

## Summary of Comments

### **HSD RESPONSES TO DISABILITY RIGHTS NM COMMENTS**

CLNM Provider Policy Manual p. 7

Levels of Care/CNA

Disability Rights NM Comment:

Regrettably, adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) often experience recurrent, rapid changes in placement. Adults with SMI may rotate from the street or home to jail or a hospital and back again, and children in the foster care system frequently move between placements, which can increase their emotional fragility.

DRNM believes that HSD must consider these unique circumstances with respect to care coordination and service delivery. Specifically, DRNM suggests that changes in a recipient's housing or placement automatically trigger a Comprehensive Needs Assessment (CNA).

Additionally, because the CLNM program is currently limited to San Juan and Curry counties, DRNM recommends that HSD develop protocols for coordinating care when recipients move in and out of CLNM service areas.

#### **Department Response:**

Re: Levels of care and frequency of CNA: The Policy Manual specifies "If a *significant change* in a member's condition leads to increasing service needs, the assessment timeframe is expedited and service changes are instituted within ten calendar days." The Policy Manual also recommends that "... the CLNM care coordinator should consider changes in a member's housing, social supports, or other nonmedical services ..." to provide additional supports to members. The language stands as proposed.

Concerning the development of protocols for coordinating care when members move out of CLNM services areas, the Policy Manual will be amended to include the following language: "In the event that a member relocates from a county served by a CLNM provider into a new county served by a different provider, Care Coordinators will assist members in identifying appropriate services in their new location, whether with a new Health Home, or with their MCO, and assist in the transition by transferring member records to the new service provider."

In April 2018, Health Home services expanded to the following additional counties: Sandoval; Bernalillo; DeBaca; Roosevelt; Quay; Hidalgo, and Lea.

CLNM Provider Policy Manual p. 8

Care Coordination Level 9

Disability Rights NM Comment:

DRNM believes that the eligibility criteria for Care Coordination Level 9, which children must meet in order to receive Wraparound services, are too limited and would exclude some of the children with the greatest potential to benefit from the program.

In order to qualify for CLNM Wraparound services, a youth must have a diagnosis of Serious Emotional Disturbance (ages 4-18) or Serious Mental Illness (ages 18-21).

A Serious Mental Illness (SMI) classification requires a current diagnosis under the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM).

A Serious Emotional Disturbance (SED) classification requires either a DSM diagnosis *or* a determination that the youth meets criteria for complex trauma, defined as the experience of one of six traumatic events, including abandonment, neglect, sexual abuse or exploitation, physical abuse, emotional abuse, or repeated exposure to domestic violence. In addition, a complex trauma determination demands *an ex parte court order requiring state custody*.

Consequently, a child who has experienced significant trauma and exhibits all of the attendant symptoms and service needs will not qualify for Wraparound services if the child has never been removed from the family home. For example, a child who has experienced neuro-developmental disruption due to emotional abuse and neglect, and who struggles with emotional regulation, substance abuse, and self-harm, may not qualify for much-needed Wraparound services if she was never subject to a court order removing her from her family home.

Additionally, Care Coordination Level 9 eligibility criteria demand that a child have “multi-system involvement” with two or more systems including juvenile justice, protective services, special education, or behavioral health.

Thus, young children who may be at risk for or who may have already experienced removal from their homes may not qualify for desperately needed services if they are not yet involved with systems other than CYFD.

DRNM believes that the definition of SED should be broadened. First, it should encompass youths who otherwise meet criteria, but who have not been subject to a custody order. This is in line with the intent of additional Wraparound program criteria, which contemplate providing services for children who are “at risk” of out-of-home placement but who are presently still living in the family home. Second, DRNM recommends elimination of the multi-system involvement criterion for Care Coordination Level 9 eligibility, so that children who meet all other criteria can receive services despite only having involvement with CYFD.

**Department Response:**

The trigger point for designation of care coordination level 9 is not an *ex parte* court order but an assessment, with consideration given to a child’s traumatic experiences, and assumes that children in CYFD custody have experienced trauma. All children in custody could conceivably meet criteria for SED diagnoses, but severity and complexity are the ultimate criteria for CCL 9 designation, with demonstrated functional impairment in two or more areas. The language stands as proposed.

Regarding broadening the definition of SED: The SED definition currently applies to children not subject to a custody order. At risk of or experiencing out of home placement are criteria for Wraparound, and a child referred for out of home placement meets the

criteria for SED. Family First Prevention Services Act Legislation includes children and families at risk for CYFD involvement and targets funding for those families. The language stands as proposed.

Considering eliminating the criteria for multi-system involvement: Behavioral Health is considered one of the systems. New Mexico's Wraparound model is based on national models, and systems considered are Behavioral Health, Special Education, Juvenile Justice, and Child Protective Services. The majority of children involved in Protective Services custody has some involvement with the Behavioral Health or Special Education system, and therefore qualify for Wraparound. Children and youth not eligible for Wraparound may still receive team-based care coordination services through Health Homes. The language stands as proposed.

#### CLNM Provider Policy Manual p. 9

##### CLNM Service Plan

##### Disability Rights NM Comment:

It is not unusual for CYFD to move children to an emergency shelter or other location when a placement "disrupts." When these situations occur, effective care demands careful coordination among many agencies, caretakers, and service providers.

DRNM encourages HSD to create Manual provisions that require providers to specifically address the unique needs of this population when developing backup and emergency/crisis plans as a required component of the CLNM Service Plan.

##### **Department Response:**

The CLNM Service Plan currently has provisions for backup and crisis/service plans that are individualized service plans, and "that differ from the standard emergency protocol in the event of an emergency".

The language in the Policy Manual will be amended as follows to include a provision for sharing service plans:

"The Service plan is a document intended to be updated frequently to reflect identified needs, communicate services a member will receive, and serve as a shared plan for the member, their family or representatives, caregivers, service providers, and other relevant stakeholders."

#### CLNM Provider Policy Manual p. 12

##### Transitions of Care

##### Disability Rights NM Comment:

In DRNM's experience with both adults and children with SMI and SED, transitions are not always planned, orderly events. It is not uncommon for individuals to be discharged from facility level of care with as little as 24 hours' notice. Managed Care Organization (MCO) Care Coordinators might not be given notice at all, much less an opportunity to effectuate an appropriate discharge plan. Discharge with little notice and opportunity to plan is particularly stressful, and in some cases has led to suicide attempts and re-hospitalization.

DRNM recommends that the Manual acknowledge and create procedures for handling crisis situations in which there is little time to plan for discharge.

**Department Response:**

Unplanned discharge situations for Health Home members trigger a team meeting convened by CLNM Care Coordinators. The Care Coordinator is the point of contact for discharges from congregate care settings and out of home placements for those Health Homes who provide Wraparound services.

The Department will amend the Policy Manual to include the following language from NMAC 7.20.11.23 (H)(3) specifically for Wraparound members:

“If the child’s parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is effected. If the child’s family refuses to take physical custody of the child, the agency refers the case to the department.”

CLNM Provider Policy Manual p. 13

Individual & Family Supports

Disability Rights NM Comment:

Foster families often need assistance with children in their care, and ensuring adequate support is critical to keeping these children in safe, stable placements.

DRNM recommends that for children in custody, the Manual’s list of individual and family support activities specifically include connection with both traditional and treatment foster care families.

**Department Response:**

The Policy Manual will be amended to include the following language:

“Services also increase health and medication literacy, enhance one’s ability to self-manage care, promote peer and *traditional and foster care family* involvement and supports ...”

CLNM Provider Policy Manual p. 15-16

Target Populations

Disability Rights NM Comment:

The Manual provides that CLNM wraparound services do not require prior authorization, and designates CYFD as part of the team determining eligibility for the services.

As mentioned in the comments regarding Care Coordination Level 9, DRNM believes that the eligibility requirements for wraparound services are too limited for two reasons.

First, the requirements exclude all children who meet complex trauma criteria *unless* they have been removed from their homes by an ex parte court order because of allegations of abuse and neglect.

Eighteen percent of New Mexican children have experienced three or more substantial traumatic experiences, which represents the highest rate of childhood trauma exposure in the nation. These children may be receiving services from CYFD in their homes, yet they would be excluded from Wraparound services because they have not been removed by court order. These are the very children that could benefit most from services, with the hope of keeping their families intact.

Second, the eligibility standards require multi-system involvement. Not all children exposed to trauma have multi-system involvement, yet it would still be appropriate to consider them for Wraparound services to *prevent* multi-system involvement.

**Department Response:**

High Fidelity Wraparound was developed specifically to target the eight to sixteen percent of the child and youth population with complex SED. Youth involved with two or more systems can be referred for services but are not necessarily eligible for Wraparound. Children with SED who are not eligible for Wraparound may still receive team-based services from Health Homes. The language stands as proposed.

CLNM Provider Policy Manual p. 16

Contracting with MCOs

Disability Rights NM Comment:

The Manual requires the CLNM provider to update their existing contracts with MCOs, or develop a contract if none exists. DRNM believes the burden to revise contracts is misplaced. The Human Services Department is the single state entity responsible for the delivery of Medicaid services in New Mexico. HSD, in turn, contracts with MCOs to deliver services to members. It is incumbent upon Medicaid and its MCO agents to assure that contracts meet program specifications, not the CLNM provider.

**Department Response:**

HSD provides the MCOs with a template to contract with Health Home providers outlining the contractual requirements for program specifications. The language stands as proposed.

CLNM Provider Policy Manual p. 18

Readiness Requirements

Disability Rights NM Comment:

DRNM believes that all CLNM providers should be required to provide Wraparound services. This is a valuable method of service delivery which, as constructed, is available to very few eligible children in New Mexico. Requiring CLNM providers to offer this service would expand access for children in need of these supports.

**Department Response:**

The current Health Home structure has been approved by CMNS. HSD will consider this recommendation for future amendments to Health Homes. The language stands as proposed.

CLNM Provider Policy Manual p. 19

## Provider Requirements

### Disability Rights NM Comment:

The Manual contains provider requirements aimed at increasing program quality, including the mandate to have adequate administrative infrastructure, maintain credentialed and trained staff, and adhere to caseload limitations for the most severe populations, Levels 8 and 9.

DRNM recommends that HSD also implement caseload limitations for Level 6 and Level 7 participants.

### **Department Response:**

Care coordination level 8 is not a designation of severity, but an indication that the CNA has not been completed for a member, and the care coordination level is undetermined. The Steering Committee has established recommended ranges for caseloads which are located on pages 7 and 8 of the CLNM policy manual. The language stands as proposed.

## CLNM Provider Policy Manual p. 20

### Psychiatric Consultants

#### Disability Rights NM Comment:

The Manual identifies MDs and DOs as the only doctors who can be considered psychiatric consultants. There are other qualified health care practitioners with the expertise and licensure to evaluate and prescribe medication, including conditional prescribing psychologists. Certain Certified Nurse Practitioners and Physicians Assistants are also authorized to provide care and prescribe medications to people with mental illness.

Given the shortage of psychiatrists in the state, DRNM suggests that including other clinicians permitted to provide psychiatric services would do as the state intended – expand the number of mental health service providers available to New Mexicans.

### **Department Response:**

Staffing is subject to specifications in the State Plan Amendment and the New Mexico Administrative Code. The CLNM Steering Committee will review psychiatric staffing recommendation in the next phase of Health Homes when a new State Plan Amendment will be developed. The language stands as proposed.

## CLNM Provider Policy Manual p. 21

### Data Requirements

#### Disability Rights NM Comment:

The Centers for Medicare & Medicaid Services (CMS) endorse Wraparound programs as both a clinically effective and cost-effective method of providing community-based treatment and supports to youths with mental health needs and their families. DRNM also recognizes the value of these programs to enable individuals with SMI and SED to successfully participate and live in the community, rather than receiving services in more restrictive residential and hospital settings.

However, research suggests that poor quality Wraparound programs are not effective in achieving desired outcomes for youths with mental health needs, so DRNM wishes to highlight the importance of implementing the program with high fidelity and careful attention.

The Manual requires CLNM providers collect data to assess service efficacy, and to engage in ongoing quality improvement activities.

DRNM believes it is necessary to include additional data points that specifically address the services delivered to children in CYFD custody, as the current data points, including those listed in Section IV, *Improve Quality of Life for Members with SMI/SED (Recovery and Resiliency)*, are inadequate to address the needs of this population.

DRNM further proposes that HSD add a data set to measure improvements in the areas of functional impairment listed in the SED definition, including functioning in the community, in social relationships, in the family, and at school or work. These indicators will truly assess the extent to which CLNM services improve the lives of children with SED.

**Department Response:**

CYFD has Wraparound-specific evaluation tools in place to measure program fidelity and ensure quality assurance and quality improvement protocols are in place. Tools are: Wraparound Fidelity Index, the Wraparound Document Assessment and Review Tool, and a Wraparound Team Evaluation Tool. The following language will be added to the Policy Manual to reflect use of evaluation tools with Wraparound providers and teams:

“CYFD will work with Health Home providers and teams participating in Wraparound to use Wraparound-specific evaluation tools to measure program fidelity and ensure quality assurance. Please refer to the Compliance and Oversight section of this manual on page 43 for specific tools and measures.”

(New language to be added to p. 43) “CYFD will work with Health Home providers employing the Wraparound model to use the following tools to ensure program fidelity, quality assurance, and quality improvement protocols are in place:

1. Wraparound Fidelity Index;
2. Wraparound Document Assessment and Review Tool;
3. Wraparound Team Evaluation Tool.”

Health Homes use BHSDStar data system to track services and referrals for all clients. HSD and CYFD are considering adding the Child and Adolescent Needs and Strengths tool (CANS) to measure improvements in functional impairment.

CLNM Provider Policy Manual p. 22

Identifying Wraparound Members

Disability Rights NM Comment:

DRNM suggests that the Manual clarify the manner in which referral sources will be informed of the availability of Wraparound services.

DRNM also recommends that the Manual describe more fully how HSD, MCOs, CLNM and other MCO-contracted behavioral health services providers will coordinate with CYFD. This linkage is particularly important to ensure effective provision of services to children in custody.

**Department Response:**

Health Homes employ Community Liaisons to build relationships with a variety of community providers and establish a referral network for clients. This position is described in the Policy Manual. CYFD has sent letters to their field office affiliates notifying them of Health Home Wraparound Programs in their service counties, and requesting they: (1) meet with Health Home staff; and, (2) make referrals to the Wraparound program. Health Home staff makes frequent presentations to CYFD field offices, and CYFD frequently delivers Wraparound 101 training and information sessions in every community in which Wraparound exists to inform community providers and stakeholders of the program. The Policy Manual will be amended as follows to include additional job requirements of the Wraparound Facilitator, such as coordinating care with other agencies and providers: “The Health Home Community Liaison (and other staff) will work with a variety of community providers to inform them of Wraparound and to develop a robust referral network for all members. Health Home and CYFD Wraparound staff will hold “Wraparound 101” education and information sessions for providers, community members, and other community stakeholders to inform them of the Wraparound program and help build referral sources”.

CLNM Provider Policy Manual p. 23

Enrollment / Disenrollment

Disability Rights NM Comment:

DRNM supports the right of individuals with disabilities to choose whether to receive treatment and from whom. The Manual provides that MCOs will share potentially eligible individuals’ health information with local providers, and will automatically enroll them in the program, subject to an opt-in procedure.

Further, program participants can only terminate coverage on their anniversary date, during the initial interview, after relocation, after losing Medicaid eligibility, or after expressing dissatisfaction with services and requesting a care transfer to an MCO.

DRNM maintains that potentially eligible individuals should receive information about program services, but that enrollment and disenrollment should be entirely voluntary and available at any time.

Additionally, the Manual should clarify enrollment and disenrollment procedures for children in CYFD custody, in both the protective services and juvenile justice divisions. The Manual should also explain how CYFD workers will be informed of CLNM enrollment and disenrollment procedures, and should specify how they will exercise these options on behalf of children in state custody.

It is also unclear whether MCOs will automatically refer children who are in CYFD custody to CLNM providers, or if it is the duty of CYFD to refer potentially-eligible children to CLNM providers. This is a critical coordination point which DRNM believes should be clearly articulated.

**Department Response:**

Health Home enrollment is available anytime and is optional. A one-year enrollment period ensures vulnerable members have continual access to integrated care and supports. Enrollment and disenrollment procedures for children and youth in CYFD custody do not differ from those already described in the Policy Manual; Protective Services and Juvenile Justice Services are listed as referral sources for Wraparound. MCOs do not automatically make referrals for children who are in CYFD custody to Health Homes; it is the duty of CYFD offices to make referrals. The language stands as proposed.

CLNM Provider Policy Manual p. 28

Service Accessibility

Disability Rights NM Comment:

Requiring care coordination and service provision after normal business hours is a critical component of care for adults with SMI and children and youth with SED.

When a crisis arises, children, especially children in custody, need rapid response to stabilize their circumstances and prevent removal from their homes. These services should include mobile crisis services (not just telephone crisis services), peer supports, and respite care. DRNM recommends that the Manual require CLNM providers to assure that those services are available for children, especially those who are in custody, at risk for out-of-home placement, or who need immediate intervention to prevent disruption of their current placements.

**Department Response:**

Provisions for service accessibility are addressed in the Policy Manual. Mobile crisis services are available through any behavioral health direct service provider. The language stands as proposed.

CLNM Provider Policy Manual p. 28

Confidentiality of Information

Disability Rights NM Comment:

The Manual requires that all disclosures of confidential information occur in accordance with state law. New Mexico law provides that children 14 years of age and older must consent to the release of their protected mental health information.

The Manual does not address the process by which MCOs and CLNM providers will obtain consent for sharing the protected mental health information of youths 14 years of age or older who are in CYFD custody.

**Department Response:**

Disclosure and confidentiality of information is addressed in the HIPAA section of the Policy Manual to comply with HIPAA, P.L. 104-191. The Policy Manual addresses consent for sharing information in the Participation Agreement (Appendix D). The language stands as proposed.

CLNM Provider Policy Manual p. 32

Grievance and Appeals

Disability Rights NM Comment:

Medicaid regulations govern the process by which an individual can file a complaint with an MCO if services are denied, reduced, modified, delayed, or terminated.

The Manual is unclear about the role of CLNM Care Coordinators when the need arises for a member to file a grievance or appeal. Will Care Coordinators assist members who wish to appeal decisions by an MCO related to services provided through the MCO? Since CLNM services are also Medicaid services, will the CLNM Care Coordinators assist the member with filing a grievance or appeal related to those services?

Additionally, there is need for clear grievance and appeals processes for children in CYFD custody. If there is an issue with a CLNM service, the CYFD worker is the person with legal standing to file a grievance or appeal on behalf of a child or youth in custody. The Manual should explain specifically how CYFD workers will assist children in these situations.

**Department Response:**

This process and the role of Care Coordinators in assisting members in filing grievances and appeals is addressed in the manual: “CLNM Care Coordinators will be responsible for assisting members with appeals and grievances, including, but not limited to, explaining the right of appeals process and reporting grievances.” The Policy Manual refers to requirements described in 8.308.15. NMAC. The CYFD worker would address any grievances a child raises as any parent or guardian would, and adhere to existing grievance processes. The language stands as proposed.

CLNM Provider Policy Manual p. 35  
Transitional Care Services, Role of Care Coordinators

Disability Rights NM Comment:

As mentioned in the comments above, DRNM believes transitional care services are extraordinarily important to ensure continuity of care for members with SMI or SED. Often, children in crisis are quickly removed from family or foster homes, taken to emergency departments, transferred to acute care hospitals, and then placed in residential treatment facilities. The Manual should clarify what role a Care Coordinator would play when the decision to move a child rests with the MCO’s Utilization Review team. Specifically, the Manual should articulate how a CLNM Care Coordinator can effectively intervene in circumstances where discharges occur abruptly, with little notice and without appropriate planning, especially with respect to children in the foster care system.

**Department Response:**

Unplanned discharge situations for Health Home members trigger a team meeting convened by CLNM Care Coordinators. The Care Coordinator is the point of contact for discharges from congregate care settings and out of home placements for those Health Homes who provide Wraparound services.

The Department will amend the Policy Manual to include the following language from NMAC 7.20.11.23 (H)(3) specifically for Wraparound members:

“If the child’s parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the

child until a safe and orderly discharge is affected. If the child’s family refuses to take physical custody of the child, the agency refers the case to the department”.

CLNM Provider Policy Manual p. 38

Quality

Disability Rights NM Comment:

It is extremely important that the CLNM agency collect and use data to support continuous quality improvement. DRNM suggests that data also be accessible and useable by front-line staff, so that it can be integrated into day-to-day work rather than simply being used to monitor compliance.

We suggest that data also include measurements to assess improvement in areas of functional impairment for both children and adults, including functioning in the community, in social relationships, in the family, and at school or work.

**Department Response:**

Health Home providers use BHSDStar to track activities contained within the six required core services. Data on service tracking is compiled through Star and available to providers, MCOs, and HSD for monitoring, oversight, and quality improvement purposes. Tracked data include quality and outcome evaluation metrics, and measures that track service delivery and referrals. The language stands as proposed.

CLNM Provider Policy Manual p. 40-41

Care Codes

Disability Rights NM Comment:

The Manual provides that care coordination fees for Wraparound services will be paid on a Per-Member Per-Month (PMPM) basis. This is extraordinarily important as it recognizes the importance of flexible services based on individual children’s needs.

**Department Response:**

Thank you for your comment.

CLNM Provider Policy Manual p. 42

Monitoring & Oversight

Disability Rights NM Comment:

The Manual contains compliance and oversight procedures to ensure program fidelity, including establishing a Steering Committee responsible for reviewing comprehensive health data and performance measures.

DRNM is concerned by the evaluation process conducted by the University of New Mexico’s Consortium for Behavioral Health Research and Training (CBHTR). CBHTR will monitor care only for children who meet SED criteria. As previously discussed, the SED criteria exclude children who have experienced significant, complex trauma but who *have not* been subject to a custody order, unless these children also have a DSM diagnosis. DRNM underscores the importance of collecting assessment data and providing services to this population.

**Department Response:**

This comment is not related to the CLNM Policy Manual. The language stands as proposed.

**HSD RESPONSES TO PRESBYTERIAN HEALTH PLAN COMMENTS**

CLNM Provider Policy Manual p. 16

Formation of Steering Committee

Presbyterian Health Plan Comment:

Criteria for who and how committee will be formed.

**Department Response:**

Thank you for your comment. Composition of the CLNM Steering Committee is addressed in the HSD CareLink NM Steering Committee Charter, updated 11/29/18 and provided to Steering Committee members. HSD will consider stating criteria in future revisions. The language stands as proposed.

CLNM Provider Policy Manual p. 17

CCSS Certification

Presbyterian Health Plan Comment:

Per Supplement 17-06 there is no process for CCSS certification.

**Department Response:**

The Policy Manual specifies a CLNM provider must “hold a Comprehensive Community Support Services (CCSS) certification *or an attestation* that the agency has received all required training for certification”. CCSS trainers provide attestations that an individual has completed CCSS training, which will suffice to document completion of required CCSS training. The language stands as proposed.

CLNM Provider Policy Manual p. 22

Wraparound review meeting

Presbyterian Health Plan Comment:

Referral review meeting should be held within 48 hours (**add - or 2 business days**) of the providers receipt of the Wraparound Referral Form.

**Department Response:**

The Policy Manual will be amended to clarify that a referral review meeting for a prospective Wraparound client be held within “two (2) business days” of the provider’s receipt of a Wraparound Referral Form.

CLNM Provider Policy Manual p. 23

Eligible Individuals

Presbyterian Health Plan Comment:

Eligible individuals (**add – or parents/guardians of eligible individuals**) must agree to opt-in to CLNM no later than 90 calendar days from notification...

**Department Response:**

The Policy Manual will be amended to include “Eligible individuals *or parents/guardians of eligible individuals* must agree to opt-in to CLNM no later than 90 calendar days from referral by signing an opt-in form”.

CLNM Provider Policy Manual p. 23Opt-out timeframePresbyterian Health Plan Comment:

If a member is no longer engaged with the Health Home, providers will opt-out the member and notify the MCO **within 7 business days of reasoning to opt-out** that they should resume care coordination.

**Department Response:**

Once providers opt-out a member in BHSDStar, the Star system interfaces with Conduent on a nightly basis and MCOs receive updates the following day, rather than the seven business days recommended in this comment. The language stands as proposed.

CLNM Provider Policy Manual p. 24Phase 2 CapacityPresbyterian Health Plan Comment:

Phase 2: Question – Will all the Health Homes providers have capacity or will there be limits? How will capacity be determined? What is the responsibility for the MCO to verify capacity?

**Department Response:**

No capacity limits exist for eligible members who choose to opt-in to Health Homes. Providers are expected to follow the caseload ratio recommendations in the Policy Manual based upon levels of care.

The Policy Manual will be amended to include the following language for monitoring and oversight of caseload ratios:

“HSD will monitor Health Home enrollment, staffing, and caseload ratios on a monthly basis and provide data to HSD leadership and Steering Committee members. MCOs may monitor enrollment through these data and BHSDStar tracking”.

CLNM Provider Policy Manual p.42OversightPresbyterian Health Plan Comment:

Question: Per HSD oversight was directed to be put on hold. What is the frequency?

**Department Response:**

The Policy Manual will be amended as follows to include the procedure for an annual oversight and monitoring process:

“An annual site visit will be conducted with each Health Home provider by a team comprised of representatives from HSD and one representative from each MCO”.

CLNM Provider Policy Manual p.43

Audit follow-up

Presbyterian Health Plan Comment:

Question: A failed audit would result in what?

**Department Response:**

The procedures for monitoring and oversight of Health Homes were clarified at the November 19, 2018 Steering Committee meeting. The Policy Manual will be amended to include the following language:

“Findings from oversight and monitoring will help inform future CLNM strategies with HSD leadership. Any deficiencies noted in oversight and monitoring will be presented to the CLNM Steering Committee and HSD leadership for review and further action. Additional education and technical support provided to Health Homes to address noted issues. Tools and measures used for monitoring and oversight shall be shared with providers to facilitate and foster proactive, continuous quality improvement efforts”.

CLNM Provider Policy Manual p.59

Participation Agreement

Presbyterian Health Plan Comment:

Update MCO participating in CLNM

**Department Response:**

The Policy Manual will be amended to include the following updates to MCOs:

“I understand that **CLNM AGENCY NAME** will notify my MCO of my decision. Identified MCO:

- Blue Cross Blue Shield
  
- Presbyterian Health Plan
  
- Western Sky Community Care”

**HSD RESPONSES TO BLUE CROSS BLUE SHIELD COMMENTS**

CLNM Provider Policy Manual p.17

Provider Requirements

BCBSNM Comments

The Clinical Director should be an eligible Medicaid BH practitioner with an independent license to properly oversee and supervise staff. For example, to BCBSNM’s knowledge neither a licensed master social worker nor a licensed psychologist associate is eligible to practice independently.

BCBSNM proposed change: Have a full-time Executive Director and full-time Clinical Director who hold one of the following licenses: Board-certified or Board-eligible psychiatrist, psychologist; licensed independent social worker, licensed master social worker, clinical nurse specialist in psychiatric nursing; registered nurse with a master’s degree in psychiatric nursing; licensed professional clinical mental health counselor; licensed marriage and family therapist; or licensed, independent school psychologist.

**Department Response:**

The Department will amend the Policy Manual to include the following language: “Have a full-time Executive Director and full-time Clinical Director who hold one of the following licenses: Board-certified or Board-eligible psychiatrist; licensed psychologist; licensed independent social worker; clinical nurse specialist in psychiatric nursing; licensed, certified nurse practitioner in psychiatry; clinical nurse specializing in psychiatric nursing; licensed professional clinical mental health counselor; licensed marriage and family therapist; or licensed, independent school psychologist”.

CLNM Provider Policy Manual p. 24

Privacy Concerns (Two references on p. 24)

BCBSNM Comments

BCBSNM has privacy concerns with providing member information to a provider when the member is not currently receiving services from that provider. The current process is to provide HSD with the list of members and HSD will provide the information to the providers. BCBSNM therefore requests that HSD please restore the original language, or equivalent.

BCBSNM proposed change: The lists of potential members will also be sent to each CLNM provider in the appropriate counties.

**Department Response:**

The existing enrollment procedure is as follows: HSD provides MCOs with lists of members who have a behavioral health condition within SMI or SED criteria, and who reside in counties with existing Health Homes. MCOs send a template for a letter created and approved by HSD to members on the lists to notify them of Health Home services, and HSD sends the lists on to the appropriate Health Home provider to contact the member and determine their interest and eligibility to participate in Health Homes. The procedure does not require MCOs to provide member information to a provider not providing services to a member. The Policy Manual will be amended to eliminate the process for automatic upload into BHSDStar as follows:

“MCOs and providers will work to engage and enroll those current MCO members potentially eligible for CLNM services who *have not engaged directly with a CLNM provider*. In these cases, HSD will provide MCOs with a list of members who have a behavioral health diagnosis within the SMI/SED criteria and are not enrolled in Health Homes. MCOs will send a letter (template to be provided by HSD) to members from the lists who live in an eligible county. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the provider to describe the program and determine their interest in participating. The lists of potential members will also be sent to each CLNM provider in the appropriate counties.

Providers will contact MCO members to arrange an appointment for an evaluation and to determine eligibility and interest. Providers will opt-in members who express interest in participating. If the provider is unable to contact these individuals, or the member is

uninterested in the program, the provider will not opt them in to the program. Opt-in determinations will be transmitted through Omnicaid to MCOs on a nightly basis, and MCOs will either transfer care coordination to the CLNM provider or retain care coordination if the member does not opt-in to the Health Home program. Those who do not meet the SMI/SED criteria after evaluation will be advised by Health Home care coordinators that they will continue to receive care coordination services through the MCO. Upon permission from the MCO member, the provider will transmit clinical records to the MCO advising them there was no SMI/SED”.

CLNM Provider Policy Manual p. 34

Providing member documentation to Health Homes

BCBSNM Comments

BCBSNM proposes the following change, as some Health Homes wish to gather this information themselves and do not want the MCOs to send this information, and if they do, the Health Homes does not use the information.

The MCO will provide member documentation to the Health Home upon request including but not limited to: History and physical; Individual service plan; HRA; CNA; Functional assessment; Comprehensive care plan; Emergency and backup plan; Behavioral health co-management summary notes; and Advance directive.

**Department Response:**

Health Homes have expressed a need for members’ health records. The CLNM Steering Committee has determined that MCOs should be providing said documents to Health Homes for opted-in members, rather than waiting for Health Homes to make a specific request to MCOs. The language stands as proposed.

CLNM Provider Policy Manual p. 35

CLNM Oversight and Monitoring

BCBSNM Comment

Sections 4.13.2.5 and 4.13.2.6 of the Medicaid Managed Care Services Agreement for Centennial Care 2.0 require MCOs to monitor and oversee the provision of care coordination by health homes. This manual should expressly recognize the MCOs' rights to do so. Accordingly, BCBSNM proposes to add the following language on Page 35 of the manual.

The MCO reserves the right to, and the CLNM provider shall cooperate with:

- Conducting regularly scheduled meetings with CLNM providers to discuss issues, concerns and overall performance;
- Requiring CLNM providers to report on delegated Care Coordination functions, as outlined in the CLNM Policy Manual, to ensure compliance;
- Conducting annual audits of the CLNM providers; and
- Issuing process improvement plans and/or corrective action plans to the CLNM providers if it is determined that noncompliance has occurred.

**Department Response:**

The procedures for monitoring and oversight of Health Homes were clarified at the November 19, 2018 Steering Committee meeting. The Policy Manual will be amended to include the following language to address deficiencies noted in Health Home oversight and monitoring processes.

“An annual site visit will be conducted with each Health Home provider conducted by a team comprised of representatives from HSD and one representative from each MCO.”

“Interviews with and/or reports from providers that yield descriptions and explanations of findings from system data and case reviews. This will include HSD oversight of staffing levels and compliance with caseload ratio recommendations (listed on page 7). Findings from oversight and monitoring will help inform future CLNM strategies with HSD leadership. Any deficiencies noted in oversight and monitoring will be presented to the CLNM Steering Committee and HSD leadership for review and further action. Additional education and technical support will be provided to Health Homes to address noted issues. Tools and measures used for monitoring and oversight shall be shared with providers to facilitate and foster proactive, continuous quality improvement efforts.”

CLNM Provider Policy Manual p. 43

CLNM Oversight and Monitoring

BCBSNM Comment

BCBSNM proposes not removing the language that allows MCOs to monitor CLNM provider performance and conduct on-site audits. Per the proposed change on page 33, the MCOs are responsible for ensuring delegated care coordination functions are being completed by the CLNM providers. The MCO needs to have the ability to properly monitor performance via reporting and by conducting audits to ensure compliance with these requirements.

**Department Response:**

MCOs have access to BHSDStar data that include quality and outcome evaluation metrics as well as well as measures that track service delivery and referrals (e.g., numbers of members receiving each service, frequency, and amounts).

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