DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID
& CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

July 3, 2018

Ms. Nancy Smith-Leslie, Director
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87504

Re: Approval of State Plan Amendment 18-0002 (MACPRo)

Dear Ms. Smith-Leslie:

The Centers for Medicare and Medicaid Services (CMS) has completed its review of New Mexico State Plan Amendment (SPA) Transmittal Number 18-0002. This SPA updates the State's current Health Home Program as authorized under Section 2703 of the Patient Protection and Affordable Care Act (1945 of the Social Security Act). In particular, HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for its most vulnerable children and adolescents. In addition, one of the providers will be our first Tribal 638 Health Home.

We have approved New Mexico SPA Transmittal Number 18-0002 on July 3, 2018 with an effective date of April 1, 2018. Enclosed is a copy of the approved pages for incorporation into the New Mexico State plan.

In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, [April 1, 2018 through March 31, 2020], the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the State's published FMAP rate, [April 1, 2020 -]. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this Health Home State Plan Amendment, please contact Ford Blunt at (214) 767-6381 or by e-mail at Ford.Blunt@cms.hhs.gov.

Sincerely,

Bill Brooks
Associate Regional Administrator

Cc: Jennifer Mondragon

CMS-10434 OMB 0938-1188

Package Information

Package ID	NM2018MS0003O	**Submission Type**	Official
Program Name	MIGRATED_HH.CareLink NM	**State**	NM
SPA ID	NM-18-0002	**Region**	Dallas, TX
Version Number	2	**Package Status**	Approved
Submitted By	Megan Pfeffer	**Submission Date**	5/10/2018
Package Disposition		**Approval Date**	7/3/2018 10:26 AM EDT
Priority Code	P2		

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850

Date: 07/03/2018

Head of Agency: Brent Earnest

Title/Dept : Cabinet Secretary, NM Human Services Department

Address 1: PO Box 2348

Address 2: 2025 S. Pacheco Street

City : Santa Fe

State: NM

Zip: 87504

MACPro Package ID: NM2018MS0003O

SPA ID: NM-18-0002

Subject

Approval of State Plan Amendment 18-0002

Dear Brent Earnest

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

NM Health Home SPA 18-0002

Reviewable Unit	Effective Date
Health Homes Intro	4/1/2018
Health Homes Geographic Limitations	4/1/2018
Health Homes Population and Enrollment Criteria	4/1/2018
Health Homes Providers	4/1/2018
Health Homes Service Delivery Systems	4/1/2018
Health Homes Payment Methodologies	4/1/2018
Health Homes Services	4/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2018

Increased Geographic Coverage

(●) Yes

( ) No

Increase in Conditions Covered

( ) Yes

(●) No

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 4/1/2018 to 3/31/2020.

HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for its most vulnerable children and adolescents. In addition, one of the providers will be the State's first Tribal 638 Health Home.

Sincerely,

Melissa Harris (on behalf of Alissa DeBoy)

Mrs.

Approval Documentation

Name	Date Created	
6.A.1 NM 18-0002 MACPRro ApprovalLet_FJB bdb	7/9/2018 2:48 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: New Mexico

Medicaid Agency Name: NM Human Services Department, Medical Assistance Division

Submission Component

◉ State Plan Amendment

◉ Medicaid

○ CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID NM-18-0002

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	4/1/2018	NM-15-0014
Health Homes Geographic Limitations	4/1/2018	NM-15-0014
Health Homes Population and Enrollment Criteria	4/1/2018	NM-15-0014
Health Homes Providers	4/1/2018	NM-15-0014
Health Homes Service Delivery Systems	4/1/2018	NM-15-0014
Health Homes Payment Methodologies	4/1/2018	NM-15-0014
Health Homes Services	4/1/2018	NM-15-0014
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2018	NM-15-0014

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

In April of 2016 the New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH). The first stage of this statewide program engaged agencies to provide coordinated care in two rural counties. These Health Homes are designed for individuals with chronic conditions in the categories of serious mental illness for adults (SMI), and severe emotional disturbance (SED) for children and adolescents. Based on the positive results in these two counties, HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for our most vulnerable children and adolescents. In addition, one of the providers will be our first Tribal 638 Health Home.

The Health Home service delivery model, called CareLink NM, provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services, and social supports. It also includes comprehensive care management, health promotion, disease management, risk prevention, comprehensive transitional care, peer and family supports, and referral for community and social services and supports.

The goals of the program are to 1) Promote acute and long term health; 2) Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Each goal has a number of process and outcome criteria.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$5125194
Second	2019	$33287414

Federal Statute / Regulation Citation

Section 2703 (P.L. 111-148, ACA)

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- (●) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Health Homes Intro

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User-Entered

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

MIGRATED_HH.CareLink NM

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

In April of 2016 the New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH). The first stage of this statewide program engaged agencies to provide coordinated care in two rural counties. These Health Homes are designed for individuals with chronic conditions in the categories of serious mental illness for adults (SMI), and severe emotional disturbance (SED) for children and adolescents. Based on the positive results in these two counties, HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for our most vulnerable children and adolescents. In addition, one of the providers will be our first Tribal 638 Health Home.

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The goals of the program are to 1) Promote acute and long term health; 2) Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Each goal has a number of process and outcome criteria.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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- (○) Health Homes services will be available statewide
- (○) Health Homes services will be limited to the following geographic areas
- (●) Health Homes services will be provided in a geographic phased-in approach

Phase 2

Title of phase

Phase 2

Implementation Date

4/1/2018

Phase-in will be done by the following geographic area

By county

Specify which counties:

1. Bernalillo
2. De Baca
3. Grant
4. Hidalgo
5. Lea
6. Quay
7. Roosevelt
8. Sandoval

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

The CLNM program is being implemented in a phased approach by county. For purposes of this SPA, the State is requesting approval for the CLNM HH Program in eight additional counties. These counties are a mix of rural, frontier and urban and include: Bernalillo, Sandoval, Quay, De Baca, Roosevelt, Lea, Grant and Hidalgo. (The two counties from the first phase – Curry and San Juan – will continue Health Homes operations.) A subsequent phase of implementation could include additional counties. We might also look at creating Health Homes with agencies that only serve adults and agencies that only serve children and youth as long as both types are available in each county. (Currently we require that CLNM Health Homes serve both children and adults.)

Name	Date Created
No items available	

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID	NM2018MS0003O	**SPA ID**	NM-18-0002
Submission Type	Official	**Initial Submission Date**	5/10/2018
Approval Date	7/3/2018	**Effective Date**	4/1/2018
Superseded SPA ID	NM-15-0014		
	User-Entered		

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2018MS0003O
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Population Criteria

The state elects to offer Health Homes services to individuals with

- [x] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another
- [x] One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

The SMI and SED criteria were developed and approved by the Behavioral Health Collaborative, a statutorily created body that includes fifteen cabinet level agencies as well as the Governor's Office. With input from the Behavioral Health Planning Council's Children and Adolescent Subcommittee (CASC), the initial criteria for SED were revised to include additional trauma related factors. Another revision updated the criteria for both SMI and SED to coincide with DSM-V. The current criteria, approved by the full Behavioral Health Collaborative, are used for eligibility for various services as well as for targeting programs and grants. The criteria checklists include symptom severity and other risk factors. The SMI and SED criteria checklists can be found in Attachments B and C. The diagnosis criteria can be found in Attachment D.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- (●) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

Describe the process used

Enrollment into the CareLink NM Health Home is voluntary. Eligible beneficiaries – both Managed Care and Fee for Service - are identified through a data driven process. Beneficiaries already receiving outpatient services from the CLNM HHs will be the initial group (Phase 1). These identified beneficiaries will be interviewed at the CLNM HH to ascertain interest and to explain their option to opt out after one year's time. Beneficiaries must affirmatively agree to remain in the CareLink NM Health Home for one year unless they meet criteria for opting out sooner. These criteria are: 1) the individual is no longer eligible for Medicaid; 2) the individual is Medicaid eligible but has moved out of the area; 3) the individual's health status has improved to the degree he/she no longer meets the criteria for SMI or SED; or 4) the individual is dissatisfied with the program and agrees to meet with the agency, the respective MCO or State representative, and others as requested to explain the circumstances related to the request to opt out. Phase I enrollment is projected to last for 6 months.

The second group of beneficiaries (Phase 2) includes eligible beneficiaries not currently receiving services at a CLNM HH provider. Historical claims data will be used to identify eligible individuals based on SMI or SED diagnosis. The State will send letters to all eligible fee-for-service beneficiaries and the MCOs will send letters to all eligible managed care beneficiaries. The letter will describe the opportunity to enroll in a CLNM HH and advise the beneficiary to contact a CLNM HH in their area or wait for the HH to contact them. The CLNM HH will also work with their community partners to engage and enroll those eligible for the services. In addition, new Centennial Care managed care members will be referred by the MCO when deemed eligible.

One exception to the processes described above relates to beneficiaries for Wraparound. Eligibility for this level of care coordination requires an SED diagnosis as well as additional criteria, namely that the child or youth is 1) between 3 and 21 years of age; 2) engaged with two or more systems: protective services, juvenile justice, behavioral health, and special education; 3) at-risk or in an out-of-home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; and 4) a functional impairment in home, school or community, as measured by the Children and Adolescents Needs and Strengths (CANS). This system involvement is not known to the claims system nor to the MCOs. The two CLNM agencies that will be offering Wraparound will thus reach out to local representatives of these systems to identify potential beneficiaries. This will begin at startup for these providers so that caseloads can be built. The concept of Phase 1 and 2 will not be applicable for beneficiaries eligible for Wraparound.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

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User-Entered

Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☒ Physicians

☑ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
1. Registered Medicaid Provider in the State of New Mexico
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
- CareLink NM Health Home Director
- Health Promotion Coordinator
- Care Managers/Care Coordinator (s)
- Community Liaison
- Clinical Supervisor (s)
- Certified Peer Support Workers
- Certified Family Peer Support Workers
- Medical Consultant
- Psychiatric Consultant
- Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners

5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State.
6. Be approved by New Mexico Human Services Department through the application process.
7. Have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources.

The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home:

The range of ratios of care managers to members is dependent on severity of case, and is as follows:
Lowest level: 1:51-100
Higher level: 1:30-50
High Fidelity Wraparound: 1:8-10

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
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Lowest level: 1:51-100
Higher level: 1:30-50
High Fidelity Wraparound: 1:8-10

☐ Community Health Centers

☑ Community Mental Health Centers

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
1. Registered Medicaid Provider in the State of New Mexico
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:

- CareLink NM Health Home Director
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- Care Managers/Care Coordinator (s)
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Higher level: 1:30-50
High Fidelity Wraparound: 1:8-10

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
1. Registered Medicaid Provider in the State of New Mexico
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06

3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
- CareLink NM Health Home Director
- Health Promotion Coordinator
- Care Managers/Care Coordinator (s)
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The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home:

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Lowest level: 1:51-100
Higher level: 1:30-50
High Fidelity Wraparound: 1:8-10

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
1. Registered Medicaid Provider in the State of New Mexico
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
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The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home:

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Lowest level: 1:51-100
Higher level: 1:30-50
High Fidelity Wraparound: 1:8-10

☒ Other (Specify)

Provider Type	Description

Provider Type	Description
IHS or Tribal 638 Clinics	Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator (s) • Community Liaison • Clinical Supervisor (s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State. 6. Be approved by New Mexico Human Services Department through the application process. 7. Have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources. The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home: The range of ratios of care managers to members is dependent on severity of case, and is as follows: Lowest level: 1:51-100 Higher level: 1:30-50 High Fidelity Wraparound: 1:8-10

☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The CareLink NM Health Home will serve as the lead entity and have a memorandum of agreement (MOA) with each partnering primary care practice (adult and child) and with local hospitals and residential treatment centers. The MOA describes standards and protocols for communication, collaboration, referral, follow up, and other information necessary to effectively deliver services without duplication. An example of this would be a behavioral health entity that would have an MOA with a primary care physician or a pediatrician. Each Centennial Care MCO is required to contract with all CareLink NM Health Homes to ensure continuity of care and support to MCO members in receiving CareLink NM Health Home services. This process includes assuring that there are an adequate number of such MOAs to ensure sufficient primary care for each of the MCOs, including dual eligible members. MOAs will not be needed if the partner providing primary care is part of the same organization operating in the same or another location.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The Health Home implementation project team is composed of a nurse with a background in large scale project leadership and business process re-engineering, an experienced behavioral health clinician, an information technology professional, a PhD quality leader, a PhD statistician and experienced facilitator, a Native American project manager, the NM State Children, Youth and Family Department's Behavioral Health Director, and assistance from a psychiatrist with the University of New Mexico's Department of Psychiatry. The team developed an educational program for prospective providers which covers a year of readiness development for the prospective CLNM HH agencies, as follows:

1) A collective learning platform for shared information exchange on relevant topics with the participation of the original 2 CLNM site Directors and access to extensive resource documents. An eight day, in-person sessions included:

i) Areas of responsibility to determine fit: CLNM population; staffing; care coordination levels; use of IT; services; reimbursement; application process
ii) The six core services; Peer and Family Support Specialist Programming; High Fidelity Wraparound for children/youth; CLNM policies
iii) Developing memorandums of agreement; review of evaluation criteria & quality reporting; and population health management
iv) Trauma informed care: historical trauma & adult trauma; trauma in children
v) Collaboration with the Centennial Care MCOs; nursing facility level of care
vi) Cost reporting, membership forecasting, and the development of the PMPMs
vii) Review of CLNM information technology:
(a) BHSD STAR: registration/activation; assessment; service plan; service tracking; referrals; quality reporting
(b) PRISM Risk Management system
(c) Emergency Department Information Exchange (EDIE)
(d) Billing and start up IT activities
viii) Readiness criteria and preparing for the onsite review
ix) Training in integrating physical health care is currently under development

2) A Steering Committee composed of HSD management, MCO management, CYFD management, Tribal Liaison, and University of NM psychiatry oversees the application, administration, and evaluation of the CLNM HHs, and offers operational support through the steering committees members' respective organizations.

3) An Operations Committee composed of the CLNM HH providers, the MCOs, Information Technology, and the CLNM Project team confers weekly to assess all operational and IT issues, and works within the relevant organizations to resolve issues and improve processes.

4) As BH services, that will be recommended as inclusions in the CLNM HH, are being introduced or updated with evidence based programs, ad hoc training will be provided. Examples include medication assisted treatment and mobile crisis teams.

5) The Children, Youth and Families Department is training the high fidelity wraparound sites and their wraparound facilitators on the NM Wraparound CARES program; they will provide coaching to the directors at each facility for 18 months.

6) The Children, Youth and Families Department is providing the requisite training for Certified Family Peer Support Workers. The Office of Peer and Family Engagement at the Human Services Department is providing the requisite training for Certified Peer Support Workers.

Health Homes Providers

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Package ID	NM2018MS0003O	**SPA ID**	NM-18-0002
Submission Type	Official	**Initial Submission Date**	5/10/2018
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Superseded SPA ID	NM-15-0014		
	User-Entered		

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The State's minimum requirements and expectations for Health Home providers are as follows:

1. Registered Medicaid Provider in the State of New Mexico
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following: a) Health Home Director; b) Health Promotion Coordinator - Relevant bachelors level degree, experience developing and delivering curriculum; c) Care Coordinator - Licensed as a registered nurse or behavioral health practitioner, or have a bachelor's or Master's level degree and two years of experience or as approved through waiver by HSD; d) Community Liaison - Multi-lingual and experienced with resources in the local community including family and caregiver support services; e) Clinical Supervisor(s) – Independently licensed professional who has experience with adults and children; f) Peer Support Workers - Certified by the State; g) Family Peer Support Workers – Certified by the State; h) physical health Consultant, either MD, DO, CNP or CNS; and i) Psychiatric Consultant, MD or DO Board certified in psychiatry.
5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA.
6. The CareLink NM Health Home must be approved by New Mexico through the application process.
7. The CareLink NM Health Home must have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

Describe below

Cost analysis

☑ Comprehensive Methodology Included in the Plan

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

Describe below

Cost analysis

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided Described below

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

To support the Health Homes, a per member per month (PMPM) care management cost was developed separately for each Health Home based on modeling estimated enrollment, staff salaries and benefits, and administrative costs that will occur during the Phase 1 implementation period from April 1, 2018 through December 31, 2018, during which time they will be enrolling their current clients and referrals from the community for the first 6 months. A separate PMPM cost was estimated for the Phase 2 ramp up period from January 1, 2019 through December 31, 2019 that will be sustained through March 30, 2020 with a 5% per annum dropout rate. The estimated number of members who enroll during each month of these two periods, the staffing developed to manage their care, and the other administrative costs of running the program contribute to the PMPM costs. The following sections discuss the key components considered in this PMPM cost development.

Two of the Health Homes are also implementing a high fidelity children's wraparound pilot within their Health Home in addition to serving the members described above. Separate projections and rates are developed for this population of most vulnerable children who meet the following conditions to be part of this service:
Children and youth Ages 4-21 with:
o Diagnosis of Serious Emotional Disturbance (SED); AND
o Multi-system involvement, i.e. two or more systems involvement including Juvenile Justice, Protective Services, Special Education or Behavioral Health; AND
o At risk of or in out-of-home placement OR previous out-of-home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; AND
o Functional impairment in home, school or community (as measured by the Children and Adolescents Needs and Strengths (CANS) or Child and Adolescent Functional Assessment Scale (CAFAS).

Enrollment Development
The Health Homes that have been approved by the State and the counties that they plan to serve for this program expansion are shown in Table 1 of Attachment E - Health Homes Payment Methodologies.

Each Health Home was asked to develop separate Phase 1 and Phase 2 enrollment projections by month for the members whom they will serve under this program. The Health Homes were provided guidance from the State as well as enrollment information from the first two Health Homes implemented in 2016 to help inform the development of these enrollment projections. The projections depend on the number of SMI/SED members currently known to the Health Homes during the first 6 months of Phase 1, and projections of total SMI/SED members that will be reached within the counties served by each Health Home during the remaining 3 months of phase 1, and the entirety of Phase 2.

The enrollment modeling for Phase 1 begins in April 2018 and continues through December 2018.

The enrollment modeling for Phase 2 begins in January 2019 and continues through December 2019 with the remaining 3 months of enhanced FMAP showing a consistent membership thereafter. This represents the number of SMI/SED members that are reached within the counties served that are new members not previously known to the Health Homes. These new members are enrolled through the outreach efforts of the community liaison, other Health Home management staff, referral relationships, and the MCOs. For most Health Homes, the Phase 2 monthly enrollment drops to slightly lower levels later in Phase 2.

Attachment E Table 2 shows the enrollment estimates for each Health Home during Phase 1 and Phase 2, representing the new number of enrolled members in each Phase. Table 3 shows the total member months for these enrollees for each Health Home during Phase 1 and Phase 2, representing the total number of member months for all members served during each Phase.

Attachment E Tables 4 and 5 show the monthly enrollment and member month estimates for each Health Home that is implementing the children's wraparound program.

Health Home Salaries, Benefits, and Overhead Development
The PMPM cost of each Health Home is driven by the number of full time equivalent employees needed to manage the care of the enrolled members, their job classification, and member enrollment projections. The salary and benefit costs utilized in the projections were developed by each Health Home using publicly available sources for similar job classifications and Health Home staff qualifications. The city of Albuquerque was used for Bernalillo county, the city of Rio Rancho was used for Sandoval county, the city of Animas was used for Hidalgo and Grant counties, the city of Hobbs was

used for Lea county, and the city of Portales was used for Quay, De Baca and Roosevelt counties. The Health Home model consists of two types of staff – operational staff and care coordination staff, as described below.

Health Home Operational Staff
The operational staff includes a Health Home director, community liaison, health promotion coordinator, medical consultant, and psychiatric consultant. One important characteristic of the staffing model is that the number of staff members in these roles will not generally fluctuate with Health Home enrollment.

Health Home Director
The Health Home Director is responsible for the day-to-day Health Home operations; the job description is modeled after a clinical operations manager. The Health Home Director's responsibilities include overall service oversight, financial performance, and quality management. The Health Home Director may have an advanced degree with multiple years of experience.

Community Liaison
The community liaison coordinates, organizes and plans programs that promote the Health Home with potential members and their health care providers in the community, developing goodwill and fostering relationships with community health care providers, including the development of memorandums of agreement. They provide oversight for the referral relationships, and are a resource to the care coordinators in finding the community resources needed for these complex members.

Health Promotion Coordinator
The health promotion coordinator designs and implements health education and disease management programs for the improvement and maintenance of SMI/SED health conditions and prevalent co-morbidities. They are knowledgeable about the prevention of common risk behaviors and stay abreast of changes in health care technology and best practices to keep education and materials current. In support of these programs, additional educational trainers and ancillary staff may be part of the team, but are not required.

Consultant – Physical Health Consultant
The consulting clinician will be available to the care team on a consulting basis related to member physical health conditions.

Consultant – Psychiatrist
The consulting psychiatrist will be available to the care team on a consulting basis related to member mental health or substance use conditions.

Health Home Care Coordination Staff
The care coordination staff includes care manager supervisors, care coordinators, and peer and family support workers. The number of employees is dependent on staffing ratios (member to staff) and member enrollment. The staffing is based on the enrollment ramp up described above, developed separately by each Health Home, and begins at the start of Phase 1.

Care Coordinators
The care coordinator staffing ratios are calculated at 1:65 for lower severity members and 1:40 for the higher severity members, with an estimated mix of 55% lower severity and 45% higher severity. These calculated ratios are based on the experience of the first two CLNM HHs and fall within the suggested ratio ranges of 1:51-100, and 1:30–50. For the high fidelity wraparound pilots, the calculated staffing ratio is 1:9, the median for a suggested ratio range of 1:8-10. The Health Homes developed their staffing ratios with these targets in mind. Care coordinators' qualifications include a registered nurse with 2 years of behavioral health care experience; or behavior health clinicians; or have a bachelor's degree and 2 years relevant healthcare experience. They should also have served as a liaison between patients, families and health care providers.

Peer and Family Support Staff
Peer and family support staff have lived experience with SMI/SED conditions or have been a parent, spouse, sibling, or significant other of one who has one or more of these conditions. Support staff team with Health Home members to increase empowerment and hope, increase social functioning, increase community engagement and activation in treatment, increase quality of life and life satisfaction, and decrease self-stigma. They support family members in dealing with member behaviors and supporting their own resilience, and are an important member of the care management team.

Supervisors
Supervisors provide supervision and serve as a clinical review or resource for the care coordination staff, the community liaison, the health promotion coordinator and the peer and family support staff. The ratio of supervisor to staff is targeted at 1:8. Supervisors are independently licensed behavior health practitioners or independent nurse practitioners, and have direct service experience in working with both adult and child populations.

Administrative Costs
The final component of the cost development is an allowance for administrative expenses associated with the Health Home operations and staff costs. Administrative expenses include rent, utilities, phone, computers, equipment, claims support, internet, training, continuing education, promotions, insurance, office supplies, travel and other indirect costs that may be required to visit members in their home or health care setting. The Health Homes provided their own estimates for administrative costs for Phases 1 & 2, either as a percent of salaries of Health Home staff or as estimated dollar amounts. As the Health Home program matures or enrolls a larger number of members, future administrative costs may be reduced to reflect economies of scale.

Projections of PMPM Rates
The PMPM cost modeling as discussed above was completed based on assumptions about enrollment ramp-up, staff salary and benefits, and administrative overhead as developed by the Health Homes. These costs are developed separately for the Phase 1 period (April through December 2018) and the Phase 2 period (January through December 2019). The enrolled members, projected member months, Health Home projected costs and PMPM rates are presented in Attachment E Table 6.

Separate rates are developed for the children's wraparound pilots for the Health Homes that are including that program. The enrolled members, projected member months, Health Home projected costs and PMPM rates for these wrap around pilots are presented in Attachment E Table 7.

A Health Home member must be seen for at least one of the six core services within the month for the PMPM to be paid. This activity is tracked through the BHSDStar system that has been developed specifically for the Health Homes. Each of the six core services has a list of activities within that service that the care coordinator checks on a daily basis. Management reports are available from this system to Health Home management to track utilization and compliance with HH policy and expectation. Quality indicators that do not require claims data also derive from this system. There are both process and outcome criteria categorized by the 5 goals of the program.

Based on the tracking of the 6 services through the BHSD Star system, claims are submitted to the state's MMIS system. Rules for this submission are:

- For reimbursement of the PMPM, the G9001 or G9003 code must be billed with one other service code listed in the table below on the same claim;
- The six services codes shall be billed with a $0.01 price indicated, but will pay $0.00;
- All service codes are to be billed with the actual dates of service and correct time units;
- FQHCs that will bill other services utilizing a UB claim form and a revenue code shall bill the CLNM codes on a CMS 1500 claim form using HCPCS codes listed below. FQHC will need to obtain a separate NPI and facility ID for CLNM services;
- IHS and 638 tribal facilities will be billing other services utilizing the OMB rate, and shall bill CLNM codes on a CMS 1500 claim form utilizing the above HCPCS codes.

The HCPC codes are listed in Attachment E Table 8.

The State will make Health Homes services available to the following categories of Medicaid participants: individuals with SMI or SED receiving services in the 8 counties listed above who are fee-for-service or managed care Medicaid beneficiaries.

Health Homes Payment Methodologies

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Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Under managed care, the MCO will make payment on a monthly basis to the CareLink NM Health Home for enrolled members. Although the PMPM for the CareLink NM Health Home is developed based on the staffing and administrative costs of the CareLink NM Health Home, the current capitated rates paid by the State to the MCO includes care coordination or case management activities as a primary function under the federal authority under which the Centennial Care program operates. These care coordination activities are similar in scope to the care coordination that will be performed by the CareLink NM Health Home and are already factored into the current MCO capitated payment rate. Currently under managed care, members who are assessed as SMI or SED are assigned to the most intensive care coordination. To ensure that there is no duplication of payment the CareLink NM Health Home PMPM payment will be evaluated against the care coordination funding included in the capitated rates. The State will monitor the payments between the MCO and CareLink NM Health Home through the evaluation of encounter data submitted by the MCO as well as MCO CareLink NM Health Home reporting.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Attachment E - Health Homes Payment Methodologies Tables 1-8	3/21/2018 11:38 AM EDT	

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management involves the CLNM Comprehensive Needs Assessment (CNA) and the development of an individualized Service Plan with active participation from the CLNM member, family, caregivers and the Health Home team.

The CLNM Comprehensive Needs Assessment (CNA)
The provider agency is responsible for conducting the CNA to determine a member's needs related to physical and behavioral health, long-term care, social and community support resources and family supports. The CNA:

- Provides all the required data elements specified in the HSD authorized CNA;
- Assesses preliminary risk conditions and health needs;
- Uses data from the risk management system to help determine care coordination levels;
- Requires outreach to potential CLNM members within 14 calendar days of receipt of a referral;
- Must document that a provider contacted and/or met with a member to at least begin assessment within the mandated 14-day timeframe;
- May conduct face-to-face meetings in a member's home. If the member is homeless, the meeting may be held at a mutually agreed upon location;
- May enroll a member during the first visit if using the Treat First model. The member would be assigned a "pending" status or assigned care coordination level 8 until a diagnosis of SMI or SED is finalized and accepted by the member. The CNA can be completed over the course of four appointments; when completed, the care coordination level is updated.

The CLNM Service Plan
The Service Plan, provided by HSD, maps a member's path toward self-management of physical and behavioral health conditions, and is specifically designed to help members meet needs and achieve goals. 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, and service providers. The plan is intended to be supplemented by treatment plans developed by practitioners. The Service Plan:

- Requires active participation from members, family, caregivers, and team members;
- Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, and other participants in a member's care;
- Identifies additional health recommended screenings;
- Addresses long-term and physical, behavioral, and social health needs;
- Is organized around a member's goals, preferences and optimal clinical outcomes, including self-management. The plan includes as many short- and long-term goals as needed;
- Specifies treatment and wellness supports that bridge behavioral health and primary care;
- Includes a backup plan that addresses situations when regularly-scheduled providers are unavailable, and provides contact information for people and agencies identified in the backup plan. This is primarily for members receiving home- and community-based services where there is a nursing facility level of care (NFLOC) determination. There is no required template; the plan is uploaded as a file into the State's web-based data collection tool, BHSDStar;
- Includes a crisis/emergency plan listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency. These are individualized plans, uploaded into BHSDStar;
- Is shared with members and their providers;
- Is updated with status and plan changes.

Comprehensive care management services must also include:

- Assignment of health team roles and responsibilities;
- Development of treatment guidelines for health teams to follow across risk levels or health conditions;
- Oversight of the implementation of the CareLink NM Plan which bridges treatment and wellness support across behavioral health, primary care and social health supports;
- Through claims-based data sets, monitoring of individual health status and service use to determine adherence to or variance from treatment guidelines; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The BHSDStar web based data collection tools will be used to create HIT linkages for this project. The modules in support of care management include registration and activation including the level of care in which the member is placed, a CareLink NM comprehensive needs assessment that requires first appointment screenings and imminent clinical risk assessment, with a more comprehensive history and information gathering over the course of 4 appointments. A service plan is developed with the member inclusive of short and long term goals, service requirements and expected outcomes. All were developed for touch screen laptops or tablets for in home or community use. It is available to CareLink NM Health Home providers in order to support the beneficiary and the CareLink NM Health Home Care Coordinator in identifying the unmet needs, gaps in care, clinical protocols required, case management, medical and behavioral health service, and social determinants of health. Offsite referral partners will have the ability to access the BHSDStar modules if consent has been given by the member.

Analytics from the Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC provides insight to the CareLink NM providers as it relates to utilization history for both behavioral and physical health, medication history, hospitalizations and ED use. It utilizes state-of-the-art predictive modeling to

identify patients at greatest risk of high future medical costs or hospitalization. The Care Coordinators access this system before the development of the service plan, and can gain new insights as case management evolves.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists — **Description**: See Other
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators — **Description**: See Other
- [x] Nurses — **Description**: See Other
- [x] Medical Specialists — **Description**: See Other
- [x] Physicians — **Description**: See Other
- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers — **Description**: See Other
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description

Provider Type	Description
CareLink NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker(s) (CPSW) who holds a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully navigated his or her own behavioral health experiences, and is willing to assist his or her peers in their recovery processes. • A Certified Family Peer Support Specialist (CFPSS) who holds a certification by the New Mexico credentialing board for behavioral health professionals as a certified family support worker. • A Health Promotion Coordinator who assures that disease management and risk prevention programs or referrals to outside programs are available based on the needs of the individual beneficiary • A Community Liaison that recommends resources outside of the CLNM Health Home to meet the needs of the individual beneficiary • Optional Health Home Multidisciplinary Team participants: o Nutritionist o Exercise Specialist o Pharmacist o Doctors of Chiropractic o Licensed complementary and alternative medicine practitioners Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Care Coordination

Definition

Care Coordination activities are conducted by care coordinators with members, their identified supports, medical and behavioral health providers and community providers. Care is coordinated across care settings to implement the individualized Service Plan, and to coordinate appropriate linkages, referrals, and follow-up. Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support members' motivation to better understand and actively self-manage his or her health conditions. Care coordinators' activities include, but are not limited to:

- Outreach and engagement of CLNM members;
- Communication with members, their family, other providers and team members, including face-to-face visits to address health and safety concerns;
- Ensuring members and their identified supports have access to medical, behavioral health, pharmacology, age-appropriate resiliency and recovery support services, and natural and community supports;
- Ensuring that services are integrated and compatible as identified in the Service Plan;
- Coordinating primary, specialty, and transitional health care from ED, hospitals and psychiatric residential treatment facilities;
- Making referrals, assisting in scheduling appointments, and conducting follow-up monitoring;
- Developing self-management plans with members;
- Delivering health education specific to a member's chronic conditions;
- Conducting a face-to-face in-home visit within two weeks of a NFLOC determination;
- Coordinating with the MCO care coordinator when a member has a NFLOC determination.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The BHSD Star web based system is available to the Health Home team, the MCOs, and outside providers that are part of a member's integrated care team. Both the assessment and service plan are constantly updated with new information and progress toward achieving outcomes. Critical risks such as suicidality, uncontrolled substance use, and pregnancy are highlighted on the home page for quick reference. A reminder system specific to each care coordinator's activities for the coming week are both automatic based on policy, or entered by the care coordinator based on activities paramount for the member condition.

An Emergency Department Information Exchange (EDIE PreManage) system is available to the Health Home, and automatically sends notifications in real-time to the Health Home as a patient presents at the ED to give immediate perspective on the patient. The content of the notification is specific to the ED including ED visit history, and other valuable clinical and social history information. Currently 80% of New Mexico hospitals are engaged with this system, and others are in process. The Health Homes all have 24 hour call lines, and can specify other modes of real time communication.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

See Other

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Behavioral Health Care Coordinator	See Other
CareLink NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Health Promotion

Definition

Prevention and health promotion services are aimed at preventing and reducing health risks and providing health promoting lifestyle interventions associated with CLNM-member populations. Prevention and health promotion services address substance use prevention and/or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention and early intervention, STD prevention and early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, obesity reduction and prevention, increasing physical activity, and improving social networks.

Health promotion activities assist CLNM members to participate in the implementation of both their treatment and medical services plans, and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion activities include, but are not limited to:

- Use of member-level, clinical data to address a member's specific health promotion and self-care needs and goals. Some data is available from the data warehouse and assessment data in BHSDStar;
- Development of disease management and self-management plans with members;
- Delivery of health education specific to a member's health conditions;
- Education of members about the importance of immunizations and screenings for general health conditions;
- Development and delivery of health-promoting lifestyle programs and interventions for topics such as substance use prevention and/or reduction, resiliency and recovery, independent living, STD prevention, family planning and pregnancy support, improving social networks, self-regulation, parenting, life skills, and more.
- Use of evidence-based, evidence-informed, best emerging and/or promising practices for prevention, health promotion, and disease management programs and interventions;
- Use of evidence-based, evidence-informed, best emerging and/or promising practices curricula that integrate physical and behavioral health concepts and meet the needs of the population served;
- Providing classes or counseling, which can be in a group or individual setting;
- Increasing the use of proactive health promotion and self-management activities;
- Tracking success of prevention, health promotion, and disease management programs and interventions, as well as identifying areas of improvement.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Curricula for the predominant co-morbidities within each county will be developed for differing chronic conditions based on comorbidity analysis from historical claims data utilizing the Ellxhauser comorbidity analysis of 31 common diagnoses. (See Attachment F for sample). Once the differing curricula have been developed they will be choices in the BHSDStar service tracking module, and each person receiving either individual counseling or group work will have their

involvement recorded. This will serve as documentation related to the CLNM Service Plan where the outcome will be documented and available for the entire multidisciplinary team to review.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  See Other
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses
  Description
  See Other
- [x] Medical Specialists
  Description
  See Other
- [x] Physicians
  Description
  See Other
- [ ] Physician's Assistants
- [x] Pharmacists
  Description
  See Other
- [x] Social Workers
  Description
  See Other
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [x] Nutritionists
  Description
  See Other
- [x] Other (specify)

Provider Type	Description
Care Link NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Provider Type	Description
Health Promotion Coordinator	Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing curriculum and curriculum delivery. The Health Promotion Coordinator manages the health promotion and risk prevention services and resources appropriate for the CLNM population. Typical programs included are substance use prevention and cessation, psychotropic medication management, nutritional counseling, healthy weight, diabetes, pulmonary and hypertensive care. Programs are developed based on the prevalent conditions and comorbidities of the regional population. This role also explores and manages relationships with outside providers such as the Department of Health and the MCOs for additional referral opportunities not available in the CLNM Health Home. This individual is part of the multi-disciplinary treatment team and assures required services are available within the CLNM HH or through referral.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

CLNM providers are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement within different levels of care, settings, or situations. Comprehensive transitional care is bidirectional, diverting members from levels of care such as ED services, residential treatment centers, and inpatient hospitalization, and transitioning members to outpatient services. Transitional services help to reduce barriers to timely access, inappropriate hospitalizations, time in residential treatment centers, and nursing home admissions. Additionally, these services interrupt patterns of frequent ED use and prevent gaps in services which could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care.
Providers of transitional services should be mindful of a member's transition from childhood to adulthood. When developing a Service Plan providers should consider a member's shift from pediatric to adult medical providers, or issues such as independent living arrangements. The provider agency will proactively work with CLNM members reaching the age of majority to ensure appropriate supports and services are in place in the member's plan to assist in the successful transition to adulthood.
Comprehensive transitional care activities include, but are not limited to:

- Supporting the use of proactive health promotion and self-management;
- Participating in all discharge and transitional planning activities;
- Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS), Tribal programs and others to continue implementing or modifying the Service Plan as needed;
- Implementing appropriate services and supports to reduce use of hospital EDs, domestic violence and other shelters, and residential treatment centers. Services should also support decreased hospital admissions and readmissions, homelessness, and involvement with State agencies such as Juvenile Justice, Protective Services, and Corrections;
- Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports;
- Sharing critical planning and transition documents with all providers involved with an individual's care via web-based tools, secure email or hard copy;
- Facilitating critical transitions from child to adult services, or to long-term services and supports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The BHSDStar service tracking has a section for comprehensive transitional care which identifies the type of facility transitioning from and to. It also documents Care Coordinator involvement in the planning. Medication reconciliation during transitions and discharge planning are both reported through BHSDStar. We also track 7 day and 30 day follow up visits through our claims system, and report this as part of our quality reporting.

PRISM, a risk management application based on 15 months of rolling claims data affords CLNM providers with insights based on utilization history for both behavioral and physical health, medication history, hospitalizations and ED use. It utilizes state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. The care Coordinators access this system before engaging in transitional care interventions to assist them in the development of strategies they can share with the patient as to future utilization of differing service options.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists — **Description**: See Other
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses — **Description**: See Other
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
CareLink NM Provider Team	• A Care Coordinator and Supervisor of the care coordinator as described above • A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with the CLNM's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources and practitioners. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. • A Physical Health Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC. • A Psychiatric Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO) and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services reduce barriers to CLNM members' care coordination, increase skills and engagement, and improve health outcomes. Services also increase health and medication literacy, enhance one's ability to self-manage care, promote peer and family involvement and support, improve access to education and employment supports, and support recovery and resiliency. Individual and family support activities include, but are not limited to:

- Supporting a member and their family in recovery and resiliency goals;
- Supporting families in their knowledge of a member's disease and possible side effects of medication;
- Enhancing the abilities of members and their support systems to manage care and live safely in the community;
- Teaching members and families self-advocacy skills and how to navigate systems;
- Providing peer support services;
- Assisting members in obtaining and adhering to medication schedules and other prescribed treatments;
- Assisting members in accessing self-help activities and services;
- Arranging for transportation to medically-necessary services;
- Identifying resources for individuals to support them in attaining their highest level of health and functionality within their families and in their community
- Assessing impacts of a member's behaviors on families, and assisting in obtaining respite services as needed.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The following activities are recorded in the BHSDStar service tracking system under "Individual/Family Support" from which reports can be garnered:

- Supported the member in recovery & resiliency goals
- Supported the family in the members recovery & resiliency goals
- Conducted family education on member's chronic condition(s)
- Identified community services
- Arranged respite services
- Arranged family legal representative meetings
- Peer support contact
- Education on client rights

Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

See Other

☑ Nurse Practitioner

☐ Nurse Care Coordinators

☑ Nurses

Description

See Other

☑ Medical Specialists

Description

See Other

- [x] Physicians

Description

See Other

- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers

Description

See Other

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Care Link NM Provider Team	• Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing curriculum and curriculum deliver. The Health Promotion Coordinator managed health promotion services and resources appropriate for a CLNM Member such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight. • Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan
Community Liaison	See Other

Referral to Community and Social Support Services

Definition

Referrals to community and social support services help overcome access and service barriers, increase self-management skills, and improve overall health. Providers identify available and effective community-based resources and actively link and manage appropriate referrals.
Linkages support the personal needs of members and are consistent with the Service Plan. Community and social support service referral activities may include, but are not limited to:

- Identifying and partnering with community-based and telehealth resources such as medical and behavioral health care, durable medical equipment (DME), legal services, housing, respite, educational and employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, personal needs, wellness and health promotion services, specialized support groups, substance use prevention and treatment, and culturally-specific programs such as veterans' or IHS and Tribal programs;
- Developing referral and communication protocols as outlined in memorandums of agreement (MOA):
- Referrals for partnerships with a MOA shall include acknowledgment of the referral and follow-up with the member by both participating partners. Once a referral is made, the healthcare provider also has access to relevant data on the member, including his or her CLNM assessment and Service Plan, unless the member does not authorize a data exchange.
- Making referrals and providing assistance to establish and maintain a member's eligibility for services;
- Actively managing appropriate referrals and access to care;
- Confirming members' and providers' encounters and following up post-referral.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The BHSDStar service tracking system has a section for "Referral to Community & Social Support Services". The activities within it are:

- Evaluate care needs for ancillary support
- Legal contact made
- Educational contact made
- ID and/or arranged housing contact
- Utilities paid or contact
- Religious contact made

- Food contact made
- Clothing contact made

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  See Other
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses
  Description
  See Other
- [x] Medical Specialists
  Description
  See Other
- [x] Physicians
  Description
  See Other
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
CareLink NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. • A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with the CLNM's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources and practitioners. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2018MS0003O
SPA ID NM-18-0002
Submission Type Official
Initial Submission Date 5/10/2018
Approval Date 7/3/2018
Effective Date 4/1/2018
Superseded SPA ID NM-15-0014
User-Entered

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Please see Attachment G for Patient Flowchart.

Name	Date Created	
Attachment F - Sample County Comorbidity Data	3/21/2018 11:45 AM EDT	
Attachment G - CLNM Patient Flow	3/21/2018 11:46 AM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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Package ID NM2018MS0003O
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User-Entered

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The State can identify the people who affirmatively enrolled in a CareLink NM Health Home. For these, we can look at total costs from our MMIS data warehouse for the preceding two years for the same individuals and compare to total costs after enrollment in the HH. We will categorize those costs by (1) those we expect to, in the long run, have savings, such as emergency department visits, inpatient admissions, and residential treatment; and (2) all other outpatient and pharmaceutical costs we expect to initially increase. We will also analyze cost data by contrasting those with fewer than 3 comorbid conditions with those with 3 or more comorbid conditions. A third contrast will examine costs for those with a substance use disorder (SUD) as a comorbidity vs. those without a SUD.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

CareLink NM Health Home providers will be required to use certified Electronic Health Records (EHRs) for the CareLink NM Health Home program. These EHRs must be able to provide state of the art technologies to both office and field based staff. In addition, the designated providers will be required to work within the BHSDStar system designed specifically for the CareLink NM Health Home, and will be required to participate in the State EDIE planning initiatives and work with the HSD as well as the MCOs to provide seamless integration of the systems data.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

Package Header

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Superseded SPA ID	NM-15-0014		
	User-Entered		

Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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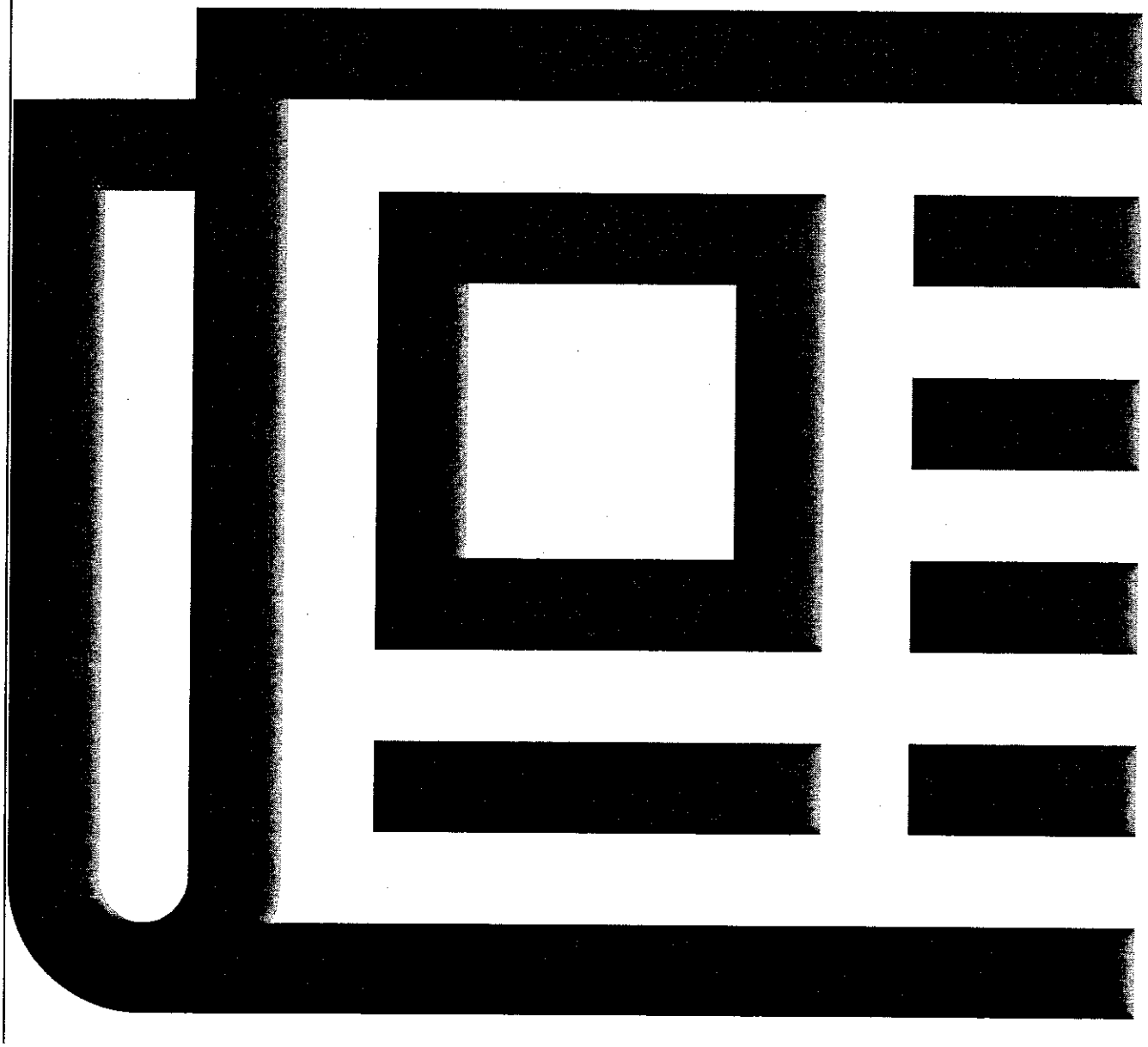
Records
Submission Packages
NM - Submission Package - NM2018MS0003O - (NM-18-0002) - Health Homes



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Summary

Reviewable Units

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CMS-10434 OMB 0938-1188

Package Information

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Program Name
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Submitted By
Megan Pfeifer

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Approved

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Dallas, TX

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Approval Notice
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Date: 07/03/2018
Head of Agency: Brent Earnest
Title/Dept : Cabinet Secretary, NM Human Services Department
Address 1: PO Box 2348
Address 2: 2025 S. Pacheco Street
City : Santa Fe
State: NM
Zip: 87504
MACPro Package ID: NM2018MS0003O
SPA ID: NM-18-0002
Subject
Approval of State Plan Amendment 18-0002
Dear Brent Earnest
This is an informal communication that will be followed with an official communication to the State's Medicaid Director.
The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for
NM Health Home SPA 18-0002

Reviewable Unit	Effective Date
Health Homes Intro	4/1/2018
Health Homes Geographic Limitations	4/1/2018
Health Homes Population and Enrollment Criteria	4/1/2018
Health Homes Providers	4/1/2018
Health Homes Service Delivery Systems	4/1/2018
Health Homes Payment Methodologies	4/1/2018
Health Homes Services	4/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2018

Increased Geographic Coverage

○ Yes

○ No

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 4/1/2018 to 3/31/2020.

Increase in Conditions Covered

○ Yes

○ No

HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for its most vulnerable children and adolescents. In addition, one of the providers will be the State's first Tribal 638 Health Home.
Sincerely,
Melissa Harris (on behalf of Alissa DeBoy)
Mrs.
Approval Documentation

Name Sortable column, activate to sort ascending	Date Created Sortable column, activate to sort ascending Sortable column, activate to sort ascending
6.A.1 NM 18-0002 MACPRo ApprovalLet_FJB.bdb	7/9/2018 2:48 PM EDT

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Submission - Summary
MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM
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State Information
State/Territory Name:
New Mexico
Medicaid Agency Name:
NM Human Services Department, Medical Assistance Division
Submission Component

○ State Plan Amendment

○ Medicaid

○ CHIP

Submission - Summary
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SPA ID
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Initial Submission Date
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Reviewable Unit	Proposed Effective Date	Superseded SPA ID

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Health Homes Intro	4/1/2018	NM-15-0014
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Health Homes Payment Methodologies	4/1/2018	NM-15-0014
Health Homes Services	4/1/2018	NM-15-0014
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2018	NM-15-0014

Submission - Summary
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Superseded SPA ID
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SPA ID
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Initial Submission Date
5/10/2018
Effective Date
N/A
Executive Summary
Summary Description Including Goals and Objectives
In April of 2016 the New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH). The first stage of this statewide program engaged agencies to provide coordinated care in two rural counties. These Health Homes are designed for individuals with chronic conditions in the categories of serious mental illness for adults (SMI), and severe emotional disturbance (SED) for children and adolescents. Based on the positive results in these two counties, HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for our most vulnerable children and adolescents. In addition, one of the providers will be our first Tribal 638 Health Home. The Health Home service delivery model, called CareLink NM, provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services, and social supports. It also includes comprehensive care management, health promotion, disease management, risk prevention, comprehensive transitional care, peer and family supports, and referral for community and social services and supports. The goals of the program are to 1) Promote acute and long term health; 2) Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Each goal has a number of process and outcome criteria.
Federal Budget Impact and Statute/Regulation Citation
Federal Budget Impact

Federal Fiscal Year	Amount
First 2018	$5126191
Second 2019	$3328741

Federal Statute / Regulation Citation
Section 2703 (P.L. 111-148, ACA)
Submission - Summary
MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM
Package Header
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Effective Date
N/A
Governor's Office Review
○ No comment
○ Comments received
○ No response within 45 days
○ Other
Submission - Public Comment
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N/A
Name of Health Homes Program
MIGRATED_HH.CareLink NM
Indicate whether public comment was solicited with respect to this submission.
○ Public notice was not federally required and comment was not solicited
○ Public notice was not federally required, but comment was solicited
○ Public notice was federally required and comment was solicited
Indicate how public comment was solicited:
☐ Newspaper Announcement

Name of Paper:Sortable column, activate to sort ascending	Date of Publication:Sortable column, activate to sort ascending	Locations covered:Sortable column, activate to sort ascending
Albuquerque Journal	3/31/2018	Central and Northern New Mexico
Las Cruces Sun-News	3/30/2018	Southern New Mexico

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
☐ Email to Electronic Mailing List or Similar Mechanism
☐ Website Notice
Select the type of website
☐ Website of the State Medicaid Agency or Responsible Agency
Date of Posting:
Mar 28, 2018
Website URL:
http://www.hsd.state.nm.us/2018.aspx
☐ Website for State Regulations
☐ Other
☐ Public Hearing or Meeting
☐ Other method
Upload copies of public notices and other documents used

Name:Sortable column, activate to sort ascending	Date Created:Sortable column, activate to sort ascending	Sortable column, activate to sort ascending
Public Notice	5/10/2018 11:53 AM EDT	pdf
Notice of Opportunity to Comment	5/10/2018 11:53 AM EDT	pdf

Upload with this application a written summary of public comments received (optional)

Name:Sortable column, activate to sort ascending	Date Created:Sortable column, activate to sort ascending	Sortable column, activate to sort ascending
No items available		

Indicate the key issues raised during the public comment period (optional)
☐ Access
☐ Quality
☐ Cost
☐ Payment methodology
☐ Eligibility
☐ Benefits
☐ Service delivery
☐ Other issue
Submission - Tribal Input
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N/A
Name of Health Homes Program
MIGRATED_HH.CareLink NM
One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

○ Yes

○ No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

○ Yes

○ No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:
Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☐ All Indian Health Programs

Date of solicitation/consultation: Sortable column, activate to sort ascending	Method of solicitation/consultation: Sortable column, activate to sort ascending
3/30/2018	Website posting and email notification

☐ All Urban Indian Organizations

Date of solicitation/consultation: Sortable column, activate to sort ascending	Method of solicitation/consultation: Sortable column, activate to sort ascending
3/30/2018	Website posting and email notification

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

Date of consultation: Sortable column, activate to sort ascending	Method of consultation: Sortable column, activate to sort ascending
3/30/2018	Website posting and email notification

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name: Sortable column, activate to sort ascending	Date Created: Sortable column, activate to sort ascending	Sortable column, activate to sort ascending
Tribal Notice SPA 18-002	5/10/2018 12:00 PM EDT	pdf

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

Submission - Other Comment
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N/A
SAMHSA Consultation
Name of Health Homes Program
MIGRATED_HH.CareLink NM

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation: Sortable column, activate to sort ascending
6/13/2015

Health Homes Info
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Program Authority
1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.
Name of Health Homes Program
MIGRATED_HH.CareLink NM
Executive Summary
Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used
In April of 2015 the New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH). The first stage of this statewide program engaged agencies to provide coordinated care in two rural counties. These Health Homes are designed for individuals with chronic conditions in the categories of serious mental illness for adults (SMI), and severe emotional disturbance (SED) for children and adolescents. Based on the positive results in these two counties, HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high fidelity wraparound model with two providers for our most vulnerable children and adolescents. In addition, one of the providers will be our first Tribal 638 Health Home. The Health Home service delivery model, called CareLink NM, provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services, and social supports. It also includes comprehensive care management, health promotion, disease management, risk prevention, comprehensive transitional care, peer and family supports, and referral for community and social services and supports. The goals of the program are to 1) Promote acute and long term health; 2) Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Each goal has a number of process and outcome criteria.
General Assurances

☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☐ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☐ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations
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○ Health Homes services will be available statewide

○ Health Homes services will be limited to the following geographic areas

○ Health Homes services will be provided in a geographic phased-in approach
Phase 2

Title of phase
Phase 2
Implementation Date
4/1/2018
Phase-in will be done by the following geographic area
By county
Specify which counties:
Bernalillo
De Baca
Grant
Hidalgo
Lea
Quay
Roosevelt
Sandoval
Health Homes services are now available statu-wide
No
Enter any additional narrative necessary to fully describe this phase
The CLNM program is being implemented in a phased approach by county. For purposes of this SPA, the State is requesting approval for the CLNM HH Program in eight additional counties. These counties are a mix of rural, frontier and urban and include: Bernalillo, Sandoval, Quay, De Baca, Roosevelt, Lea, Grant and Hidalgo. (The two counties from the first phase – Curry and San Juan – will continue Health Homes operations.) A subsequent phase of implementation could include additional counties. We might also look at creating Health Homes with agencies that only serve adults and agencies that only serve children and youth as long as both types are available in each county. (Currently we require that CLNM Health Homes serve both children and adults.)
NameSortable column, activate to sort ascendingDate CreatedSortable column, activate to sort ascendingSortable column, activate to sort ascending
No items available
Health Homes Population and Enrollment Criteria
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Categories of Individuals and Populations Provided Health Homes Services
The state will make Health Homes services available to the following categories of Medicaid participants

☐ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria
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Population Criteria
The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions

☐ One chronic condition and the risk of developing another

☐ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition
The SMI and SED criteria were developed and approved by the Behavioral Health Collaborative, a statutorily created body that includes fifteen cabinet level agencies as well as the Governor's Office. With input from the Behavioral Health Planning Council's Children and Adolescent Subcommittee (CASC), the initial criteria for SED were revised to include additional trauma related factors. Another revision updated the criteria for both SMI and SED to coincide with DSM-V. The current criteria, approved by the full Behavioral Health Collaborative, are used for eligibility for various services as well as for targeting programs and grants. The criteria checklists include symptom severity and other risk factors. The SMI and SED criteria checklists can be found in Attachments B and C. The diagnosis criteria can be found in Attachment D.
Health Homes Population and Enrollment Criteria
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Enrollment of Participants
Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

○ Opt-In to Health Homes provider

○ Referral and assignment to Health Homes provider with opt-out

○ Other (describe)

Describe the process used
Enrollment into the CareLink NM Health Home is voluntary. Eligible beneficiaries – both Managed Care and Fee for Service - are identified through a data driven process. Beneficiaries already receiving outpatient services from the CLNM HHs will be the initial group (Phase 1). These identified beneficiaries will be interviewed at the CLNM HH to ascertain interest and to explain their option to opt out after one year's time. Beneficiaries must affirmatively agree to remain in the CareLink NM Health Home for one year unless they meet criteria for opting out sooner. These criteria are: 1) the individual is no longer eligible for Medicaid; 2) the individual is Medicaid eligible but has moved out of the area; 3) the individual's health status has improved to the degree he/she no longer meets the criteria for SMI or SED; or 4) the individual is dissatisfied with the program and agrees to meet with the agency, the respective MCO or State representative, and others as requested to explain the circumstances related to the request to opt out. Phase I enrollment is projected to last for 6 months. The second group of beneficiaries (Phase 2) includes eligible beneficiaries not currently receiving services at a CLNM HH provider. Historical claims data will be used to identify eligible individuals based on SMI or SED diagnosis. The State will send letters to all eligible fee-for-service beneficiaries and the MCOs will send letters to all eligible managed care beneficiaries. The letter will describe the opportunity to enroll in a CLNM HH and advise the beneficiary to contact a CLNM HH in their area or wait for the HH to contact them. The CLNM HH will also work with their community partners to engage and enroll those eligible for the services. In addition, new Centennial Care managed care members will be referred by the MCO when deemed eligible. One exception to the processes described above relates to beneficiaries for Wraparound. Eligibility for this level of care coordination requires an SED diagnosis as well as additional criteria, namely that the child or youth is 1) between 3 and 21 years of age; 2) engaged with two or more systems: protective services, juvenile justice, behavioral health, and special education; 3) at-risk or in an out-of-home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; and 4) a functional impairment in home, school or community, as measured by the Children and Adolescents Needs and Strengths (CANS). This system involvement is not known to the claims system nor to the MCOs. The two CLNM agencies that will be offering Wraparound will thus reach out to local representatives of these systems to identify potential beneficiaries. This will begin at startup for these providers so that caseloads can be built. The concept of Phase 1 and 2 will not be applicable for beneficiaries eligible for Wraparound.
Health Homes Providers
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Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards
Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator (s) • Community Liaison • Clinical Supervisor (s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State. 6. Be approved by New Mexico Human Services Department through the application process. 7. Have the ability to provide primary care services for adults and children; or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources. The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home: The range of ratios of care managers to members is dependent on severity of case, and is as follows: Lowest level: 1:51-100 Higher level: 1:30-50 High Fidelity Wraparound: 1:8-10

☐ Rural Health Clinics

Describe the Provider Qualifications and Standards
Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator (s) • Community Liaison • Clinical Supervisor (s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State. 6. Be approved by New Mexico Human Services Department through the application process. 7. Have the ability to provide primary care services for adults and children; or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources. The

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☐ Community Health Centers

☐ Community Mental Health Centers

Describe the Provider Qualifications and Standards

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☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator (s) • Community Liaison • Clinical Supervisor (s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State. 6. Be approved by New Mexico Human Services Department through the application process. 7. Have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources. The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home: The range of ratios of care managers to members is dependent on severity of case, and is as follows: Lowest level: 1:51-100 Higher level: 1:30-50 High Fidelity Wraparound: 1:8-10

☐ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

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☐ Other (Specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
IHS or Tribal 638 Clinics	Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator (s) • Community Liaison • Clinical Supervisor (s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State. 6. Be approved by New Mexico Human Services Department through the application process. 7. Have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources. The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home: The range of ratios of care managers to members is dependent on severity of case, and is as follows: Lowest level: 1:51-100 Higher level: 1:30-50 High Fidelity Wraparound: 1:8-10

☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The CareLink NM Health Home will serve as the lead entity and have a memorandum of agreement (MOA) with each partnering primary care practice (adult and child) and with local hospitals and residential treatment centers. The MOA describes standards and protocols for communication, collaboration, referral, follow up, and other information necessary to effectively deliver services without duplication. An example of this would be a behavioral health entity that would have an MOA with a primary care physician or a pediatrician. Each Centennial Care MCO is required to contract with all CareLink NM Health Homes to ensure continuity of care and support to MCO members in receiving CareLink NM Health Home services. This process includes assuring that there are an adequate number of such MOAs to ensure sufficient primary care for each of the MCOs, including dual eligible members. MOAs will not be needed if the partner providing primary care is part of the same organization operating in the same or another location.

Health Homes Providers

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services

Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines

Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders

Coordinate and provide access to mental health and substance abuse services

Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

Coordinate and provide access to chronic disease management, including self-management support to individuals and their families

Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services

Coordinate and provide access to long-term care supports and services

Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services

Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The Health Home implementation project team is composed of a nurse with a background in large scale project leadership and business process re-engineering, an experienced behavioral health clinician, an information technology professional, a PhD quality leader, a PhD statistician and experienced facilitator, a Native American project manager, the NM State Children, Youth and Family Department's Behavioral Health Director, and assistance from a psychiatrist with the University of New Mexico's Department of Psychiatry. The team developed an educational program for prospective providers which covers a year of readiness development for the prospective CLNM HH agencies, as follows: 1) A collective learning platform for shared information exchange on relevant topics with the participation of the original 2 CLNM site Directors and access to extensive resource documents. An eight day, in-person sessions included: i) Areas of responsibility to determine fit: CLNM population; staffing; care coordination levels; use of IT; services; reimbursement; application process ii) The six core services; Peer and Family Support Specialist Programming; High Fidelity Wraparound for children/youth; CLNM policies iii) Developing memorandums of agreement; review of evaluation criteria & quality reporting; and population health management iv) Trauma informed care: historical trauma & adult trauma; trauma in children v) Collaboration with the Centennial Care MCOs; nursing facility level of care vi) Cost reporting, membership forecasting, and the development of the PMPMs vii) Review of CLNM information technology: (a) BHSD STAR; registration/activation; assessment; service plan; service tracking; referrals; quality reporting (b) PRISM Risk Management system (c) Emergency Department Information Exchange (EDIE) (d) Billing and start up IT activities viii) Readiness criteria and preparing for the onsite review ix) Training in integrating physical health care is currently under development 2) A Steering Committee composed of HSD management, MCO management, CYFD management, Tribal Liaison, and University of NM psychiatry oversees the application, administration, and evaluation of the CLNM HHs, and offers operational support through the steering committees members' respective organizations. 3) An Operations Committee composed of the CLNM HH providers, the MCOs, Information Technology, and the CLNM Project team confers weekly to assess all operational and IT issues, and works within the relevant organizations to resolve issues and improve processes. 4) As BH services, that will be recommended as inclusions in the CLNM HH, are being introduced or updated with evidence based programs, ad hoc training will be provided. Examples include medication assisted treatment and mobile crisis teams. 5) The Children, Youth and Families Department is training the high fidelity wraparound facilitators on the NM Wraparound CARES program; they will provide coaching to the directors at each facility for 18 months. 6) The Children, Youth and Families Department is providing the requisite training for Certified Family Peer Support Workers. The Office of Peer and Family Engagement at the Human Services Department is providing the requisite training for Certified Peer Support Workers.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NM2018MS0003O | NM-18-0002 | MIGRATED_HH.CareLink NM

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Effective Date

4/1/2018

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The State's minimum requirements and expectations for Health Home providers are as follows: 1. Registered Medicaid Provider in the State of New Mexico. 2. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following: a) Health Home Director; b) Health Promotion Coordinator - Relevant bachelors level degree, experience developing and delivering curriculum; c) Care Coordinator - Licensed as a registered nurse or behavioral health practitioner, or have a bachelor's or Master's level degree and two years of experience or as approved through waiver by HSD; d) Community Liaison - Multi-lingual and experienced with resources in the local community including family and caregiver support services; e) Clinical Supervisor(s) – Independently licensed professional who has experience with adults and children; f) Peer Support Workers - Certified by the State; g) Family Peer Support Workers – Certified by the State; h) physical health Consultant, either MD, DO, CNP or CNS; and i) Psychiatric Consultant, MD or DO Board certified in psychiatry. 5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA. 6. The CareLink NM Health Home must be approved by New Mexico through the application process. 7. The CareLink NM Health Home must have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults. 8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

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Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☐ Fee for Service
- ☐ PCCM
- ☐ Risk Based Managed Care
- ☐ Other Service Delivery System

Health Homes Payment Methodologies
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Payment Methodology
The State's Health Homes payment methodology will contain the following features

- ☐ Fee for Service
- ☐ Individual Rates Per Service
- ☐ Per Member, Per Month Rates
- ☐ Fee for Service Rates based on
- ☐ Severity of each individual's chronic conditions
- ☐ Capabilities of the team of health care professionals, designated provider, or health team
- ☐ Other

Describe below
Cost analysis

- ☐ Comprehensive Methodology included in the Plan
- ☐ Fee for Service Rates based on
- ☐ Severity of each individual's chronic conditions
- ☐ Capabilities of the team of health care professionals, designated provider, or health team
- ☐ Other

Describe below
Cost analysis

- ☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided
Described below

- ☐ PCCM (description included in Service Delivery section)
- ☐ Risk Based Managed Care (description included in Service Delivery section)
- ☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

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Agency Rates
Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

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Rate Development
Provide a comprehensive description in the SPA of the manner in which rates were set
In the SPA please provide the cost data and assumptions that were used to develop each of the rates
Please identify the reimbursable unit(s) of service
Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
Please describe the state's standards and process required for service documentation, and
Please describe in the SPA the procedures for reviewing and rebasing the rates, including
the frequency with which the state will review the rates, and
the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.
Comprehensive Description
To support the Health Homes, a per member per month (PMPM) care management cost was developed separately for each Health Home based on modeling estimated enrollment, staff salaries and benefits, and administrative costs that will occur during the Phase 1 implementation period from April 1, 2018 through December 31, 2018, during which time they will be enrolling their current clients and referrals from the community for the first 6 months. A separate PMPM cost was estimated for the Phase 2 ramp up period from January 1, 2019 through December 31, 2019 that will be sustained through March 30, 2020 with a 5% per annum dropout rate. The estimated number of members who enroll during each month of these two periods, the staffing developed to manage their care, and the other administrative costs of running the program contribute to the PMPM costs. The following sections discuss the key components considered in this PMPM cost development. Two of the Health Homes are also implementing a high fidelity children's wraparound pilot within their Health Home in addition to serving the members described above. Separate projections and rates are developed for this population of most vulnerable children who meet the following conditions to be part of this service: Children and youth Ages 4-21 with: o Diagnosis of Serious Emotional Disturbance (SED); AND o Multi-system involvement, i.e. two or more systems involvement including Juvenile Justice, Protective Services, Special Education or Behavioral Health; AND o At risk of or in out-of-home placement OR previous out-of-home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; AND o Functional impairment in home, school or community (as measured by the Children and Adolescents Needs and Strengths (CANS) or Child and Adolescent Functional Assessment Scale (CAFAS). Enrollment Development The Health Homes that have been approved by the State and the counties that they plan to serve for this program expansion are shown in Table 1 of Attachment E - Health Homes Payment Methodologies. Each Health Home was asked to develop separate Phase 1 and Phase 2 enrollment projections by month for the members whom they will serve under this program. The Health Homes were provided guidance from the State as well as enrollment information from the first two Health Homes implemented in 2016 to help inform the development of these enrollment projections. The projections depend on the number of SMI/SED members currently known to the Health homes during the first 6 months of Phase 1, and projections of total SMI/SED members that will be reached within the counties served by each Health Home during the remaining 3 months of phase 1, and the entirety of Phase 2. The enrollment modeling for Phase 1 begins in April 2018 and continues through December 2018. The enrollment modeling for Phase 2 begins in January 2019 and continues through December 2019 with the remaining 3 months of enhanced FMAP showing a consistent membership thereafter. This represents the number of SMI/SED members that are reached within the counties served that are new members not previously known to the Health Homes. These new members are enrolled through the outreach efforts of the community liaison, other Health Home management staff, referral relationships, and the MCOs. For most Health Homes, the Phase 2 monthly enrollment drops to slightly lower levels later in Phase 2. Attachment E Table 2 shows the enrollment estimates for each Health Home during Phase 1 and Phase 2, representing the new number of enrolled members in each Phase. Table 3 shows the total member months for these enrollees for each Health Home during Phase 1 and Phase 2, representing the total number of member months for all members served during each Phase. Attachment E Tables 4 and 5 show the monthly enrollment and member month estimates for each Health Home that is implementing the children's wraparound program. Health Home Salaries, Benefits, and Overhead Development The PMPM cost of each Health Home is driven by the number of full time equivalent employees needed to manage the care of the enrolled members, their job classification, and member enrollment projections. The salary and benefit costs utilized in the projections were developed by each Health Home using publicly available sources for similar job classifications and Health Home staff qualifications. The city of Albuquerque was used for Bernalillo county, the city of Rio Rancho was used for Sandoval county, the city of Animas was used for Hidalgo and Grant counties, the city of Hobbs was used for Lea county, and the city of Portales was used for Quay, De Baca and Roosevelt counties. The Health Home model consists of two types of staff – operational staff and care coordination staff, as described below. Health Home Operational Staff The operational staff includes a Health Home director, community liaison, health promotion coordinator, medical consultant, and psychiatric consultant. One important characteristic of the staffing model is that the number of staff members in these roles will not generally fluctuate with Health Home enrollment. Health Home Director The Health Home Director is responsible for the day-to-day Health Home operations; the job description is modeled after a clinical operations manager. The Health Home Director's responsibilities include overall service oversight, financial performance, and quality management. The Health Home Director may have an advanced degree with multiple years of experience. Community Liaison The community liaison coordinates, organizes and plans programs that promote the Health Home with potential members and their health care providers in the community, developing goodwill and fostering relationships with community health care providers, including the development of memorandums of agreement. They provide oversight for the referral relationships, and are a resource to the care coordinators in finding the community resources needed for these complex members. Health Promotion Coordinator The health promotion coordinator designs and implements health education and disease management programs for the improvement and maintenance of SMI/SED health conditions and prevalent co-morbidities. They are knowledgeable about the prevention of common risk behaviors and stay abreast of changes in health care technology and best practices to keep education and materials current. In support of these programs, additional educational trainers and ancillary staff may be part of the team, but are not required. Consultant – Physical Health Consultant The consulting clinician will be available to the care team on a consulting basis related to

member physical health conditions. Consultant – Psychiatrist The consulting psychiatrist will be available to the care team on a consulting basis related to member mental health or substance use conditions. Health Home Care Coordination Staff The care coordination staff includes care manager supervisors, care coordinators, and peer and family support workers. The number of employees is dependent on staffing ratios (member to staff) and member enrollment. The staffing is based on the enrollment ramp up described above, developed separately by each Health Home, and begins at the start of Phase 1. Care Coordinators The care coordinator staffing ratios are calculated at 1:65 for lower severity members and 1:40 for the higher severity members, with an estimated mix of 55% lower severity and 45% higher severity. These calculated ratios are based on the experience of the first two CLNM HHs and fall within the suggested ratio ranges of 1:51–100, and 1:30–50. For the high fidelity wraparound pilots, the calculated staffing ratio is 1:9, the median for a suggested ratio range of 1:8-10. The Health Homes developed their staffing ratios with these targets in mind. Care coordinators' qualifications include a registered nurse with 2 years of behavioral health care experience; or behavior health clinicians; or have a bachelor's degree and 2 years relevant healthcare experience. They should also have served as a liaison between patients, families and health care providers. Peer and Family Support Staff Peer and family support staff have lived experience with SMI/SED conditions or have been a parent, spouse, sibling, or significant other of one who has one or more of these conditions. Support staff team with Health Home members to increase empowerment and hope, increase social functioning, increase community engagement and activation in treatment, increase quality of life and life satisfaction, and decrease self-stigma. They support family members in dealing with member behaviors and supporting their own resilience, and are an important member of the care management team. Supervisors Supervisors provide supervision and serve as a clinical review or resource for the care coordination staff, the community liaison, the health promotion coordinator and the peer and family support staff. The ratio of supervisor to staff is targeted at 1:8. Supervisors are independently licensed behavior health practitioners or independent nurse practitioners, and have direct service experience in working with both adult and child populations. Administrative Costs The final component of the cost development is an allowance for administrative expenses associated with the Health Home operations and staff costs. Administrative expenses include rent, utilities, phone, computers, equipment, claims support, internet, training, continuing education, promotions, insurance, office supplies, travel and other indirect costs that may be required to visit members in their home or health care setting. The Health Homes provided their own estimates for administrative costs for Phases 1 & 2, either as a percent of salaries of Health Home staff or as estimated dollar amounts. As the Health Home program matures or enrolls a larger number of members, future administrative costs may be reduced to reflect economies of scale. Projections of PMPM Rates The PMPM cost modeling as discussed above was completed based on assumptions about enrollment ramp-up, staff salary and benefits, and administrative overhead as developed by the Health Homes. These costs are developed separately for the Phase 1 period (April through December 2018) and the Phase 2 period (January through December 2019). The enrolled members, projected member months, Health Home projected costs and PMPM rates are presented in Attachment E Table 6. Separate rates are developed for the children's wraparound pilots for the Health Homes that are including that program. The enrolled members, projected member months, Health Home projected costs and PMPM rates for these wrap around pilots are presented in Attachment E Table 7. A Health Home member must be seen for at least one of the six core services within the month for the PMPM to be paid. This activity is tracked through the BHSDStar system that has been developed specifically for the Health Homes. Each of the six core services has a list of activities within that service that the care coordinator checks on a daily basis. Management reports are available from this system to Health Home management to track utilization and compliance with HH policy and expectation. Quality indicators that do not require claims data also derive from this system. There are both process and outcome criteria categorized by the 5 goals of the program. Based on the tracking of the 6 services through the BHSD Star system, claims are submitted to the state's MMIS system. Rules for this submission are: • For reimbursement of the PMPM, the G9001 or G9003 code must be billed with one other service code listed in the table below on the same claim; • The six services codes shall be billed with a $0.01 price indicated, but will pay $0.00; • All service codes are to be billed with the actual dates of service and correct time units; • FQHCs that will bill other services utilizing a UB claim form and a revenue code shall bill the CLNM codes on a CMS 1500 claim form using HCPCS codes listed below. FQHC will need to obtain a separate NPI and facility ID for CLNM services; • IHS and 638 tribal facilities will be billing other services utilizing the DMB rate, and shall bill CLNM codes on a CMS 1500 claim form utilizing the above HCPCS codes. The HCPC codes are listed in Attachment E Table 8. The State will make Health Homes services available to the following categories of Medicaid participants: individuals with SMI or SED receiving services in the 8 counties listed above who are fee-for-service or managed care Medicaid beneficiaries.

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved
Under managed care, the MCO will make payment on a monthly basis to the CareLink NM Health Home for enrolled members. Although the PMPM for the CareLink NM Health Home is developed based on the staffing and administrative costs of the CareLink NM Health Home, the current capitated rates paid by the State to the MCO includes care coordination or case management activities as a primary function under the federal authority under which the Centennial Care program operates. These care coordination activities are similar in scope to the care coordination that will be performed by the CareLink NM Health Home and are already factored into the current MCO capitated payment rate. Currently under managed care, members who are assessed as SMI or SED are assigned to the most intensive care coordination. To ensure that there is no duplication of payment the CareLink NM Health Home PMPM payment will be evaluated against the care coordination funding included in the capitated rates. The State will monitor the payments between the MCO and CareLink NM Health Home through the evaluation of encounter data submitted by the MCO as well as MCO CareLink NM Health Home reporting.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

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Attachment E - Health Homes Payment Methodologies Tables 1-8/3/21/2018 11:38 AM EDT		pdf

Health Homes Services
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Service Definitions
Provide the state's definitions of the following Health Homes services and the specific activities performed under each service
Comprehensive Care Management
Definition
Comprehensive Care Management involves the CLNM Comprehensive Needs Assessment (CNA) and the development of an individualized Service Plan with active participation from the CLNM member, family, caregivers and the Health Home team. The CLNM Comprehensive Needs Assessment (CNA) The provider agency is responsible for conducting the CNA to determine a member's needs related to physical and behavioral health, long-term care, social and community support resources and family supports. The CNA: • Provides all the required data elements specified in the HSD authorized CNA; • Assesses preliminary risk conditions and health needs; • Uses data from the risk management system to help determine care coordination levels; • Requires outreach to potential CLNM members within 14 calendar days of receipt of a referral; • Must document that a provider contacted and/or met with a member to at least begin assessment within the mandated 14-day timeframe; • May conduct face-to-face meetings in a member's home. If the member is homeless, the meeting may be held at a mutually agreed upon location; • May enroll a member during the first visit if using the Treat First model. The member would be assigned a "pending" status or assigned care coordination level 8 until a diagnosis of SMI or SED is finalized and accepted by the member. The CNA can be completed over the course of four appointments; when completed, the care coordination level is updated. The CLNM Service Plan The Service Plan, provided by HSD, maps a member's path toward self-management of physical and behavioral health conditions, and is specifically designed to help members meet needs and achieve goals. 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, and service providers. The plan is intended to be supplemented by treatment plans developed by practitioners. The Service Plan: • Requires active participation from members, family, caregivers, and team members; • Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, and other participants in a member's care; • Identifies additional health recommended screenings; • Addresses long-term and physical, behavioral, and social health needs; • Is organized around a member's goals, preferences and optimal clinical outcomes, including self-management. The plan includes as many short- and long-term goals as needed; • Specifies treatment and wellness supports that bridge behavioral health and primary care; • Includes a backup plan that addresses situations when regularly-scheduled providers are unavailable, and provides contact information for people and agencies identified in the backup plan. This is primarily for members receiving home- and community-based services where there is a nursing facility level of care (NFLOC) determination. There is no required template; the plan is uploaded as a file into the State's web-based data collection tool, BHSDStar; • Includes a crisis/emergency plan listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency. These are individualized plans, uploaded into BHSDStar; • Is shared with members and their providers; - Is updated with status and plan changes. Comprehensive care management services must also include: - Assignment of health team roles and responsibilities; - Development of treatment guidelines for health teams to follow across risk levels or health conditions; • Oversight of the implementation of the CareLink NM Plan which bridges treatment and wellness support across behavioral health, primary care and social health supports; • Through claims-based data sets, monitoring of individual health status and service use to determine adherence to or variance from treatment guidelines; and - Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
The BHSDStar web based data collection tools will be used to create HIT linkages for this project. The modules in support of care management include registration and activation including the level of care in which the member is placed, a CareLink NM comprehensive needs assessment that requires first appointment screenings and imminent clinical risk assessment, with a more comprehensive history and information gathering over the course of 4 appointments. A service plan is developed with the member inclusive of short and long term goals, service requirements and expected outcomes. All were developed for touch screen laptops or tablets for in home or community use. It is available to CareLink NM Health Home providers in order to support the beneficiary and the CareLink NM Health Home Care Coordinator in identifying the unmet needs, gaps in care, clinical protocols required, case management, medical and behavioral health service, and social determinants of health. Offsite referral partners will have the ability to access the BHSDStar modules if consent has been given by the member. Analytics from the Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC provides insight to the CareLink NM providers as it relates to utilization history for both behavioral and physical health, medication history, hospitalizations and ED use. It utilizes state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. The Care Coordinators access this system before the development of the service plan, and can gain new insights as case management evolves.
Scope of service
The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
Description
See Other

☐ Nurse Practitioner

☐ Nurse Care Coordinators
Description
See Other

☐ Nurses
Description
See Other

☐ Medical Specialists
Description
See Other

☐ Physicians
Description
See Other

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers
Description
See Other

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
CareLink NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker(s) (CPSW) who holds a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully navigated his or her own behavioral health experiences, and is willing to assist his or her peers in their recovery processes. • A Certified Family Peer Support Specialist (CFPSS) who holds a certification by the New Mexico credentialing board for behavioral health professionals as a certified family support worker. • A Health Promotion Coordinator who assures that disease management and risk prevention programs or referrals to outside programs are available based on the needs of the individual beneficiary • A Community Liaison that recommends resources outside of the CLNM Health Home to meet the needs of the individual beneficiary • Optional Health Home Multidisciplinary Team participants: o Nutritional o Exercise Specialist o Pharmacist o Doctors of Chiropractic o Licensed complementary and alternative medicine practitioners Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Care Coordination

Definition
Care coordination activities are conducted by care coordinators with members, their identified supports, medical and behavioral health providers and community providers. Care is coordinated across care settings to implement the Individualized Service Plan, and to coordinate appropriate linkages, referrals, and follow-up. Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support members' motivation to better understand and actively self-manage his or her health conditions. Care coordinators' activities include, but are not limited to: • Outreach and engagement of CLNM members; • Communication with members, their family, other providers and team members, including face-to-face visits to address health and safety concerns; • Ensuring members and their identified supports have access to medical, behavioral health, pharmacology, age-appropriate resiliency and recovery support services, and natural and community supports; • Ensuring that services are integrated and compatible as identified in the Service Plan; • Coordinating primary, specialty, and transitional health care from ED, hospitals and psychiatric residential treatment facilities; • Making referrals, assisting in scheduling appointments, and conducting follow-up monitoring; • Developing self-management plans with members; • Delivering health education specific to a member's chronic conditions; • Conducting a face-to-face in-home visit within two weeks of a NFLOC determination; • Coordinating with the MCO care coordinator when a member has a NFLOC determination.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
The BHSD Star web based system is available to the Health Home team, the MCOs, and outside providers that are part of a member's integrated care team. Both the assessment and service plan are constantly updated with new information and progress toward achieving outcomes. Critical risks such as suicidality, uncontrolled substance use, and pregnancy are highlighted on the home page for quick reference. A reminder system specific to each care coordinator's activities for the coming week are both automatic based on policy, or entered by the care coordinator based on activities paramount for the member condition. An Emergency Department Information Exchange (EDIE PreManage) system is available to the Health Home, and automatically sends notifications in real-time to the Health Home as a patient presents at the ED to give immediate perspective on the patient. The content of the notification is specific to the ED including ED visit history, and other valuable clinical and social history information. Currently 80% of New Mexico hospitals are engaged with this system, and others are in process. The Health Homes all have 24 hour call lines, and can specify other modes of real time communication.
Scope of service
The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
Behavioral Health Care Coordinator	See Other
CareLink NM Provider Team	- Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. - A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations - A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Health Promotion
Definition
Prevention and health promotion services are aimed at preventing and reducing health risks and providing health promoting lifestyle interventions associated with CLNM-member populations. Prevention and health promotion services address substance use prevention and/or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention and early intervention, STD prevention and early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, obesity reduction and prevention, increasing physical activity, and improving social networks. Health promotion activities assist CLNM members to participate in the implementation of both their treatment and medical services plans, and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion activities include, but are not limited to: - Use of member-level, clinical data to address a member's specific health promotion and self-care needs and goals. Some data is available from the state warehouse and assessment data in BHSDStar; • Development of disease management and self-management plans with members; • Delivery of health education specific to a member's health conditions; • Education of members about the importance of immunizations and screenings for general health conditions; • Development and delivery of health-promoting lifestyle programs and interventions for topics such as substance use prevention and/or reduction, resiliency and recovery, independent living, STD prevention, family planning and pregnancy support, improving social networks, self-regulation, parenting, life skills, and more. • Use of evidence-based, evidence-informed, best emerging and/or promising practices for prevention, health promotion, and disease management programs and interventions; • Use of evidence-based, evidence-informed, best emerging and/or promising practices curricula that integrate physical and behavioral health concepts and meet the needs of the population served; • Providing classes or counseling, which can be in a group or individual setting; - Increasing the use of proactive health promotion and self-management activities; • Tracking success of prevention, health promotion, and disease management programs and interventions, as well as identifying areas of improvement.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Curricula for the predominant co-morbidities within each county will be developed for differing chronic conditions based on comorbidity analysis from historical claims data utilizing the Elixhauser comorbidity analysis of 31 common diagnoses. (See Attachment F for sample). Once the differing curricula have been developed they will be choices in the BHSDStar service tracking module, and each person receiving either individual counseling or group work will have their involvement recorded. This will serve as documentation related to the CLNM Service Plan where the outcome will be documented and available for the entire multidisciplinary team to review.
Scope of service
The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists

Description
See Other

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses

Description
See Other

- ☐ Medical Specialists

Description
See Other

- ☐ Physicians

Description
See Other

- ☐ Physician's Assistants
- ☐ Pharmacists

Description
See Other

- ☐ Social Workers

Description
See Other

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists

Description
See Other

- ☐ Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
Care Link NM Provider Team	- Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. - A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations - A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.
Health Promotion Coordinator	Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing curriculum and curriculum delivery. The Health Promotion Coordinator manages the health promotion and risk prevention services and resources appropriate for the CLNM population. Typical programs included are substance use prevention and cessation, psychotropic medication management, nutritional counseling, healthy weight, diabetes, pulmonary and hypertensive care. Programs are developed based on the prevalent conditions and comorbidities of the regional population. This role also explores and manages relationships with outside providers such as the Department of Health and the MCOs for additional referral opportunities not available in the CLNM Health Home. The individual is part of the multi-disciplinary treatment team and assures required services are available within the CLNM HH or through referral.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)
Definition
CLNM providers are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement within different levels of care, settings, or situations. Comprehensive transitional care is bidirectional, diverting members from levels of care such as ED services, residential treatment centers, and inpatient hospitalization, and transitioning members to outpatient services. Transitional services help to reduce barriers to timely access, inappropriate hospitalizations, time in residential treatment centers, and nursing home admissions. Additionally, these services interrupt patterns of frequent ED use and prevent gaps in services which could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care. Providers of transitional services should be mindful of a member's transition from childhood to adulthood. When developing a Service Plan providers should consider a member's shift from pediatric to adult medical providers, or issues such as independent living arrangements. The provider agency will proactively work with CLNM members reaching the age of majority to ensure appropriate supports and services are in place in the member's plan to assist in the successful transition to adulthood. Comprehensive transitional care activities include, but are not limited to: • Supporting the use of proactive health promotion and self-management; • Participating in all discharge and transitional planning activities; • Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS), Tribal programs and others to continue implementing or modifying the Service Plan as needed; • Implementing appropriate services and supports to reduce use of hospital EDs, domestic violence and other shelters, and residential treatment centers. Services should also support decreased hospital admissions and readmissions, homelessness, and involvement with State agencies such as Juvenile Justice, Protective Services, and Corrections; • Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports; • Sharing critical planning and transition documents with all providers involved with an individual's care via web-based tools, secure email or hard copy; • Facilitating critical transitions from child to adult services, or to long-term services and supports.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
The BHSDStar service tracking has a section for comprehensive transitional care which identifies the type of facility transitioning from and to. It also documents Care Coordinator involvement in the planning. Medication reconciliation during transitions and discharge planning are both reported through BHSDStar. We also track 7 day and 30 day follow up visits through our claims system, and report this as part of our quality reporting. PRISM, a risk management application based on 15 months of rolling claims data affords CLNM providers with insights based on utilization history for both behavioral and physical health, medication history, hospitalizations and ED use. It utilizes state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. The care Coordinators access this system before engaging in transitional care interventions to assist them in the development of strategies they can share with the patient as to future utilization of differing service options.
Scope of service
The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists

Description
See Other

- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses

Description

See Other
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
CareLink NM Provider Team	• A Care Coordinator and Supervisor of the care coordinator as described above. • A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with the CLNM's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources and practitioners. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. • A Physical Health Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.9 NMAC. • A Psychiatric Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO) and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Individual and Family Support (which includes authorized representatives)
Definition
Individual and family support services reduce barriers to CLNM members' care coordination, increase skills and engagement, and improve health outcomes. Services also increase health and medication literacy, enhance one's ability to self-manage care, promote peer and family involvement and support, improve access to education and employment supports, and support recovery and resiliency. Individual and family support activities include, but are not limited to: • Supporting a member and their family in recovery and resiliency goals; • Supporting families in their knowledge of a member's disease and possible side effects of medication; • Enhancing the abilities of members and their support systems to manage care and live safely in the community; • Teaching members and families self-advocacy skills and how to navigate systems; • Providing peer support services; • Assisting members in obtaining and adhering to medication schedules and other prescribed treatments; • Assisting members in accessing self-help activities and services; • Arranging for transportation to medically-necessary services; • Identifying resources for individuals to support them in attaining their highest level of health and functionality within their families and in their community • Assessing impacts of a member's behaviors on families, and assisting in obtaining respite services as needed.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
The following activities are recorded in the BHSDStar service tracking system under "Individual/Family Support" from which reports can be garnered: • Supported the member in recovery & resiliency goals • Supported the family in the members recovery & resiliency goals • Conducted family education on member's chronic condition(s) • Identified community services • Arranged respite services • Arranged family legal representative meetings • Peer support contact • Education on client rights Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.
Scope of service
The service can be provided by the following provider types
- [ ] Behavioral Health Professionals or Specialists

Description
See Other
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses

Description
See Other
- [ ] Medical Specialists

Description
See Other
- [ ] Physicians

Description
See Other
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description
See Other
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
Care Link NM Provider Team	• Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing curriculum and curriculum delivery. The Health Promotion Coordinator managed health promotion services and resources appropriate for a CLNM Member such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight. • Case Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Community Liaison See Other
Referral to Community and Social Support Services
Definition
Referrals to community and social support services help overcome access and service barriers, increase self-management skills, and improve overall health. Providers identify available and effective community-based resources and actively link and manage appropriate referrals. Linkages support the personal needs of members and are consistent with the Service Plan. Community and social support service referral activities may include, but are not limited to: • Identifying and partnering with community-based and telehealth resources such as medical and behavioral health care, durable medical equipment (DME), legal services, housing, respite, educational and employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, personal needs, wellness and health promotion services, specialized support groups, substance use prevention and treatment, and culturally-specific programs such as veterans' or IHS and Tribal programs; • Developing referral and communication protocols as outlined in memorandums of agreement (MOA); • Referrals for partnerships with a MOA shall include acknowledgment of the referral and follow-up with the member by both participating partners. Once a referral is made, the healthcare provider also has access to relevant data on the member, including his or her CLNM assessment and Service Plan, unless the member does not authorize a data exchange. • Making referrals and providing assistance to establish and maintain a member's eligibility for services; • Actively managing appropriate referrals and access to care; • Confirming members' and providers' encounters and following up post-referral.
Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
The BHSDStar service tracking system has a section for "Referral to Community & Social Support Services", The activities within it are: • Evaluate care needs for ancillary support • Legal contact made • Educational contact made • ID and/or arranged housing contact • Utilities paid or contact • Religious contact made • Food contact made • Clothing contact made
Scope of service
The service can be provided by the following provider types
- [ ] Behavioral Health Professionals or Specialists

Description
See Other
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses

Description
See Other
- [ ] Medical Specialists

Description
See Other
- [ ] Physicians

Description
See Other
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider TypeSortable column, activate to sort ascending	DescriptionSortable column, activate to sort ascending
CareLink NM Provider Team	• Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner, or holds a human services bachelor's level or master's level degree and has two years of behavioral health experience, or is a registered nurse with behavioral health experience, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. • A Supervisor of the care coordinators, community liaison, health promotion coordinator, family and peer support workers, and any other clinical staff, who is an independently licensed behavioral health practitioner or behavioral health nurse practitioner or behavioral health clinical nurse specialist as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations. • A Certified Peer Support Worker (CPSW) or Certified Family Peer Support Worker (CFPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professions. The CPSW and/or CFPSW has successfully remediated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery/support process. • A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with the CLNM's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources and practitioners. Only CareLink NM Health Home designated providers will be paid for the Health Home services, all non-health home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Health Homes Services
MEDICAID | Medicaid State Plan | Health Homes | NM2018MS00030 | NM- 18-0002 | MIGRATED_HH.CareLink NM
Package Header

Package ID
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Submission Type
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Superseded SPA ID
NM-15-0014
User-Entered
SPA ID
NM-18-0002
Initial Submission Date
5/10/2018
Effective Date
4/1/2018
Health Homes Patient Flow
Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter
Please see Attachment G for Patient Flowchart.

Name Sortable column, activate to sort ascending	Date Created Sortable column, activate to sort ascending	
Attachment F - Sample County Comorbidity Data	3/21/2018 11:45 AM EDT	pdf
Attachment G - CLNM Patient Flow	3/21/2018 11:46 AM EDT	pdf

Health Homes Monitoring, Quality Measurement and Evaluation
MEDICAID | Medicaid State Plan | Health Homes | NM2018MS00030 | NM-18-0002 | MIGRATED_HH.CareLink NM
Package Header
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Superseded SPA ID
NM-15-0014
User-Entered
SPA ID
NM-18-0002
Initial Submission Date
5/10/2018
Effective Date
4/1/2018
Monitoring
Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates.
The State can identify the people who affirmatively enrolled in a CareLink NM Health Home. For these, we can look at total costs from our MMIS data warehouse for the preceding two years for the same individuals and compare to total costs after enrollment in the HH. We will categorize those costs by (1) those we expect to, in the long run, have savings, such as emergency department visits, inpatient admissions, and residential treatment; and (2) all other outpatient and pharmaceutical costs we expect to initially increase. We will also analyze cost data by contrasting those with fewer than 3 comorbid conditions with those with 3 or more comorbid conditions. A third contrast will examine costs for those with a substance use disorder (SUD) as a comorbidity vs. those without a SUD.
Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)
CareLink NM Health Home providers will be required to use certified Electronic Health Records (EHRs) for the CareLink NM Health Home program. These EHRs must be able to provide state of the art technologies to both office and field based staff. In addition, the designated providers will be required to work within the BHSDStar system designed specifically for the CareLink NM Health Home, and will be required to participate in the State EDIE planning initiatives and work with the HSD as well as the MCOs to provide seamless integration of the systems data.
Health Homes Monitoring, Quality Measurement and Evaluation
MEDICAID | Medicaid State Plan | Health Homes | NM2018MS00030 | NM-18-0002 | MIGRATED_HH.CareLink NM
Package Header
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NM-15-0014
User-Entered
SPA ID
NM-18-0002
Initial Submission Date
5/10/2018
Effective Date
4/1/2018
Quality Measurement and Evaluation

- ☐ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☐ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☐ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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