WORKGROUP REPORT:

Medicaid and Early Childhood Home Visiting

October 2021

Prepared by The Focus Group Consulting for
New Mexico Early Childhood Education and Care Department

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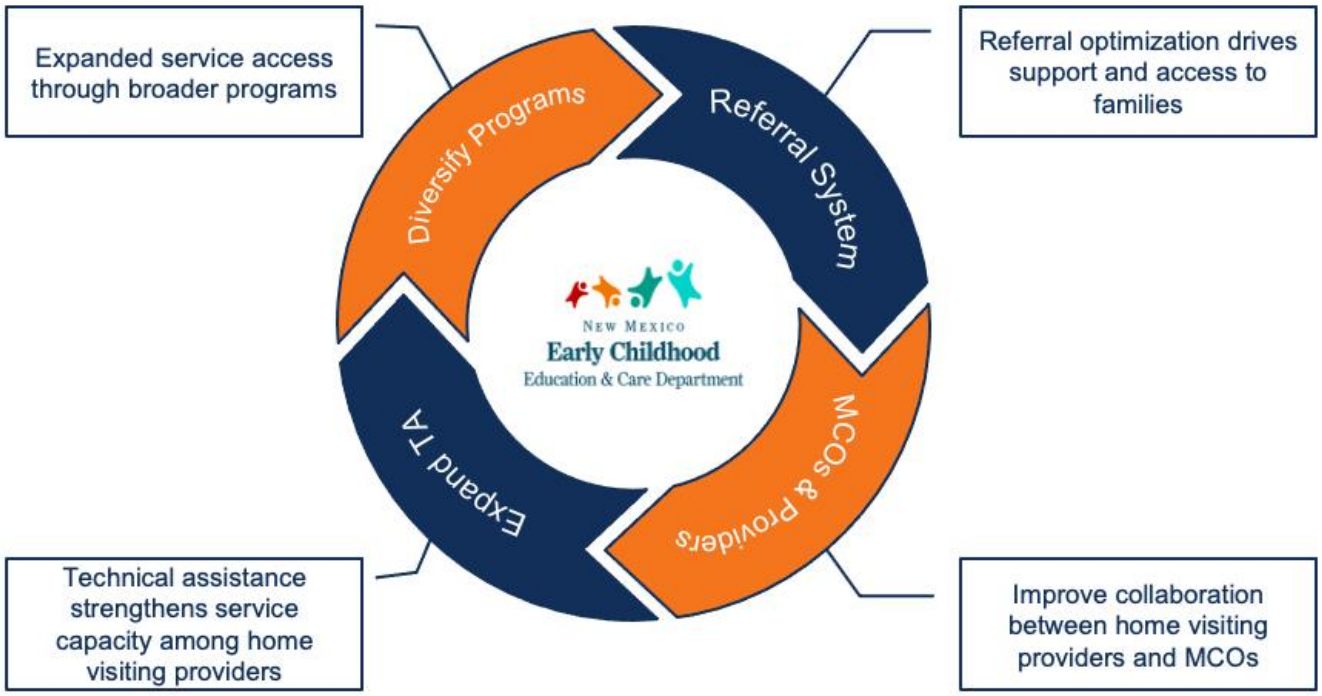
Summary of Recommendations



Introduction

New Mexico's Centennial Home Visiting (CHV) Program was established in 2020 as part of the state's Centennial Care 2.0 Medicaid 1115 Waiver (the "Waiver"). CHV services are provided in a home setting to young children, children with special health care needs, and to the parents(s)/primary caregiver(s) of those young children.

New Mexico CHV's Program Goals are to:

- Improve maternal and child health,
- Promote child development and school readiness,
- Encourage positive parenting, and
- Connect families to the formal and informal support in their communities.

The original Waiver served as the state's CHV Pilot and provided CHV services to 150 eligible Centennial Care 2.0 MCO members who resided in Bernalillo, Curry, Roosevelt and Taos counties (UNM NFP=70, UNM PAT=40, ENMRSH=20). Medicaid beneficiaries who were not eligible or able to enroll in that Pilot CHV Program could qualify for similar services offered by the Early Childhood Education & Care Department (ECECD). From July 1, 2019 – June 30, 2020, 152 families were served by the pilot program. In 2020, the Centers for Medicare and Medicaid Services (CMS) accepted New Mexico's proposed Waiver amendment, which expanded CHV services statewide and increased number of families served.

CHV providers are currently contracted (per Waiver stipulations) to operate one of two home visiting models - Nurse-Family Partnership (NFP) or Parents as Teachers (PAT). The U.S. Department of Health and Human Services, Health Resources Services Administration, Department Home Visiting Evidence of Effectiveness (HomVEE) designates NFP and PAT as evidence-based models. To maintain program fidelity, agencies must adhere to the New Mexico Home Visiting Program Standards and CHV home visitors must maintain caseload limits.

In November 2020, the Early Childhood Home Visiting Medicaid Expansion Workgroup (or ECHV Medicaid Expansion Workgroup) was formed to address CHV program expansion, to drive existing provider improvement, to increase existing provider program utilization, and to consider how the CHV could expand to include additional HV models and additional providers. The Workgroup additionally explored opportunities to expand the State's non-Medicaid HV programs to ensure greater access to and support for services throughout the State. The ECHV Medicaid Expansion Workgroup's activities culminated in April 2021. The Workgroup's 36 members included representatives from the Human Services Department (HSD), ECECD, home visiting providers, staff of the Legislative Finance Committee, representatives from the early childhood funders groups, Medicaid Managed Care Organizations (MCO) representatives, CHV participants, and other early childhood service providers from across the State.

The Workgroup's efforts align with the ongoing efforts of the Pritzker Initiative: Growing Up New Mexico. In May 2020, the Pritzker Foundation awarded New Mexico a 3-year, $1 million implementation grant to build a broad coalition focused on the expansion of programs and services for low-income infants and

toddlers (prenatal to age three) across New Mexico. The Pritzker Initiative brought together a statewide prenatal to three (Pn-3) steering committee. With over 50 organizations represented, the Pn-3 Steering Committee reflects the commitment of the State and of the many dedicated early childhood professionals and stakeholders, who continue to contribute their time and expertise.

The Workgroup contracted with The Focus Group to help facilitate the process. In November, a Core Team was established to centrally drive the Workgroup's main goals and objectives. This Core Team consisted of ECECD and HSD senior leadership, and other participating foundation partners. Core Team members met and established Workgroup goals and objectives. The Workgroup identified three common Goals, and for each goal formed a corresponding Project Team. These project Teams were tasked to address each of the three main goals and associated objectives.

Project Team Goals

Project Team 1: ECHV Medicaid Expansion: Provide recommendations and a roadmap for expansion of the Home Visiting Pilot, with a focus on enhancing support for qualifying providers to bill Medicaid and sustain	***Project Team 2: MCO and ECHV Alignment:*** Drive alignment of home visiting with managed care state contract goals as part of Centennial 2.0.	***Project Team 3: ECHV Provider Efficiencies:*** Develop strategy recommendations to enhance key operational synergies across qualifying Home Visiting Programs
1.a. Move home visiting providers from state billing to direct Medicaid billing (under current CHV fee schedule mechanisms) through technical assistance support via ECECD General Fund dollars. 1.b. Determine use and appropriations of ECECD General Fund dollars, including allocation for training, data systems, credentialing support, and direct services. 1.c. Identify and recommend possible amendments to the Centennial 2.0 Waiver for program inclusion, including those in tribal communities	2.a. Make recommendations on fee schedule adjustments. 2.b. Develop a strategy for how MCOs can develop wraparound care models integrated with ECHV. 2.c. Provide recommendations on program credentialing needs, improvements in contracting with MCOs, and other technical assistance to providers. 3.d Offer recommendations and priorities on support to MCOs in satisfying contract mandates (e.g., delegated care, service delivery).	3a. Provide recommendations on centralized billing and contracting structure. 3.b. Develop a strategy for operational synergies between providers (possibly in collaboration with UNM), including recommendations for a seamless referral system that manages waitlists and supports families with transitions. This includes alignment with MCOs on a centralized ECHV referral system. 3.c. Develop a centralized data model including possible recommendations and strategy for a new statewide data system (through ECECD support).

In December 2020, Project Teams were formed, and an ECECD staff was nominated to chair and lead each Project Team. Each Project Team was directed to 1) contextualize existing challenges, 2) identify current processes, and 3) propose recommendations for potential future implementation, all towards the overarching goal of CHV expansion. A virtual Kickoff Meeting was convened December 2020, which brought together stakeholders from the State, MCOs, foundations, tribal communities, and home visiting

providers. At that Kickoff, the goals, purpose, and timeline for the Workgroup were shared, and participants were encouraged to volunteer to join a Project Team. There were 33 people, and three Project Chairs who volunteered to lead one or more Project Teams.

Project Teams met monthly in January, February, and March 2021. The aim of the first meeting was to determine the current state and historical challenges with regards to the Team's objectives. The aim of the second meeting was to outline possible process(es) for improvement as a framework for recommendations. The third meeting aimed to finalize the recommendations and discuss possible implementation. The Project Teams were not established to implement solutions but rather to clarify and coalesce around a shared vision of success. In addition to the nine Project Team meetings, there were working sessions with current Medicaid billing providers, MCO representatives, the state Medicaid Director, and the Core Project Team, all to advance the efforts of the Workgroup.

During the Workgroup, there was clear overlap and alignment between Project Teams on core themes and ways to improve home visiting. After further vetting with the Core Team, four recommendations were proposed to advance and expand CHV:

1. **Recommendation 1:** Support CHV providers to successfully bill Medicaid for CHV services
2. **Recommendation 2:** Enhance Collaboration and Communication between MCOs and HV Providers
3. **Recommendation 3:** Improve the Intake and Referral Process
4. **Recommendation 4**: Expand Access to a Variety of ECHV Program Models

CHV currently serves 130-135 families and is allocated to serve 803 families in fiscal year 2022. The recommendations and action plans below are designed to help ECECD meet its goal of serving more families, will require further clarification, alignment, and refinement prior to being finalized and implemented.

Recommendation 1: Support CHV Providers to Successfully Bill Medicaid for CHV Services

Project Team participants and CHV Pilot sites noted that home visiting providers may need additional funding and technical assistance (TA) support to bill Medicaid at both the startup phase and in ongoing operations. When starting to bill Medicaid, there is potentially a multi-month delay in revenue while claims are being adjudicated. Understanding and meeting program requirements are high barriers to entry for new home visiting providers who have not historically billed Medicaid. As organizations continue to bill Medicaid, ongoing billing covers direct services (per service unit requirements stipulated by HSD), and included in the fee-for-service rate it is designed to indirectly cover administrative costs. Further, there is confusion among some home visiting providers about how to clearly define a unit of service in alignment with the Letter of Direction (LOD). This recommendation and its corresponding actions will contribute to CHV expansion by successfully onboarding new organizations and helping to sustain current provider operations.

Objective 1.1: Provide personalized technical assistance and funding to enable agencies to begin billing Medicaid for CHV services

Action 1.1a: Implement process for regional TA support

The Workgroup saw the need for specific regional Medicaid TA to help guide home visiting providers through the Medicaid program, specifically the denial and back-office billing process (which causes confusion). Workgroup members noted that some new home visiting providers may need support from the State (ECECD, HSD, MCOs) because they do not have the initial internal expertise for Medicaid billing. This recommendation needs further exploration and there may be opportunities to help simplify this through improving billing processes and interagency structures.

Action 1.1b: Create a start-up checklist

The Workgroup recommends the need to create a startup checklist to successfully onboard an organization to Medicaid billing. This checklist will provide support and assess key factors about a home visiting program's operational capacity for Medicaid billing and associated readiness. This will give a better understanding of the process and the requirements needed to bill Medicaid while recognizing that a fee-for-service structure may not be a good fit for every organization.

Action 1.1c: Clearly define and align a Unit of Service

Providers noted in the Workgroup that a unit of service is not clearly defined (or understood) in the Letter of Direction (LOD) and the service time is unclear. The standards in HSD's LOD need to reflect and align with ECECD's standards.

For ECECD Home Visiting, the State currently provides a set dollar amount per family per year based on the level of care, while CHV reimburses on a fee for service model (see more below). For fiscal year 2022, the ECECD base rate will be $4,500 per family.

The Medicaid fee-for-service rates and the capitation rates above are currently not comparable and require further examination. Part of the plan would be to investigate the economics of reimbursement to justify any changes in fee schedule. The Workgroup recommends that the LOD align with the 90 cumulative minutes of interactive visits with families (video, phone, and face to face) over the course of the month.

Action 1.1d: Each agency will be supported to develop a business plan for CHV billing

The Workgroup recommends that before new providers begin CHV billing, they are supported in developing a business model and financial forecast that details the cost and new processes for billing Medicaid. The business plan will understand new provider financials and capability to bill under CHV. This action plan will be an addition to the start-up checklist in Action 1.1b and will be further supported by the Mentor Network in Action 2.2b.

Objective 1.2: Provide funding to support implementation of CHV services

Action 1.2a: Identify budgeted amount and source of start-up funding

In addition to the business plan in Action 1.1d, the Workgroup also recommends supporting home visiting providers in developing a budgeting process for engaging in CHV. Providers will work with ECECD to develop a funding source and distribution mechanism. This would likely be intended as a stopgap mechanism for CHV program expansion. As other efforts for home visiting operational capacity and support grow, startup funding could transition to other areas of focus.

Action 1.2b: Provide initial start-up funding to agencies

Based on Action 1.2a, this would be direct distribution for a determined period of time to organizations for start-up activities. Given the standard delay in revenue when starting to bill Medicaid, Workgroup members, most notably home visiting providers, recommend initial startup funding to help organizations maintain a steady cash flow during multiple months of waiting on accounts receivables.

Action 1.2c: Identify other funding sources (e.g., additional braided state funding)

This action plan could involve alternative financing from ECECD and partners around the state and region. Funding sources could include foundations, and other philanthropy as well. Additional funding options could be explored such as debt free financing to organizations pending Medicaid reimbursement, or other alternative financing models such as structuring a bundled rate that is paid monthly or annually. An alternative payment model is further discussed in Action 1.3d.

Action 1.2d: Adjust fee-for-service rate to support the cost of care

Workgroup members discussed the need to offer TA to home visiting providers under CHV to improve the cost of service delivery through both shared services and operational improvements. This could involve additional investigation into rate adjustments with the goal of establishing a rate that is compensatory with service delivery costs. In addition, there is an opportunity to create operational effectiveness to reduce cost of care to align with fee-for-service rates. This would support other operational improvements within Recommendation 1.

Project Teams shared feedback that services and workshops would support early-stage CHV providers and help more established organizations continue operations. To off-set the cost, shared services such as billing and claims, denial support services, and associated IT could be increased. Technical assistance could include support on operational efficiencies within service delivery operations, documentation (relating to billing), and billing operations. This would allow for CHV home visiting provider organizations to more effectively match unit service economics with cost of home visiting provider services.

Objective 1.3: Streamline data bases and billing to improve efficiency

Action 1.3a: Automate Billing Systems through a Shared Online Portal

Workgroup members discussed an opportunity to streamline and make the reporting databases and billing systems more efficient and potentially better connected. Currently, all CHV providers are manually billing via three separate MCO portals and updating the Home Visiting Database. This double entry takes added time and resources. As the CHV program grows and home visiting providers expand services, this process will become increasingly harder to track and organize. There is limited continuity in the data between the Home Visiting Database and MCO billing process, and as one provider stated, “the Home Visiting Database and the MCO billing systems should better talk to each other.” As the program scales, a transition to a more sophisticated system will be required, and this will support future growth.

Action 1.3b: Phaseout manual billing and develop a centralized billing approach for CHV providers

As discussed above, CHV providers are currently entering billing claims into three separate MCO portals. Workgroup participants identified manual processes for individual billing as a bottleneck for scale. The Workgroup recommends creating one shared online portal for all billing. This expanded online platform will better incorporate billing and claims and create more system automation. This will save providers time and money, and better position the program to scale. However, this may be out of scope for the Workgroup as independent billing portals are used for a breadth of other clinical services across the State.

It is recommended to explore a centralized billing option (platform, services, provider portal). This will allow current CHV providers and future organizations to streamline cost of service delivery and improve accounts receivable.

Action 1.3c: Incorporate a Medicaid Billing System into the Home Visiting Database

Workgroup participants were interested in opportunities to embed billing into the Home Visiting Database. One option may be through the ECSC Database Services and its ability to incorporate their Medicaid billing system with home visiting providers, although other integrated data platforms could be used as well. There needs to be further conversations and explorations to assess the appropriate technology solution but integration between systems will likely improve home visiting services administration and overall operational efficiencies.

Action 1.3d: Develop alternative payment approaches to fee-for-service approach (e.g., capitated, annualized)

As an alternative to Action 1.2d, Workgroup members expressed an interest in annualized or capitated family rates as an alternative to traditional fee-for-service billing in CHV. It is recommended to explore this feasibility with HSD, and in turn with CMS, as the 1115 waiver would require adjustment to make this change. Further financial analysis is recommended regarding the cost of service delivery against potential capitated rates.

Recommendation 2: Enhance Collaboration and Communication between MCOs and HV Providers

Across all three Project Teams, participants expressed the need for enhanced communication mechanisms between MCOs and ECHV providers. These could be specified in the MCO contracts and future Letters of Direction. MCOs and ECHV providers need more opportunities to connect, such as at the monthly CHV meeting and through additionally scheduled provider-to-provider meetings. These formal touchpoints can expand CHV by creating successful collaboration to alleviate bottlenecks in billing and billing-related services, create synergies between care management handoffs and referrals, and establish a shared dialog which leads to more positive outcomes. This recommendation encompasses goals 1.a, 1.b, 2.c, and continues to build synergies between providers, a focus of Project Team 3.

MCO representatives that participated in the Workgroup shared the need to continue to improve the feedback loop for MCOs on [their] members receiving home visiting services. Further, as expressed, claims data takes too long to adjudicate to effectively understand the needs of high-risk members, and MCOs requested better insight on the types of services both CHV and non-CHV home visiting providers offer. This theme addresses goals 2.c and 2.d.

Objective 2.1: Provide opportunities for collaboration between MCOs and HV Providers

Action 2.1a: Continue and Expand Home Visiting Stakeholder Meetings

Throughout the Workgroup, participants recognized the need for formal meetings and clear lines of communication to advance the goals of CHV. As CHV scales up by onboarding more home visiting provider organizations, the Workgroup noted the importance of keeping existing monthly CHV meetings (established through a Letter of Direction from HSD) in place and possibly expanding more opportunities to meet. In addition to the monthly CHV meeting, a proposed option was a quarterly meeting between MCOs and home visiting providers that would focus on a specific topic or gap in service delivery. An alternative and/or addition could be to expand the monthly CHV meeting to two hours and reprioritize the meeting to respond to specific needs of the providers. Regardless of the cadence, these formal collaborations help break down institutional silos and allow for the sharing of valuable information between providers, the State, and MCOs.

Action 2.1b: Establish connections between MCH regional care coordinators and HV agencies and complement existing MCO wraparound services

Wraparound care models identify the holistic services new moms and children need across various points of care. In the case of home visiting, this would better facilitate the transition from pregnancy to early childhood through existing MCO case management services. Blue Cross Blue Shield, Western Sky, and Presbyterian, the three MCOs in New Mexico, all reported their own unique wraparound care models for families. A standardized referral model would better link into these programs for better statewide synergy regardless of MCO coverage. Further, families should not need to wait for services (as is often the case), and a standardized regional hub model would be more efficient in referring them to an appropriate home visiting provider with necessary capacity. One participant in Team 3 summarized this point by saying, "babies can't wait, and any mom who wants home visiting services should have access."

Action 2.1c: Maximize role of the MCO care coordinator in the communication process (single point of contact for care coordination) for levels 2 and 3 under Centennial Care

Aligned with Action 2.1b, MCOs have their own care coordination program. It is recommended to create strong operational linkages between these program leads and CHV providers. This would involve potential training updates with these coordinators to improve member communication. By enhancing the role of the care coordinators and better aligning with a single point of contact at the MCOs, it will increase the number of members referred to and receiving home visiting services.

Objective 2.2: Streamline communication and clarify roles

Action 2.2a: Establish clear points of contact at each MCO

Both home visiting providers and MCOs recommended the need to establish a point of contact at each MCO for home visiting organizations. These clear and established lines of communication will help ensure the MCOs and providers share information and develop transparent lines of communication. As home visiting providers address billing and associated compliance challenges, clear lines of communication can drive quick resolution and effective payment for CHV services.

Action 2.2b: Establish a mentor network for new providers

Multiple Workgroup participants expressed the need for and interest in creating a formal mentor network between CHV provider organizations currently billing Medicaid and those home visiting providers who are new to the process. This statewide peer-to-peer collaboration between provider organizations would benefit programs that are applying for Medicaid expansion and guide new programs through the process of Medicaid billing.

Action 2.2c: Grant MCO care coordinators access to HV Database

Representatives from MCOs that participated in the Workgroup recommended that they have access to the Home Visiting Database. This access will help them better measure beneficiary progress, to correlate to their own HEDIS measures, and thus improve quality. Expanding MCO database access would also allow them to see greater visibility into home visiting provider

coverage and services. By connecting MCOs directly to the Home Visiting Database, they could have the ability to use claims data to show an ROI and downstream cost savings.

However, this action plan needs to be further explored and clarified as it is not customary and has potential concerns. Alternatively, the State could prepare specially run data from the Home Visiting Database that contains information MCOs need, rather than giving them access to the full database. There are potential HIPAA concerns and other potential issues related to MIECHV that need further exploration before steps are taken to implement this plan.

Action 2.2d: Enhance Medicaid contract language to specify CHV responsibilities.

It is recommended to work with HSD to define the roles and responsibilities of MCOs in CHV support and coordination. MCOs currently do a strong job of aligning with CHV delivery, but there is room for improvement in how this is documented and communicated. Through additional workgroups this language can be clarified and updated with future LODs.

Recommendation 3: Improve the Intake and Referral Process

CHV Programs lack a universal referral system to accurately track referrals for home visiting services. This includes a lack of consistency in who provides referrals and how they are received. This creates inefficiencies and potential lapses in communication between home visiting providers, referral sources (clinical and non-clinical), and families receiving services. Certain organizations provide more referrals than others, potentially due to a lack of a coordinated and standardized system that is easily accessible, and there is a current lack of trackable data in the referral system on closed referrals and completed service delivery. This can create gaps in care, and it is unclear if home visiting providers are at capacity or can accept more families. Improving the intake and referral system was discussed across all three Project Teams, such improvement will directly contribute to CHV expansion by creating more efficient access and follow-through for families, referral sources, and home visiting provider wraparound care. This theme aligns with objectives 1.b, 2.b, and 3.b.

Objective 3.1: Develop a Centralized Intake and Referral System Responsive to Regional Needs

Action 3.1a: Establish regional hubs for intake and referrals using knowledge of local community needs and resources

Throughout the Workgroup, participants noted that New Mexico is a large and diverse state with regions that have unique needs. Workgroup participants noted that a large, centralized state system may create disconnects between referrals, the unique characteristics of the region, existing home visiting provider relationships, and the needs of the families. This points to the possible need for a regional hub model that better respects local relationships and incorporates established providers. This proposed model would still allow for and respect family choice while giving an equal opportunity to all regardless of access to technology. It should be noted that a regional approach to a referral system does not preclude a statewide referral network; rather, there should be a preference for local and regional relationships.

Action 3.1b: Standardize the technology system across regions

A regional hub model will accommodate the diversity of the State and the needs of local providers serving unique communities, but the regional hubs should use the same technology and IT system and likely rely on a single State infrastructure. Each regional hub should use the same data and intake system to make sure data can aggregate up to the State level for clear, immediate, and transparent reporting.

Objective 3.2: Systematically engage primary care and prenatal providers in referring and linking families to Home Visiting

Action 3.2a: Provide clear, concise information on locally available HV models

The Workgroup noted that there is a lack of clear information on availability of home visiting providers among primary care and prenatal clinicians. This results in gaps in care and fragmented referrals. There is an opportunity to provide clear information on availability of home visiting as well as better communication and messaging on the benefits. Objective 3.1 and a universal home visiting referral platform would help address some of these gaps, but there needs to be further coordinated outreach to primary care and prenatal networks about home visiting options for their patients.

Action 3.2b: Create simplified referral process for medical providers and hospitals.

As stated above, referrals are fragmented and primary care and prenatal providers lack an understanding of home visiting providers' availability and service offerings. A universal referral system as described in Objective 3.1 would help address this gap. However, clinical providers such as primary care physicians and provider associations will need to be informed about the new system and educated on the process to increase adoption and overall use.

Recommendation 4: Expand Access to a Variety of ECHV Program Models

Workgroup participants consistently stated that New Mexico is a diverse state that requires unique local considerations and not a one-size-fits-all approach. Providers and families should have more flexibility and choice in the home visiting program model they use. Additional home visiting models (notably First Born) may need to be included in the Centennial 2.0 Medicaid Waiver to help scale the program. However, some Workgroup members believe there is additional opportunity to continue to expand Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) throughout the State under existing coverage eligibility. Expanding program models aligns with the goal of Project Team 1 and objective 1.c. Action plans implemented from this recommendation would immediately give families more options to select the program that best meets their needs expand the supply of home visiting providers and expand utilization of CHV.

Objective 4.1: Expand capacity of current HV models

Action 4.1a: Increase number of NFP and PAT sites under CHV

Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) are currently the only two approved home visiting models in the New Mexico Centennial Care 2.0 1115 Medicaid Waiver. A clear proposal from the Workgroup is to continue to expand home visiting through organizations that use NFP and PAT throughout the State and benefit from the economies of scale and shared resources such as training and workshops. This could be through three concurrent strategies: 1) expanding the reach of existing CHV providers, 2) onboarding new CHV providers among existing home visiting programs in the State that use the NFP and PAT models and 3) expand PAT and NFP services to other home visiting provider sites (followed by onboarding these providers to CHV). All three strategies would expand utilization of CHV directly without policy changes to the Centennial 2.0 Waiver.

Action 4.1b: Expand number of families served under current NFP/PAT sites

The main goal of CHV is to expand the number of families served under the program. The recommendations above, including operational improvements and start-up support in Recommendation 1, as well as Action 4.1a, will address CHV capacity and help achieve this goal. It is recommended to enhance key performance indicator (KPI) reporting to understand families served by site as well as opportunities for system improvement. An example of this would be to set and monitor monthly targets for CHV enrollment and participation (e.g., through contract language or other expectations for plans). Another example of monitoring KPIs could be specific CHV provider site reports that are sent to ECECD quarterly. These reports would contain demographic information of the families served, some maternal/caregiver health outcomes, and infant/child health outcomes.

Objective 4.2: Increase number of HV models used in New Mexico

Action 4.2a: Expand use of additional evidence-based HV models

The Department of Health and Human Services (HHS) uses the Home Visiting Evidence of Effectiveness (HomVEE) review to conduct a thorough and transparent analysis of early childhood home visiting models. HomVEE has a list of 19 models (https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees) that have met HHS criteria as evidence-based early childhood home visiting service delivery models although only 15 are in active use across other states. The state is already piloting Family Connects, an evidence-based universal light touch home visiting model, and adding this model to CHV has the potential to significantly increase the number of families receiving support and linkage to services. The Centennial Waiver states, “If the state chooses to incorporate additional evidence-based models into the demonstration, the state will have to submit a demonstration amendment as per STC 7.” In the next Medicaid Waiver amendment or next Waiver, there is an opportunity to include other models (among the 19 approved) beyond NFP and PAT that will continue to meet the unique needs of New Mexico’s families and providers.

Action 4.2b: Expand use of research-based and promising practice models in NM

First Born is widely used across the state as a promising practice. It is recommended, given its success and saturation across the state, to continue to expand program sites and service delivery through First Born. In the near future, this will not be through the CHV Waiver, but will help expand the total number of families served by early-childhood home visiting. Action 4.2d, will align with this action, and ideally move First Born funding under MIECHV.

Action 4.2c: Apply to HRSA to expand use of research-based and promising practice models under MIECHV

MIECHV's authorizing statute allows awardees to utilize a portion of their MIECHV funding for a model that qualifies as a promising approach. Up to 25% of funding is available to implement promising approaches that will undergo rigorous evaluation.

Action 4.2d: Continue efforts to secure MIECHV approval for First Born program

As stated above, First Born is widely used throughout the state and is deeply responsive to the challenges and diversity unique to New Mexico families and new mothers. It is important to continue to evaluate the First Born program to gain designation as an evidence-based home visiting model. This designation would place First Born under Action 4.2a.

Conclusion

ECECD is allocated to serve 800 families in fiscal year 2022 through CHV. The recommendations and associated action plans presented in this report are the culmination of feedback and multiple working sessions with home visiting stakeholders and experts from across New Mexico. These recommendations require further review to appropriately prioritize their importance, define their impact, and assess implementation viability.

The Workgroup believes that these recommendations and action plans will help successfully expand CHV, increase efficiencies for home visiting providers, and ultimately better serve families in their local communities. Clear themes - such as the importance of collaboration between the State, MCOs, and providers; developing shared technology systems; and providing targeted TA support - are beneficial to any health and social service delivery program. By understanding the challenges and gaining clear perspectives on how to improve program delivery for all stakeholders, home visiting providers will have direct and immediate opportunity to expand to more families across New Mexico.

Recommendations to Increase the Availability, Efficiency, and Effectiveness of the ECHV System

- **Recommendation 1: Support CHV providers to successfully bill Medicaid for CHV services**
  - Objective 1.1: Provide personalized technical assistance and funding to enable agencies to begin billing Medicaid for CHV services
    - Action 1.1a: Implement process for regional TA support
    - Action 1.1b: Create a start-up checklist
    - Action 1.1c: Clearly define and align a Unit of Service
    - Action 1.1d: Each agency will be supported to develop a business plan for CHV billing
  - Objective 1.2: Provide funding to support implementation of CHV services
    - Action 1.2a: Identify budgeted amount and source of start-up funding
    - Action 1.2b: Provide initial start-up funding to agencies
    - Action 1.2c: Identify other funding sources (e.g., additional braided state funding)
    - Action 1.2d: Adjust fee-for-service rate to support the cost of care
  - Objective 1.3: Streamline data bases and billing to improve efficiency
    - Action 1.3a: Automate Billing Systems through a Shared Online Portal
    - Action 1.3b: Phaseout manual billing and develop a centralized billing approach for CHV providers
    - Action 1.3c: Incorporate a Medicaid Billing System into the Home Visiting Database
    - Action 1.3d: Develop alternative payment approaches to fee-for-service approach (e.g., capitated, annualized)

- **Recommendation 2: Enhance Collaboration and Communication between MCOs and HV Providers**
  - Objective 2.1: Provide opportunities for collaboration between MCOs and HV Providers
    - Action 2.1a: Continue and Expand Home Visiting Stakeholder Meetings
    - Action 2.1b: Establish connections between MCH regional care coordinators and HV agencies and complement existing MCO wraparound services
    - Action 2.1c: Maximize role of the MCO care coordinator in the communication process (single point of contact for care coordination) for levels 2 and 3 under Centennial Care
  - Objective 2.2: Streamline communication and clarify roles
    - Action 2.2a: Establish clear points of contact at each MCO
    - Action 2.2b: Establish a mentor network for new providers
    - Action 2.2c: Grant MCO care coordinators access to HV Database
    - Action 2.2d: Enhance Medicaid contract language to specify CHV responsibilities.

- **Recommendation 3: Improve the Intake and Referral Process**
  - Objective 3.1: Develop a Centralized Intake and Referral System Responsive to Regional Needs
    - Action 3.1a: Establish regional hubs for intake and referrals using knowledge of local community needs and resources
    - Action 3.1b: Standardize the technology system across regions

- Objective 3.2: Systematically engage primary care and prenatal providers in referring and linking families to Home Visiting
  - Action 3.2a: Provide clear, concise information on locally available HV models
  - Action 3.2b: Create simplified referral process for medical providers and hospitals.

- **Recommendation 4: Expand Access to a Variety of ECHV Program Models**
  - Objective 4.1: Expand capacity of current HV models
    - Action 4.1a: Increase number of NFP and PAT sites under CHV
    - Action 4.1b: Expand number of families served under current NFP/PAT sites
  - Objective 4.2: Increase number of HV models used in New Mexico
    - Action 4.2a: Expand use of additional evidence-based HV models
    - Action 4.2b: Expand use of research-based and promising practice models in NM
    - Action 4.2c: Apply to HRSA to expand use of research-based and promising practice models under MIECHV
    - Action 4.2d: Continue efforts to secure MIECHV approval for First Born program

HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
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Letter of Direction #1-1

Date: **November 10, 2020**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **The Centennial Home Visiting Program Repeal and Replace LOD #1**

Title: **Guidance for CHV Program Implementation, Statewide**

The purpose of this letter of direction is to provide the Centennial Care Managed Care Organization (CC MCOs) with additional information in:

- Expanding and operating the Centennial Home Visiting (CHV) Program at statewide locations at HSD's discretion dependent upon provider capacity and available budget, effective February 7, 2020;
- Transfering of the home visiting collaborative agency from the New Mexico Children, Youth and Families Department (CYFD) Early Childhood Services Division to the New Mexico Early Childhood Education and Care Department (ECECD);
- Addition of knowledge and skills in working with the NM Tribes, Pueblos or Nations as one of the preferred skills for home visitors;
- Addition of approved ICD diagnosis codes to be used with the approved procedure codes and modifiers when billing on the professional claim type to identify the services rendered; and
- Allowing for services to be billed under each child's Medicaid ID number during infant home visit when services are provided to children who are products of multiple births of enrolled pregnant members.

This LOD will replace the previous LOD#1 issued on December 31, 2018 and will sunset with the next iteration of the CHV LOD.

In collaboration with the New Mexico Children, Youth and Families Department (CYFD) Early Childhood Services Division which is now the New Mexico Early Childhood Education and Care Department (ECECD), HSD is expanding an evidence-based home visiting program for eligible pregnant women that focuses on pre-natal care, post-partum care and early childhood development. The services as described in Table 1 below will be delivered to eligible pregnant women statewide. As approved by the Centers for Medicare and Medicaid Services (CMS), the Centennial Care MCOs will contract with ECECD designated agencies that provide either one or both of the following two evidence-based early childhood home visiting delivery models as defined by the US Department of Health and Human Services (DHHS):

1. **Nurse Family Partnership (NFP):** The services to be delivered under the NFP national program standards are for first-time parents only. The number of families served will be determined based on the number of active NFP teams in any program year. In addition to the existing program in Bernalillo County, HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity and available budget. The NFP services will be suspended once the child reaches two years of age.

2. **Parents as Teachers (PAT):** The PAT evidence-based program services will adhere to the national model and curriculum. Services will begin during pregnancy and may continue until the child reaches five years of age or kindergarten entry. In addition to the existing programs in four counties, HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity and available budget. The number of families served in each county will be determined based on the number of active PAT teams in the program year.

Table 1: Description of Services

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

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

Working with the ECECD and its existing early childhood home visiting infrastructure and network of providers statewide, the MCOs shall:

1) Timely execute contracts with the perspective agencies referred by ECECD.

2) Provide oversight to assure that agencies deliver home visiting services with fidelity as defined by the NFP and PAT curriculum foundational organizations as well as meeting the ECECD Program Standards. This includes ensuring provider qualifications as described in Table 2.

3) Assure that home visitors receive support from the MCO Care Coordinator who is assigned as the family's single point of contact for any family members assessed to need care coordination level 2 or 3 and enrolled in this program.

4) Send relevant staff and representative to participate with the CHV Program workgroup. The workgroup will work collaboratively on various implementation, operational and reporting issues, including the MCO CHV Program reporting template.

5) Submit CHV Program reports per HSD's instruction, including the required monthly MCO CHV referral reports.

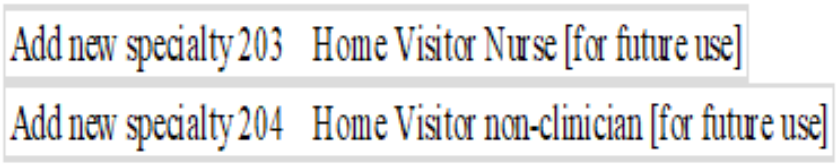
6) Collaborate and share data with ECECD or its designee in order to evaluate the program effectiveness and meet the annual outcomes reporting requirements as stated in the NM Stat § 32A-23B-3 (2017) Home Visiting Accountability Act.

Table 2: Provider Qualifications

Home Visitor Provider Qualifications				
Home Visitors	**Education (typical)**	**Experience (typical)**	**Skills (preferred)**	**Training**
NFP Nurse Home Visitors –Hired by approved NFP implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife, current licensure.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association Healthcare Provider Cardiopulmonary Resuscitation (CPR) and valid Automated External Defibrillator (AED) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills; and knowledge/skills in working with the NM Tribes/Pueblos/Nations.	Comprehensive training and preparation as required by NFP model.
NFP Nurse Home Visitor Supervisor – Hired by approved NFP implementing agency	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 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May 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 beneficiaries level of care 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 level of care.	Comprehensive training and preparation as required by NFP model.
PAT Home Visitors – Hired by approved PAT implementing agency	High School Diploma or GED	At least 2-years of experience working with children/families in a related activity	Certification in Family and Infant Studies; Bilingual Spanish and English; and knowledge/skills in working with NM Tribes/Pueblos/Nations.	Comprehensive training and preparation as required by PAT model.
PAT Clinical Manager – Hired by approved PAT implementing agency	Licensed Master Social Worker or equivalent	A Master's degree in a relevant discipline, 1-3 years in related program oversight experience.	Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model

PROVIDER ENROLLMENT:
All home visiting providers, both NFP and PAT, will enroll as a **Provider Type 317** which has been renamed to "**Nurse Agency, Home Visiting, EPSDT Personal Care**," with a **Specialty 202 Home Visiting Agency**.

At this time, claims may come in without a rendering provider identified. However, HSD anticipates that in the future CMS may require rendering providers to be present on these claims. To that end, we are adding specialty codes for the rendering providers who could also enroll as PT 317 (if not already enrolled) with these specialties, as appropriate:



PROCEDURE CODES:

The provider type 317 will bill on the professional claim type using the approved procedure codes and modifiers as well as ICD diagnosis codes listed below to identify the services rendered. Three different procedure codes will be used to distinguish between the three service types. For each of the procedure codes, modifiers will be used to indicate whether the visit is performed by a nurse under the NFP model or by a non-nurse home visitor under the PAT model. The current reimbursement rate for each code is listed after each code.

Prenatal Home Visit

H1005 Prenatal care, at-risk enhanced service package (include management, coordination, education, follow-up home visit)

H1005 U1	Nurse Home Visitors (NFP)	$314.94
H1005 U2	Non-Nurse Home Visitors (PAT)	$244.02

ICD Code Z34.9: Encounter for supervision of normal pregnancy, <u>without the fifth digit</u> to signify the pregnancy trimester

Postpartum Home Visit to be billed on a parent's claim:

S5111 Home Care Training, Family per session

S5111 U1	Nurse Home Visitors (NFP)	$314.94
S5111 U2	Non-Nurse Home Visitors (PAT)	$244.02

ICD Code:

Z39.2 Encounter for routine postpartum follow-up (NFP)

Z32.3 Encounter for childcare instruction (PAT)

Infant Home Visit to be billed on an infant/child's claim:

S9445 Patient Education, non-physician provider, individual, per session

S9445 U1	Nurse Home Visitors (NFP)	$314.94
S9445 U2	Non-Nurse Home Visitors (PAT)	$244.02

ICD Code Z76.2: Encounter for healthy supervision and care of other healthy infant and child

SERVICE LIMITATIONS AND UTILIZATION CONTROL:

- The agency cannot bill for both mother and child for a single visit.
- A family will either be enrolled on NFP or PAT as both curricula have different eligibility (for example, NFP is for a first-time mother only, while PAT is not).
- When using S9445 billing code, if a single visit is to provide services to children who are products of multiple births of enrolled pregnant members, services can be billed under each child's Medicaid ID number.

Utilization Control will be accomplished by having three utilization exceptions set up:

- Limiting H1005 U1 to 18 NFP prenatal services per 280 consecutive days.
- Limiting H1005 U2 to 18 PAT prenatal services per 280 consecutive days.

- Limiting S5111 U1 to 6 postpartum services in 60 consecutive days.
- Limiting S5111 U2 to 6 postpartum services in 60 consecutive days.

- Limiting S9445 U1 to 40 infant services in 2 years.
- Limiting S9445 U2 to 74 infant services in 5 years.

	Utilization Control - Max Visits			
	Prenatal	Postpartum	Infant	Total
NFP	18	6	40	64
PAT	18	6	74	98