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

State Demonstrations Group

January 2, 2025

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

Dear Director Flannery:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health-Related Social Needs (HRSN) services protocol for the New Mexico Turquoise Care section 1115(a) demonstration (Project Number 11-W00285/6). We have determined the services protocol is consistent with the requirements outlined in the demonstration Special Terms and Conditions (STCs) and are therefore approving it. A copy of the approved protocol is enclosed and will be incorporated into the STCs as Attachment N.

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

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations
State Demonstrations Group

Enclosure

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

Attachment N

New Mexico Turquoise Care 1115 Demonstration HRSN Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications:

Housing Interventions (Medical Respite) and Nutrition Interventions for Pregnant Members

Submitted December 13, 2024

In compliance with STC #10.6 of the Turquoise Care 1115 Demonstration, the New Mexico Health Care Authority (HCA) is submitting an HRSN Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for Housing Interventions (Medical Respite) and Nutrition Interventions for Pregnant Members to CMS for review and approval.

Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment N. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in this Attachment N, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in this approved Attachment N, the state must follow the process below to update the protocol:
    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this

STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 20.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes.

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process. This restriction is not applicable to the process and scope of changes outlined in STC 3.6.

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

HCA submitted a separate Attachment N HRSN Infrastructure Protocol for CMS approval.

ii. A list of the covered HRSN services with associated service descriptions and service-specific provider qualification requirements.

Short-term post-hospitalization housing (Medical Respite)

Covered Service: Short-term post-hospitalization housing (medical respite) with room and board for up to six months per rolling year, only where integrated, clinically-oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing services are limited to a clinically appropriate amount of time.

Service Definition: Acute and post-acute medical care for people who are homeless who are too ill to recover from sickness or injury on the street or in a shelter, but not sick enough to warrant hospital level care.

Medical Respite providers may provide tiered levels of support and receive reimbursement according to the service tier.

Medical respite service components may include:

(1) Onsite case management/care coordination provided by Community Health Workers (CHW), Community Support Workers (CSWs), Engagement Specialists, and/or other similarly qualified staff. For example:

- Coordination and/or transportation[1] to offsite medical appointments
- Completion of case management and supportive services onsite as applicable

[1] Transportation is provided as part of the bundled service payment and there is no separate billing or payment for standalone transportation services.

- Referral or connection to community case management services as applicable

(2) Connection and transition to primary care provider/health home before discharge

(3) Onsite clinical services, which will include the creation of an individual clinical care plan by an appropriately licensed clinical provider, and may include (based on provider capacity):

- Daily evaluation (or as indicated by clinical care plan) by an appropriately licensed clinical provider.
- Provision of medical clinical services within scope of licensure and as indicated by discharge instructions and clinical care plan.
- 24/7 access to a provider on call and a nurse advice line.
- Medication management
- Chronic condition management by appropriately licensed clinical provider.
- Medical management and treatment by an appropriately licensed clinical provider.
- Behavioral health by licensed clinical social
- Substance use treatment by an interdisciplinary team of licensed clinical social worker and appropriately licensed clinical
- Care coordination with home health and home-based clinical care services
- Other integrated health services as needed including dental, harm reduction, art therapy, public benefits enrollment, housing navigation, community health workers, and housing navigators to facilitate exit to housing.

(4) Room and board, including shelter services that meet National Standards for Medical Respite Care

Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.

Medical Respite Provider Qualifications:

Medical Respite Providers must agree to meet the National Institute for Medical Respite Care (NIMRC) Standards developed by the National Health Care for the Homeless Council.

Clinical services will be conducted by appropriately licensed, trained, credentialed, and privileged Medicaid-enrolled providers which may include Registered Nurses (RNs), Doctor of Medicine (MDs), Advanced Practice Providers (APPs), Dentists, Dental

Hygienists, and Licensed Clinical Social Workers (LCSW), and will be based on individual patient needs as outlined in the care plan.

Nutrition Interventions for Pregnant and Postpartum Members

Covered Services and Descriptions:

Home delivered meals (medically-tailored meals), tailored to health risk, or pantry stocking for pregnant individuals who meet risk and needs-based criteria. This service will provide prepared meals or grocery boxes that provide the nutritional equivalent of up to three meals per day and will be available for up to the length of the pregnancy and up to twelve months postpartum.

Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers for pregnant individuals as defined in the risk and needs-based criteria. Nutrition prescriptions may supplement a pregnant/postpartum member's existing nutrition supports (e.g., a produce-only prescription) or may constitute a fully nutritional regimen, based on the member's needs. Nutrition prescriptions will be available for up to the length of the pregnancy and up to twelve months postpartum.

The following nutrition interventions represent the full scope of allowable nutrition services. Subject to state budget availability and the process for updates to this Protocol described on page 1. The quantity of nutrition supports provided may be adjusted for family size using the NM SNAP definition of households.

New Mexico will phase-in nutrition interventions, beginning with medically-tailored meals provided to pregnant members with diabetes. As state budget availability allows, it is New Mexico's intent to expand to all pregnant and postpartum members and their family members over the five-year demonstration period.

Nutrition interventions for pregnant and postpartum members in New Mexico are designed to be person-centered and flexible to meet the changing needs of a member and the family throughout the pregnancy and post-partum period. For example, members may prefer nutrition prescriptions that allow the member to select their own groceries earlier in pregnancy but may need cooked and delivered meals in the late pregnancy/early postpartum period. Members who opt for medically-tailored meals cannot concurrently receive nutrition prescriptions.

The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods.

Nutrition Interventions Provider Qualifications:

Providers of nutrition interventions must:

- Enroll in Medicaid;

- Have knowledge of principles, methods, and procedures of the covered nutrition interventions meant to support an individual in obtaining food security and meeting their nutritional needs;
- Be able to receive referrals from providers and Turquoise Care MCOs;
- Be able to track and report on service delivery (including unsuccessful deliveries) according to the standards established by HCA;
- Comply, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of individuals receiving meals (if providing home-delivered meals);
- Follow best practice guidelines and industry standards for food safety;
- Include a Registered Dietician or Registered Dietician Nutritionist or other comparable professional to develop the nutritional content of the Meals/Grocery Boxes;
- Be able to customize Meals/Grocery Boxes to a member's cultural, religious and personal preferences.
- Be able to attain information from the member about their receipt of SNAP or WIC assistance and factor this assistance into the total number of meals requested for the member.

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

Medical Respite Inclusion Criteria:

People experiencing homelessness as defined by 24 CFR 91.5 who:

- Are hospitalized and preparing for discharge,
- Have full decision-making capacity,
- Can live independently,
- Have an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a Medical Respite stay, and
- Have been assessed by a Medical Respite Nurse Manager for medical respite and referred from a hospital partner.

Exclusion Criteria:

- Conditions that require services the medical respite provider site cannot support (e.g., PICC lines, wound vacuums, IV fluids or IV antibiotics, medical help to take medications, ADL assistance, incontinence support, or other high-acuity behavioral or physical health needs). This may vary by provider site and capacity.

Nutrition Interventions:

See Sections iv, v, and vii.

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

and

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

Medical Respite:

An individual must be referred by a hospital partner and assessed by a Medical Respite Nurse Manager to meet the inclusion/exclusion criteria for medical respite. Medical respite is limited to a clinically-appropriate amount of time, and after 60 days individuals will be reassessed to determine the appropriate extension period (not exceeding the 6 month per year limit). An individual's stay may be extended (not exceeding the 6 month limit) if the individual has not achieved the clinical goals outlined in the plan of care, cannot be discharged to shelter and requires medical respite to continue healing.

Nutrition Interventions:

Providers and MCO care coordination staff may determine the nutrition interventions benefit to be medically appropriate for a pregnant individual if the following criteria are met:

- Member-experiencing low or very low food insecurity as defined by the USDA[2];
- Confirmed pregnancy; and
- To the extent HCA has not yet expanded coverage to all pregnant members, a clinical risk factor or confirmed diagnosis of a condition identified as eligible by HCA documented in the member's medical record.

HCA will begin phasing in the nutrition interventions by providing medically-tailored meals to pregnant members with diabetes. In this case, the member must have a confirmed diabetes diagnosis documented in the member's medical record or confirmed with testing. Members who report food insecurity will also be referred for WIC and SNAP benefits.

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

Medical Respite:

The HCA Turquoise Care website will include a page dedicated to the Medical Respite benefit. This page will include the inclusion and exclusion criteria, provide stakeholders with opportunities to provide additional input on this benefit, and provide information on

[2] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

how FFS and managed care members can access this benefit. Turquoise Care MCOs, hospitals and medical respite providers will also be responsible for publicizing information about the benefit, including the criteria for member participation.

Nutrition Interventions:

The HCA Turquoise Care website will include a page dedicated to the “Food as Medicine” nutritional interventions benefit. HCA will maintain the clinical and social risk criteria on this public-facing webpage. The content will be updated if the criteria are changed. The Turquoise Care MCOs will also be responsible for publicizing the criteria. HCA will partner with members of the health and food communities to publicize the availability of this new Medicaid benefit.

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

HCA is designing the delivery system for Nutrition Interventions consistent with our vision for Turquoise Care: Every Medicaid member will have a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health. We envision that the member's primary care provider, who in New Mexico may be a midwife, an obstetrician or a Family Medicine provider, will coordinate care for all of the member’s needs, including their food insecurity needs, through this benefit. We also acknowledge the need for a “no wrong door” approach to nutrition supports. A member may self-refer for nutrition services, may be identified through a provider visit, may be identified by a Meals/Grocery Box vendor (vendor), a community partner (e.g., a food bank), or may be identified by their MCO.

The process for initiating a care plan may vary by delivery system (FFS vs. managed care), provider capacity, MCO and the delegated care coordination model. In general:

- Once a member and their primary care provider determine a member is eligible and has a need for nutrition supports that is not being served by other sources (e.g., WIC, SNAP), the member will be provided information about the benefit and a referral will be made to the applicable vendor(s) and MCO care coordinator. For FFS members, the primary care provider will provide the care coordination.
- The member’s primary care provider or care coordinator will open up a care plan for the member and coordinate with the vendor for any necessary authorizations.
- The member’s primary care provider or care coordinator may outreach to the member to ensure they receive the food from the vendor to close the referral loop and care plan. The member’s primary care provider or care coordinator will also provide information on SNAP and WIC as needed.
- For FFS and MCO members, the vendor will eventually report through HCA’s planned closed-loop referral system. HCA will require providers and MCO care coordinators to coordinate utilization of this benefit.

Medical Respite:

Each medical respite provider will be responsible for the creation of an individual clinical care plan by an appropriately licensed clinical provider. Each care plan will be developed in conjunction with the member, will include input from the Medical Respite Nurse Manager's assessment of need and will be reassessed periodically as appropriate for the member's condition and length of stay.

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

The nutrition interventions are intended to supplement, not supplant, WIC and SNAP, and Older Americans Act Nutrition Services as needed. No benefit will be covered that duplicates or displaces existing state or federally-funded food and nutrition services. Providers, MCOs and Meals/Grocery Box vendors will be instructed to assess for the member receipt of other nutrition benefits and to refer to those programs if the member is not enrolled. The Medicaid benefit may be provided while a member is applying for other benefits and may be provided as a supplement to other benefits when necessary to prioritize the nutritional needs of the pregnant individual and minimize any unmet food insecurity within the household.

HCA administers the Medicaid and SNAP. When members apply for Medicaid on the basis of pregnancy or apply for SNAP, the HCA Income Support Division will provide members with information about the Medicaid nutrition interventions and information about how to access these benefits through the member's pregnancy medical home provider.

This is not applicable to Medical Respite.

ix. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.5 and STC 15.4 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.2 affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 14.5 and STC 15.4, the monitoring protocol and evaluation design are subject to CMS approval.

HCA agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.5 and STC 15.4, which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.2 affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

This is not applicable to Medical Respite. HCA does agree to meet all monitoring and evaluation requirements stipulated in the Turquoise Care 1115 Waiver.