seniors.
As anticipated, no Medical Respite programs were identified as only one Medical Respite program exists and is funded through a local partnership (no state funding).

ATTACHMENT N
Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol

HRSN Services Protocol Approved: January 2, 2025
HRSN Infrastructure Protocol Approved: December 20, 20204

Attachment N

New Mexico Turquoise Care 1115 Demonstration HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications:

Housing Interventions (Medical Respite) and Nutrition Interventions for Pregnant Members

Submitted December 13, 2024

In compliance with STC #10.6 of the Turquoise Care 1115 Demonstration, the New Mexico Health Care Authority (HCA) is submitting an HRSN Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for Housing Interventions (Medical Respite) and Nutrition Interventions for Pregnant Members to CMS for review and approval.

Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment N. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in this Attachment N, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in this approved Attachment N, the state must follow the process below to update the protocol:
    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this

STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 20.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes.

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process. This restriction is not applicable to the process and scope of changes outlined in STC 3.6.

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

HCA submitted a separate Attachment N HRSN Infrastructure Protocol for CMS approval.

ii. A list of the covered HRSN services with associated service descriptions and service-specific provider qualification requirements.

Short-term post-hospitalization housing (Medical Respite)

Covered Service: Short-term post-hospitalization housing (medical respite) with room and board for up to six months per rolling year, only where integrated, clinically-oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing services are limited to a clinically appropriate amount of time.

Service Definition: Acute and post-acute medical care for people who are homeless who are too ill to recover from sickness or injury on the street or in a shelter, but not sick enough to warrant hospital level care.

Medical Respite providers may provide tiered levels of support and receive reimbursement according to the service tier.

Medical respite service components may include:

(1) Onsite case management/care coordination provided by Community Health Workers (CHW), Community Support Workers (CSWs), Engagement Specialists, and/or other similarly qualified staff. For example:

- Coordination and/or transportation[1] to offsite medical appointments
- Completion of case management and supportive services onsite as applicable

[1] Transportation is provided as part of the bundled service payment and there is no separate billing or payment for standalone transportation services.

- Referral or connection to community case management services as applicable

(2) Connection and transition to primary care provider/health home before discharge

(3) Onsite clinical services, which will include the creation of an individual clinical care plan by an appropriately licensed clinical provider, and may include (based on provider capacity):

- Daily evaluation (or as indicated by clinical care plan) by an appropriately licensed clinical provider.
- Provision of medical clinical services within scope of licensure and as indicated by discharge instructions and clinical care plan.
- 24/7 access to a provider on call and a nurse advice line.
- Medication management
- Chronic condition management by appropriately licensed clinical provider.
- Medical management and treatment by an appropriately licensed clinical provider.
- Behavioral health by licensed clinical social
- Substance use treatment by an interdisciplinary team of licensed clinical social worker and appropriately licensed clinical
- Care coordination with home health and home-based clinical care services
- Other integrated health services as needed including dental, harm reduction, art therapy, public benefits enrollment, housing navigation, community health workers, and housing navigators to facilitate exit to housing.

(4) Room and board, including shelter services that meet National Standards for Medical Respite Care

Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.

Medical Respite Provider Qualifications:

Medical Respite Providers must agree to meet the National Institute for Medical Respite Care (NIMRC) Standards developed by the National Health Care for the Homeless Council.

Clinical services will be conducted by appropriately licensed, trained, credentialed, and privileged Medicaid-enrolled providers which may include Registered Nurses (RNs), Doctor of Medicine (MDs), Advanced Practice Providers (APPs), Dentists, Dental

Hygienists, and Licensed Clinical Social Workers (LCSW), and will be based on individual patient needs as outlined in the care plan.

Nutrition Interventions for Pregnant and Postpartum Members

Covered Services and Descriptions:

Home delivered meals (medically-tailored meals), tailored to health risk, or pantry stocking for pregnant individuals who meet risk and needs-based criteria. This service will provide prepared meals or grocery boxes that provide the nutritional equivalent of up to three meals per day and will be available for up to the length of the pregnancy and up to twelve months postpartum.

Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers for pregnant individuals as defined in the risk and needs-based criteria. Nutrition prescriptions may supplement a pregnant/postpartum member's existing nutrition supports (e.g., a produce-only prescription) or may constitute a fully nutritional regimen, based on the member's needs. Nutrition prescriptions will be available for up to the length of the pregnancy and up to twelve months postpartum.

The following nutrition interventions represent the full scope of allowable nutrition services. Subject to state budget availability and the process for updates to this Protocol described on page 1. The quantity of nutrition supports provided may be adjusted for family size using the NM SNAP definition of households.

New Mexico will phase-in nutrition interventions, beginning with medically-tailored meals provided to pregnant members with diabetes. As state budget availability allows, it is New Mexico's intent to expand to all pregnant and postpartum members and their family members over the five-year demonstration period.

Nutrition interventions for pregnant and postpartum members in New Mexico are designed to be person-centered and flexible to meet the changing needs of a member and the family throughout the pregnancy and post-partum period. For example, members may prefer nutrition prescriptions that allow the member to select their own groceries earlier in pregnancy but may need cooked and delivered meals in the late pregnancy/early postpartum period. Members who opt for medically-tailored meals cannot concurrently receive nutrition prescriptions.

The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods.

Nutrition Interventions Provider Qualifications:

Providers of nutrition interventions must:

- Enroll in Medicaid;

- Have knowledge of principles, methods, and procedures of the covered nutrition interventions meant to support an individual in obtaining food security and meeting their nutritional needs;
- Be able to receive referrals from providers and Turquoise Care MCOs;
- Be able to track and report on service delivery (including unsuccessful deliveries) according to the standards established by HCA;
- Comply, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of individuals receiving meals (if providing home-delivered meals);
- Follow best practice guidelines and industry standards for food safety;
- Include a Registered Dietician or Registered Dietician Nutritionist or other comparable professional to develop the nutritional content of the Meals/Grocery Boxes;
- Be able to customize Meals/Grocery Boxes to a member's cultural, religious and personal preferences.
- Be able to attain information from the member about their receipt of SNAP or WIC assistance and factor this assistance into the total number of meals requested for the member.

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

Medical Respite Inclusion Criteria:

People experiencing homelessness as defined by 24 CFR 91.5 who:

- Are hospitalized and preparing for discharge,
- Have full decision-making capacity,
- Can live independently,
- Have an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a Medical Respite stay, and
- Have been assessed by a Medical Respite Nurse Manager for medical respite and referred from a hospital partner.

Exclusion Criteria:

- Conditions that require services the medical respite provider site cannot support (e.g., PICC lines, wound vacuums, IV fluids or IV antibiotics, medical help to take medications, ADL assistance, incontinence support, or other high-acuity behavioral or physical health needs). This may vary by provider site and capacity.

Nutrition Interventions:

See Sections iv, v, and vii.

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

and

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

Medical Respite:

An individual must be referred by a hospital partner and assessed by a Medical Respite Nurse Manager to meet the inclusion/exclusion criteria for medical respite. Medical respite is limited to a clinically-appropriate amount of time, and after 60 days individuals will be reassessed to determine the appropriate extension period (not exceeding the 6 month per year limit). An individual's stay may be extended (not exceeding the 6 month limit) if the individual has not achieved the clinical goals outlined in the plan of care, cannot be discharged to shelter and requires medical respite to continue healing.

Nutrition Interventions:

Providers and MCO care coordination staff may determine the nutrition interventions benefit to be medically appropriate for a pregnant individual if the following criteria are met:

- Member-experiencing low or very low food insecurity as defined by the USDA[2];
- Confirmed pregnancy; and
- To the extent HCA has not yet expanded coverage to all pregnant members, a clinical risk factor or confirmed diagnosis of a condition identified as eligible by HCA documented in the member's medical record.

HCA will begin phasing in the nutrition interventions by providing medically-tailored meals to pregnant members with diabetes. In this case, the member must have a confirmed diabetes diagnosis documented in the member's medical record or confirmed with testing. Members who report food insecurity will also be referred for WIC and SNAP benefits.

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

Medical Respite:

The HCA Turquoise Care website will include a page dedicated to the Medical Respite benefit. This page will include the inclusion and exclusion criteria, provide stakeholders with opportunities to provide additional input on this benefit, and provide information on

[2] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

how FFS and managed care members can access this benefit. Turquoise Care MCOs, hospitals and medical respite providers will also be responsible for publicizing information about the benefit, including the criteria for member participation.

Nutrition Interventions:

The HCA Turquoise Care website will include a page dedicated to the “Food as Medicine” nutritional interventions benefit. HCA will maintain the clinical and social risk criteria on this public-facing webpage. The content will be updated if the criteria are changed. The Turquoise Care MCOs will also be responsible for publicizing the criteria. HCA will partner with members of the health and food communities to publicize the availability of this new Medicaid benefit.

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

HCA is designing the delivery system for Nutrition Interventions consistent with our vision for Turquoise Care: Every Medicaid member will have a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health. We envision that the member's primary care provider, who in New Mexico may be a midwife, an obstetrician or a Family Medicine provider, will coordinate care for all of the member’s needs, including their food insecurity needs, through this benefit. We also acknowledge the need for a “no wrong door” approach to nutrition supports. A member may self-refer for nutrition services, may be identified through a provider visit, may be identified by a Meals/Grocery Box vendor (vendor), a community partner (e.g., a food bank), or may be identified by their MCO.

The process for initiating a care plan may vary by delivery system (FFS vs. managed care), provider capacity, MCO and the delegated care coordination model. In general:

- Once a member and their primary care provider determine a member is eligible and has a need for nutrition supports that is not being served by other sources (e.g., WIC, SNAP), the member will be provided information about the benefit and a referral will be made to the applicable vendor(s) and MCO care coordinator. For FFS members, the primary care provider will provide the care coordination.
- The member’s primary care provider or care coordinator will open up a care plan for the member and coordinate with the vendor for any necessary authorizations.
- The member’s primary care provider or care coordinator may outreach to the member to ensure they receive the food from the vendor to close the referral loop and care plan. The member’s primary care provider or care coordinator will also provide information on SNAP and WIC as needed.
- For FFS and MCO members, the vendor will eventually report through HCA’s planned closed-loop referral system. HCA will require providers and MCO care coordinators to coordinate utilization of this benefit.

Medical Respite:

Each medical respite provider will be responsible for the creation of an individual clinical care plan by an appropriately licensed clinical provider. Each care plan will be developed in conjunction with the member, will include input from the Medical Respite Nurse Manager's assessment of need and will be reassessed periodically as appropriate for the member's condition and length of stay.

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

The nutrition interventions are intended to supplement, not supplant, WIC and SNAP, and Older Americans Act Nutrition Services as needed. No benefit will be covered that duplicates or displaces existing state or federally-funded food and nutrition services. Providers, MCOs and Meals/Grocery Box vendors will be instructed to assess for the member receipt of other nutrition benefits and to refer to those programs if the member is not enrolled. The Medicaid benefit may be provided while a member is applying for other benefits and may be provided as a supplement to other benefits when necessary to prioritize the nutritional needs of the pregnant individual and minimize any unmet food insecurity within the household.

HCA administers the Medicaid and SNAP. When members apply for Medicaid on the basis of pregnancy or apply for SNAP, the HCA Income Support Division will provide members with information about the Medicaid nutrition interventions and information about how to access these benefits through the member's pregnancy medical home provider.

This is not applicable to Medical Respite.

ix. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.5 and STC 15.4 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.2 affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 14.5 and STC 15.4, the monitoring protocol and evaluation design are subject to CMS approval.

HCA agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.5 and STC 15.4, which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.2 affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

This is not applicable to Medical Respite. HCA does agree to meet all monitoring and evaluation requirements stipulated in the Turquoise Care 1115 Waiver.

New Mexico Turquoise Care 1115 Demonstration HRSN Protocol for Infrastructure Planning

Nutrition Interventions for Pregnant Members and Medical Respite (Short-term post-hospitalization housing with room and board)

In compliance with STC #10.6 of the Turquoise Care 1115 Demonstration, the New Mexico Health Care Authority (HCA) is submitting an HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for Nutrition Interventions for Pregnant Members and for Medical Respite (Short-term post-hospitalization housing with room and board) to CMS for review and approval.

I. Proposed uses of HRSN infrastructure (provider capacity-building) expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

HCA's HRSN program allows qualifying Medicaid members to receive evidence-based clinically appropriate services, including nutrition supports for pregnant members and medical respite services. Over the course of the Turquoise Care 1115 demonstration, HCA is authorized to spend up to $99.474M on infrastructure investments necessary to support the development and implementation of these HRSN services. All expenditures will be subject to State budget availability. This section outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts, and implementation timeline.

A. Implementation Timeline and Approach

1. Timeline for disbursement of infrastructure funding

HCA intends to begin awarding infrastructure funds to eligible entities no sooner than July 1, 2025 (DY 13). HCA will use a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity. HCA will also align the timing of the application and disbursement of infrastructure funding with HCA's planned expansion to (1) up to 10 medical respite sites; (2) nutrition supports for pregnant members with clinical risk factors beyond diabetes; and (3) family members of pregnant individuals. HCA will fund both medical respite and nutrition supports service categories as needed to support Turquoise Care implementation goals.

2. Approach to infrastructure funding applications and disbursements

HCA, either directly or via existing or contracted fiscal relationships, will conduct the following activities:

- Determine the need for additional provider capacity in FFS and Turquoise Care MCO provider networks.
- Conduct outreach and education to eligible entities regarding infrastructure funding opportunities.
- Develop the infrastructure funding application(s) and application process.
- Review applications against eligibility criteria and funding availability.
- Award infrastructure funding to eligible entities.
- Disburse funding to awarded entities.
- Monitor infrastructure funding uses and implementation progress of awardees.
- Monitor for fraud, waste and abuse.
- Ensure infrastructure funding awards are reported appropriately under the HRSN Infrastructure MEG on the CMS 64.

HCA will develop a process to evaluate and approve applications for funding requests from eligible entities. HCA may permit applications on a rolling basis (which may be most appropriate for future providers of medical respite services) or set a specific application window in which entities can plan to apply and receive funding. HCA will develop standardized criteria to support evaluation of HRSN funding applications and requests, including but not limited to:

- The entity has submitted a complete application and budget request for one of the allowable activities described below;
- The entity has submitted a justification for the need for funding;
- The entity has demonstrated the ability to provide or support the provision of HRSN services, if supported by infrastructure funding;
- The entity attests to non-duplication of other federal, state or local funding; and
- The entity agrees to contract as a Medicaid FFS provider and as a Turquoise Care MCO provider, if offered an MCO provider contract.

3. Monitoring and Oversight

HCA will monitor to ensure that any HRSN infrastructure fund disbursements are consistent with the Turquoise Care 1115 demonstration STCs. HCA will ensure that any HRSN infrastructure funding is subject to program integrity and standards, including:

- Participating in federal or state audit processes. HCA, either directly or via existing or contracted fiscal relationships, will conduct audits as needed to ensure that infrastructure funds are being spent on allowable items and are being documented and reported on appropriately.
- Taking action to address non-compliance. HCA will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, HCA may impose corrective action (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). HCA will provide notice to any funding recipient prior to initiating corrective action. HCA will report any instances to CMS as part of the quarterly 1115 reporting.
- Ensuring non-duplication of funds. HCA will monitor for funding irregularities and potential duplication of funds.
- Monitoring for fraud, waste and abuse. HCA, either directly or via existing or contracted fiscal relationships, will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. HCA will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste and/or abuse and report such instances to CMS. The state reserves the right to recoup funding as necessary.
- Monitoring participation of providers awarded infrastructure funding in the Turquoise Care MCO networks and FFS to ensure access to HRSN services.

B. Eligible Entities

The following entities may be eligible to apply for and receive HRSN infrastructure funding:

Medical Respite:

- Entities that are preparing to have the capacity to deliver medical respite HRSN services (or preparing to partner with future providers of medical respite services), including FQHCs/RHCs, hospitals, counties, community-based organizations, social service organizations, traditional health care providers, case management providers, housing and shelter providers, tribal providers, and Urban Indian Organizations.
- Medical respite providers in New Mexico that have the capacity to deliver peer-to-peer training and implementation supports to future medical respite providers.
- Entities that are preparing to support the delivery of medical respite, including state, city, county and local governments, community-based organizations, or other entities that support medical respite contracting, implementation, invoicing, and service delivery.
- State agencies, local government, or contracted partners to facilitate setup, operation, and ongoing oversight of medical respite programs.

Nutrition Supports for Pregnant Members:

- Entities that are preparing to have the capacity to deliver nutrition supports to pregnant members, including food and nutrition service providers, food pantries, and non-profit community-based organizations.
- Entities that are preparing to support the delivery of nutrition supports to pregnant members, including primary care providers, OB/GYN providers and midwives, state, city, county and local governments, community-based organizations, or other entities that support nutrition supports contracting, implementation, invoicing and service delivery.
- State agencies, local government, or contracted partners to facilitate setup, operation, and ongoing oversight of nutrition supports programs.

All entities must (1) demonstrate financial stability; (2) be capable of providing or supporting the provision of medical respite and/or nutrition supports for pregnant members; and (3) be willing to provide documentation to HCA in support of implementation progress required by any infrastructure funding award.

C. Intended Purpose of HRSN Infrastructure Funding

HCA may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains:

- Technology
- Workforce development
- Development of business or operational practices
- Stakeholder engagement and outreach

HCA intends to provide infrastructure funding to eligible entities for the following activities:

1. Technology

Eligible entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support the use of New Mexico's statewide Findhelp closed-loop referral platform and other community information exchange priorities. Entities may apply for infrastructure funding to procure IT infrastructure, data platforms, and systems needed to enable:

- Communication across support partners for HRSN services (e.g., communication among clinically-integrated partners for medical respite).
- Authorization of HRSN services, including any food as medicine "prescription."
- Documentation of eligibility for HRSN services and tracking enrollment.

- Closed loop referral to HRSN services.

- Electronic medical records that include plans of care.

- Participation in the HIE.

- HRSN service delivery.

- HRSN service billing to FFS and to Turquoise Care MCOs.

- HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program).

- Eligibility determination for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC).

- Eligible entities may also apply for technology-related infrastructure funding to:

    - Modify existing systems (e.g., community information exchange) to support HRSN.
    - Develop an HRSN eligibility/services screening tool.
    - Integrate data platforms/systems/tools.
    - Onboard new, modified, or existing systems.

2. Workforce development

HCA will consider applications from eligible entities for the following activities:

- Training provided by a technical assistance organization to support one or more HRSN providers.

- Technical assistance provided by an experienced provider of HRSN services (e.g., training for future medical respite providers by current medical respite providers, including the development of “roadmaps” and provider toolkits).

- Supporting the costs of recruiting, hiring and training new staff to provide HRSN, and salary and fringe benefits for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities, time limited to 18 months.

- Supporting the costs to obtain necessary certifications, training, technical assistance and or education for staff participating in one or both HRSN services.

- Supporting the costs of participation in privacy/confidentiality training or technical assistance related to HRSN service delivery.

- Supporting the costs to produce training materials for HRSN services.

3. Development of business or operational practices

HCA will consider applications from eligible entities for the following activities:

- Training for the use of new, modified or existing systems.
- Training on contracting with and billing Turquoise Care MCOs and Medicaid FFS for HRSN services.
- Training and technical assistance on HRSN program and roles/responsibilities.
- Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HRSN operations).
- Costs of office furnishings, supplies, and equipment that support the delivery of HRSN services (e.g., computers, desks, chairs, etc.).
- Procurement of administrative supports to assist implementation of HRSN.
- Development of polices/procedures related to:
    - MCO participation
    - HRSN referral, service delivery workflows, and care plans
    - Billing/invoicing
    - Data sharing/reporting
    - Program oversight/monitoring
    - Evaluation
    - Privacy and confidentiality.

4. Conducting stakeholder engagement and outreach

HCA will consider applications from eligible entities for activities that include:

- Production of materials and online content necessary for marketing, outreach, training and/or education related to HRSN.
- Translation of materials.
- Planning for and facilitation of community-based outreach events to support awareness of and engagement in HRSN services.
- Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN.

- Registration and costs associated with participation in key webinars or conferences necessary for participant learning and technical assistance (e.g., attendance at the National Healthcare for the Homeless annual Conference and Policy Symposium).
- Convening and/or participating in stakeholder forums directly associated with HRSN services.
- Community engagement activities necessary to support HRSN program implementation and go-live (e.g., stakeholder forums, roundtables).
- Administration or overhead costs associated with outreach, education or convening directly tied to HRSN services.
- Supporting the costs of developing partnerships among key stakeholders (e.g., convening hospitals with future provider sites for medical respite), including the development of MOUs and other agreements necessary to document partnership agreements.

D. Projected Expenditure Amounts:

HRSN infrastructure expenditures will begin no sooner than DY 13 (CY 2025). HCA estimates the following infrastructure expenditure amounts by allowable use category over the Turquoise Care demonstration. HCA used the annual infrastructure spending amounts articulated in the demonstration STCs and an analysis of anticipated need across the state to develop the estimates below. HCA anticipates that the percentage of spend by permissible spend categories will stay relatively constant across the demonstration years (DYs). As allowed by the STCs, any unused amounts will rollover to the subsequent DY.

Allowable Provider Capacity-Building Category	Expected Amount	Percentage of Capacity-Building Spend
Technology	$39.790M	40%
Workforce Development	$34.816M	35%
Operations and Business Practices	$14.921M	15%
Stakeholder Engagement and Outreach	$9.947M	10%
Total	$99.474M	100%

ATTACHMENT O
Provider Rate Increase Attestation Table
Approved March 27, 2026

New Mexico HRSN Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to HRSN related provider payment increase requirements for the demonstration period of performance DY 12 through DY 17.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	91%	91%
	Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3), following STC method 12.2(c)(i)	Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3), following STC method 12.2(c)(i)
Obstetric Care Services	98%	98%
	Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3), following STC method 12.2(c)(i)	Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3), following STC method 12.2(c)(i)
Behavioral Health Care Services	89%	89%
	"Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021. Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)", following STC method 12.2(c)(i)	"Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021. Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)", following STC method 12.2(c)(i)
In accordance with STCs 12.1 through 12.2, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on DY14 and will not be lower than the highest rate for that service code in DY 12 plus a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least DY17. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and		

to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

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

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

[*Select the applicable effective date, must check either a., b., or c. below*]
☒a. New Mexico is not subject to the provider payment rate increase because the Medicaid to Medicare provider payment rate ratio in each service category and delivery system is equal to or greater than 80 percent prior to the first day of DY 14. New Mexico will sustain these rates, if not increase them, through DY 17.
☐b. The effective date of the rate increases is the first day of DY 14 and will be at least sustained, if not higher, through DY 17.
☐c. New Mexico has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 14. New Mexico will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 17.

New Mexico does make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

[*Select the applicable requirement, must check either a. or b. below*]
☐a. For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than N/A for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than N/A
☒b. New Mexico is not subject to the provider payment rate increase.

New Mexico does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

[*Select the applicable requirement, must check either a. or b. below*]
☐a. For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 12.2(h) through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than DY14

☒b. New Mexico is not subject to the provider payment rate increase.

[*Select the applicable requirement, must check either a. or b. below*] ☐a. If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 12.2(h), I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans. ☒b. New Mexico is not subject to the provider payment rate increase.
New Mexico further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 12.
I, Carlos Ulibarri, Acting Chief Financial Officer, attest that the above information is complete and accurate.  _ 11/10/2025 Carlos Ulibarri, Acting Chief Financial Officer