

# Health Home State Plan Amendment

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:  
Attachment 3.1-H Page Number:

## Submission Summary

### Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

### Supersedes Transmittal Number:

Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

- The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.

### Name of Health Homes Program:

### State Information

State/Territory name:

New Mexico

Medicaid agency:

### Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:

Title:

Telephone number:

Email:

The primary contact for this submission package.

Name:

**Title:**

**Telephone number:**

**Email:**

**The secondary contact for this submission package.**

**Name:**

**Title:**

**Telephone number:**

**Email:**

**The tertiary contact for this submission package.**

**Name:**

**Title:**

**Telephone number:**

**Email:**

**Proposed Effective Date**

(mm/dd/yyyy)

**Executive Summary**

**Summary description including goals and objectives:**

The New Mexico Human Services Department (HSD) is leading the statewide initiative to provide coordinated care through a Health Home for individuals with chronic conditions. Our CareLink NM Health Home service delivery model will enhance integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons with chronic illness across the lifespan. The CareLink NM Health Home model enhances the efforts made through the development and implementation of the Centennial Care program to improve integrated care and enhance member engagement in managing their health. In New Mexico's CareLink NM Health Home Model, licensed Behavioral Health organizations will enhance their structure to provide care coordination, partnership with physical health providers and provide comprehensive record management to serve members already receiving behavioral health services as well as new members who elect to participate.

The CareLink NM Health Home will integrate with and not duplicate services currently offered in Centennial Care that was implemented on January 1, 2014 as an improvement to the New Mexico Medicaid system. The Centennial Care program allows New Mexico to seek a different approach to slowing the cost of growth in the program while avoiding reductions in benefits. Our vision is to educate our recipients to become more savvy health care consumers, promote more integrated care, properly manage the most at-risk members, involve members in their own wellness, and pay providers for outcomes, rather than transactions.

**Federal Budget Impact**

Federal Fiscal Year		Amount
First Year	2016	\$ 1651.00
Second Year	2017	\$ 3524.00

**Federal Statute/Regulation Citation**

Affordable Care Act Section 2703 is the authorizing legislation for Health Homes

**Governor's Office Review**

**No comment.**

**Comments received.**  
Describe:

**No response within 45 days.**

**Other.**  
Describe:

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

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Attachment 3.1-H Page Number:*

**Submission - Public Notice**

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Indicate whether public notice was solicited with respect to this submission.

- Public notice was not required and comment was not solicited**
- Public notice was not required, but comment was solicited**
- Public notice was required, and comment was solicited**

**Indicate how public notice was solicited:**

**Newspaper Announcement**

**Publication in State's administrative record, in accordance with the administrative procedures requirements.**

**Date of Publication:**

(mm/dd/yyyy)

**Email to Electronic Mailing List or Similar Mechanism.**

**Date of Email or other electronic notification:**

(mm/dd/yyyy)

**Description:**

**Website Notice**

Select the type of website:

**Website of the State Medicaid Agency or Responsible Agency**

**Date of Posting:**

(mm/dd/yyyy)

**Website URL:**

**Website for State Regulations**

**Date of Posting:**

(mm/dd/yyyy)

**Website URL:**

**Other**

**Public Hearing or Meeting**

**Other method**

**Indicate the key issues raised during the public notice period:(This information is optional)**

**Access**

**Summarize Comments**

**Summarize Response**

**Quality**

**Summarize Comments**

**Summarize Response**

**Cost**

**Summarize Comments**

**Summarize Response**

**Payment methodology**

**Summarize Comments**

**Summarize Response**

**Eligibility**

**Summarize Comments**

**Summarize Response**

**Benefits**

**Summarize Comments**

**Summarize Response**

**Service Delivery**

**Summarize Comments**

**Summarize Response**

**Other Issue**

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:  
Attachment 3.1-H Page Number:*

**Submission - Tribal Input**

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- One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**
  - This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**
  - The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

**Complete the following information regarding any tribal consultation conducted with respect to this submission:**

**Tribal consultation was conducted in the following manner:**

- Indian Tribes**
- Indian Health Programs**
- Urban Indian Organization**

**Indicate the key issues raised in Indian consultative activities:**

**Access**

**Summarize Comments**

**Summarize Response**

**Quality**

**Summarize Comments**

**Summarize Response**

**Cost**

**Summarize Comments**

**Summarize Response**

**Payment methodology**

**Summarize Comments**

**Summarize Response**

**Eligibility**

**Summarize Comments**

**Summarize Response**

**Benefits**

**Summarize Comments**

**Summarize Response**

**Service delivery**

**Summarize Comments**

**Summarize Response**

**Other Issue**

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

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Attachment 3.1-H Page Number:*



**Submission - SAMHSA Consultation**

- 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.**

<b>Date of Consultation</b>	
Date of consultation: 08/13/2015 (mm/dd/yyyy)	

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

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Attachment 3.1-H Page Number:*

**Health Homes Population Criteria and Enrollment**

**Population Criteria**

The State elects to offer Health Homes services to individuals with:

- Two or more chronic conditions**

Specify the conditions included:

- Mental Health Condition**
- Substance Abuse Disorder**
- Asthma**
- Diabetes**
- Heart Disease**
- BMI over 25**

<b>Other Chronic Conditions</b>	
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- One chronic condition and the risk of developing another**

Specify the conditions included:

- Mental Health Condition**
- Substance Abuse Disorder**
- Asthma**
- Diabetes**
- Heart Disease**
- BMI over 25**

<b>Other Chronic Conditions</b>	
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Specify the criteria for at risk of developing another chronic condition:

**One or more 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 to initially identify core service agency members as well as members who are eligible to receive certain services such as comprehensive community support services (CCSS). The criteria were revised to add additional trauma related criteria to the SED definition, discussed with the Behavioral Health Planning Council's Children and Adolescent Subcommittee (CASC), and approved by the Collaborative. The third revision was designed to update the criteria to coincide with DSM-V. This revised set of criteria are used for a variety of services and grants and have been discussed with and approved by the full Behavioral Health Collaborative.

See Attachment 1 and Attachment 2 for more detailed information

**Geographic Limitations**

**Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

**If no, specify the geographic limitations:**

**By county**

Specify which counties:

This program will be implemented in a phased in approach. For purposes of this SPA, the State is requesting approval for the CareLink NM Health Home in 2 rural counties: San Juan County and Curry County. Following this implementation, and based on lessons learned, the state will consider additional CareLink NM Health Homes in other areas of New Mexico as well as an expansion of qualifying conditions to include Substance Use Disorder (SUD)

**By region**

Specify which regions and the make-up of each region:

**By city/municipality**

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

**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

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

Initial enrollment into the CareLink NM Health Home will be a data driven process. Beneficiaries will be identified as currently receiving services from the state designated CareLink NM Health Home providers. Both managed care and fee for service beneficiaries will be eligible for participation in the CareLink NM Health Home program. HSD, at its discretion, may impose maximum enrollment limits in the designated CareLink NM Health Home based on administrative and staffing capacities.

- These identified beneficiaries already engaged with the CareLink NM Health Home providers will be automatically enrolled in the CareLink NM Health Home with the option to opt out at any time and must affirmatively agree to remain in the CareLink NM Health Home no later than 90 days following the start date of the program.
- For beneficiaries that are not currently receiving services at a CareLink NM Health Home awarded provider, the CareLink NM Health Home will work within the community to engage and enroll those eligible for the services. In addition to this, Centennial Care managed care members could be referred by the MCO when appropriate.
- Please see Attachment III that provides a flow for CareLink NM Health Home enrollment.

**The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

Other

Describe:

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The State 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 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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.
- The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Attachment 3.1-H Page Number:*

## 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

Describe the Provider Qualifications and Standards:

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, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held

Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.

3. Meet the State standards and requirements as a Behavioral Health Organization

4. Employ the following staff:

a. CareLink NM Health Home Director

b. Health Promotion Coordinator

c. Care Managers/Care Coordinator

d. Community Liaison

e. Clinical Supervisor

f. Peer Support Specialists

g. Medical Consultant

h. Psychiatric Consultant

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.

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

The range of ratio of care managers to members could be in the range of 1:50 up to 1:100 depending upon the severity of the case.

**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, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.

3. Meet the State standards and requirements as a Behavioral Health Organization

4. Employ the following staff:

a. CareLink NM Health Home Director

b. Health Promotion Coordinator

c. Care Managers/Care Coordinator

d. Community Liaison

e. Clinical Supervisor

f. Peer Support Specialists

g. Medical Consultant

h. Psychiatric Consultant

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.

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

The range of ratio of care managers to members could be in the range of 1:50 up to 1:100 depending upon the severity of the case.

**Community Health Centers**

**Describe the Provider Qualifications and Standards:**

**Community Mental Health Centers**

**Describe the Provider Qualifications and Standards:**

**Home Health Agencies**

**Describe the Provider Qualifications and Standards:**

**Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

**Case Management Agencies**

**Describe the Provider Qualifications and Standards:**

**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, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
  - a. CareLink NM Health Home Director
  - b. Health Promotion Coordinator
  - c. Care Managers/Care Coordinator
  - d. Community Liaison
  - e. Clinical Supervisor
  - f. Peer Support Specialists
  - g. Medical Consultant
  - h. Psychiatric Consultant
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.

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

The range of ratio of care managers to members could be in the range of 1:50 up to 1:100 depending upon the severity of the case.

**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, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
  - a. CareLink NM Health Home Director
  - b. Health Promotion Coordinator
  - c. Care Managers/Care Coordinator
  - d. Community Liaison
  - e. Clinical Supervisor
  - f. Peer Support Specialists
  - g. Medical Consultant
  - h. Psychiatric Consultant
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.

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

The range of ratio of care managers to members could be in the range of 1:50 up to 1:100 depending upon the severity of the case.

**Other (Specify)**

**Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

**Physicians**

**Describe the Provider Qualifications and Standards:**

**Nurse Care Coordinators**

**Describe the Provider Qualifications and Standards:**

**Nutritionists**

**Describe the Provider Qualifications and Standards:**

**Social Workers**

**Describe the Provider Qualifications and Standards:**

**Behavioral Health Professionals**

**Describe the Provider Qualifications and Standards:**

**Other (Specify)**

**Health Teams**

**Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:**

**Medical Specialists**

**Describe the Provider Qualifications and Standards:**

**Nurses**

**Describe the Provider Qualifications and Standards:**



**Pharmacists**

**Describe the Provider Qualifications and Standards:**

**Nutritionists**

**Describe the Provider Qualifications and Standards:**

**Dieticians**

**Describe the Provider Qualifications and Standards:**

**Social Workers**

**Describe the Provider Qualifications and Standards:**

**Behavioral Health Specialists**

**Describe the Provider Qualifications and Standards:**

**Doctors of Chiropractic**

**Describe the Provider Qualifications and Standards:**

**Licensed Complementary and Alternative Medicine Practitioners**

**Describe the Provider Qualifications and Standards:**

**Physicians' Assistants**

**Describe the Provider Qualifications and Standards:**

### **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 CareLink NM providers will use their experience currently serving the community to address behavioral health needs and integrating physical and social health needs to promote comprehensive and holistic care. They will utilize their PCMH experience and enhanced assessment to meet member needs. The State will support the CareLink NM through initial readiness assessment and support, initial and ongoing training for staff and technical and data driven support from Centennial Care MCOs. These multi-disciplinary teams of behavioral health providers that partner with CareLink NM beneficiaries to develop and implement a CareLink NM Plan designed to meet all of the beneficiary's needs. The team will include multiple collaborating entities with the beneficiary in the center. CareLink NM will serve as the primary source of care. Direct involvement of a Care Coordinator in the discharge process, information sharing between the hospitals or nursing facilities and CareLink NM Health Home providers will be facilitated via web-based tools, census type updates or they may be shared via secure email. CareLink NM will play a lead role in transitional care. Activities include coordinating CareLink NM Plans, reducing hospital admissions, easing the transition to long-term services and supports and interrupting patterns of frequent hospital emergency department use. Providers will collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients' and family members' ability to manage care and live safely in the community, and enhancing the use of proactive health promotion and self-management. CareLink NM will

identify community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports and follow-up post-engagement.

### **Provider Infrastructure**

#### **Describe the infrastructure of provider arrangements for Health Homes Services.**

New Mexico's CareLink NM Health Homes will be multi-disciplinary teams of behavioral health providers that partner with members to develop and implement a comprehensive care plan designed to meet all of their physical, behavioral and social health needs. The health care professionals will consist of multiple entities collaborating with the member at the center and the CareLink NM Health Home will serve as the primary source of care coordination. The CareLink NM Health Home may partner with more than one primary care practice to best meet the needs of the members based on their choice, age, location and primary concerns or needs.

The CareLink NM Health Home will serve as the lead entity and have a memorandum of agreement (MOA) with each partnering primary practice that describes standards and protocols for communication and collaboration 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 is a sufficient number of such MOAs to ensure that there is sufficient primary care for each of the MCOs, including dual eligibles. MOAs will not be needed if the partner is a part of the same organization operating in another location. The State will work with its' provider and MCO stakeholders to further flesh out this process and ensure all needed agreements are in place prior to implementation.

### **Provider Standards**

#### **The State's minimum requirements and expectations for Health Homes providers are as follows:**

Providers must meet the following requirements:

Registered Medicaid Provider in the State of New Mexico.

Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.

Meet the State standards and requirements as a Behavioral Health Organization

Employ the following: a) Health Home Director, b ) Health Promotion Coordinator – Relevant bachelors level degree, experience developing and delivering curriculum c) Care Managers/Care Coordinator – Licensed or Human Services bachelor's level degree and four years of experience or Human services masters' 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 – Licensed professional who has experience with adults and children f) Peer Support Specialists – Certified by the State g) Medical Consultant h) Psychiatric Consultant.

Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA. The CareLink NM Health Home must be approved by New Mexico through the application process.

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. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

Maintain a care coordinator ratio for all members within a range that is approved by the state.

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

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Attachment 3.1-H Page Number:*

**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**

- PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**
- The PCCMs will be a designated provider or part of a team of health care professionals.**

**The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:**

- Fee for Service**
- Alternative Model of Payment (describe in Payment Methodology section)**
- Other**

Description:

- Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

- Risk Based Managed Care**

- The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**
- The current capitation rate will be reduced.**

- The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

In designing and implementing Centennial Care, New Mexico anticipated the development of a Health Homes Program and included relevant language in the CMS approved managed care contracts.

The current CMS approved Centennial Care Contract includes language addressing Health Homes in the following sections: Definitions, 4.4.6.3.3, 4.4.12.2, 4.4.12.5, 4.4.12.16.1, 4.10.2.3, 4.13.2, 4.14.10.3, 4.20.2.6.5, 4.20.2.6.9, 4.21.7.8. Additional requirements may be necessary and will be addressed in the next contract amendment and in required Provider Agreements.

Other

Describe:

**The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

**The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

**The State intends to include the Health Homes payments in the Health Plan capitation rate.**

**Yes**

**The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.

No

Indicate which payment methodology the State will use to pay its plans:

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Other Service Delivery System:

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

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Attachment 3.1-H Page Number:*

### Health Homes Payment Methodologies

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

Fee for Service

**Fee for Service Rates based on:**

**Severity of each individual's chronic conditions**

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

**Capabilities of the team of health care professionals, designated provider, or health team.**

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

**Other: Describe below.**

See the description below.

**Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.**

The total costs associated with the salaries of the staff and administrative costs will be projected and divided by the number of enrollees participating and their annual duration. These inputs will be used to calculate a monthly cost per person or per member per month (PMPM). Since the CareLink NM Health Home is targeted to SMI/SED, including those with a substance abuse diagnosis, the population is distinct and therefore additional levels for severity will not be established for payment purposes. This payment will be utilized to reimburse the CareLink NM Health Home on a monthly basis for care coordination activities regardless of whether the member is enrolled in managed care or FFS. Note that the payment will not include the cost associated with the delivery of any services. In the circumstance that the CareLink NM Health Home provider renders a State Plan approved service the CareLink NM Health Home will submit a claim to the State's MMIS claims system or MCO for the rendered service.

**Per Member, Per Month Rates**

**Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.**

The total costs associated with the salaries of the staff and administrative costs will be projected and divided by the number of enrollees participating and their annual duration. These inputs will be used to calculate a monthly cost per person or per member per month (PMPM). Since the CareLink NM Health Home is targeted to SMI/SED, including those with a substance abuse diagnosis, the population is

distinct and therefore additional levels for severity will not be established for payment purposes. This payment will be utilized to reimburse the CareLink NM Health Home on a monthly basis for care coordination activities regardless of whether the member is enrolled in managed care or FFS. Note that the payment will not include the cost associated with the delivery of any services. In the circumstance that the CareLink NM Health Home provider renders a State Plan approved service the CareLink NM Health Home will submit a claim to the State's MMIS claims system or MCO for the rendered service.

**Incentive payment reimbursement**

**Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**

**PCCM Managed Care (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 PM/PM payments (describe below)**

**Tiered Rates based on:**

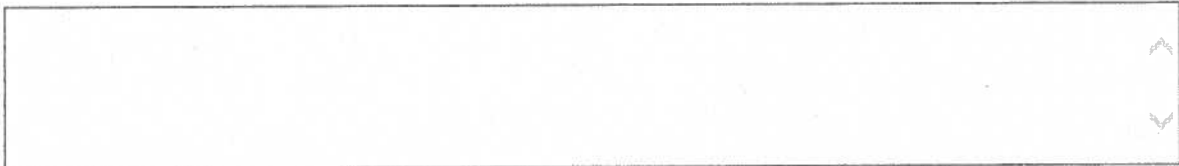
- Severity of each individual's chronic conditions**
- Capabilities of the team of health care professionals, designated provider, or health team.**

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

**Rate only reimbursement**

**Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**





**Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.**

Under managed care, the MCO will make payment on a monthly basis to the CareLink NM Health Home for enrolled members. Although the PMPM developed for the CareLink NM Health Home is done 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 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.

No services of this nature are provided to FFS beneficiaries in New Mexico.

- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**
- The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:  
Attachment 3.1-H Page Number:*

**Submission - 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 eligibility groups**

**Health Homes Services (1 of 2)**

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**Category of Individuals**  
CN individuals

**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 services must include:

- Assessment of preliminary risk conditions and health needs;
- CareLink NM Plan development, which will include client goals, preferences and optimal clinical outcome and identify specific additional health screenings required based on the individual's risk assessment;
- 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 and primary care;
- Through claims-based data sets and patient registries, monitoring of individual and population 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:**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

**Key items include:**

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

**Scope of benefit/service**

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

**Nurse Care Coordinators**

**Description**

**Nurses**

**Description**

**Medical Specialists**

**Description**

**Physicians**

**Description**

**Physicians' Assistants**

**Description**

**Pharmacists**

**Description**

**Social Workers**

**Description**

**Doctors of Chiropractic**

**Description**

**Licensed Complementary and Alternative Medicine Practitioners**

**Description**

**Dieticians**

**Description**

**Nutritionists**

**Description**

**Other (specify):**

**Name**

See Health Homes Providers section

**Description**

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 is the implementation of the individualized, culturally appropriate Comprehensive CareLink NM Plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The CareLink NM Plan is always developed in active partnership with the member and the member's family, as appropriate.

Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support the member's motivation to better understand and actively self-manage his or her health condition. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and client/family members.

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

**Key items include:**

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

**Scope of benefit/service**

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

**Nurse Care Coordinators**

**Description**

**Nurses**

**Description**

**Medical Specialists**

**Description**

**Physicians**

**Description**

**Physicians' Assistants**

**Description**

**Pharmacists**

**Description**

**Social Workers**

**Description**

**Doctors of Chiropractic**

**Description**

**Licensed Complementary and Alternative Medicine Practitioners**

**Description**

**Dieticians**

**Description**

**Nutritionists**

**Description**

**Other (specify):**

**Name**

See Health Homes Providers Section

**Description**

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:**

Health promotion services must include:

- Providing health education specific to an individual’s chronic conditions;
  - Developing self-management care plans with the individual;
  - Educating members about the importance of immunizations, other primary prevention activities, and screening for overall general health;
  - Providing support for improving social networks; and
  - Providing health-promoting lifestyle interventions, including, but not limited to: substance use prevention and/or reduction; resiliency and recovery, independent living, smoking prevention and cessation; nutritional counseling, healthy weight management and increasing physical activity.
- Health promotion services also assist clients to participate in the implementation of both their

treatment and medical services plan and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion reinforces strategies that support the member's motivation to better understand and actively self-manage her or his chronic health condition

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

**Key items include:**

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

**Scope of benefit/service**

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

**Nurse Care Coordinators**

**Description**

**Nurses**

**Description**



**Medical Specialists**

**Description**

**Physicians**

**Description**

**Physicians' Assistants**

**Description**

**Pharmacists**

**Description**

**Social Workers**

**Description**

**Doctors of Chiropractic**

**Description**

**Licensed Complementary and Alternative Medicine Practitioners**

**Description**

**Dieticians**

**Description**

**Nutritionists**

**Description**

**Other (specify):**

**Name**

See Health Homes Providers Section

**Description**

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

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**Health Homes Services (2 of 2)**

**Category of Individuals**  
CN individuals

**Service Definitions**

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

**Comprehensive transitional care from inpatient to other settings, including appropriate follow-up**

**Definition:**

CareLink NM Health Homes are responsible for taking a lead role in transitional care. Activities include: coordinating self-management care plans, reducing hospital admissions, easing the transition to long term services and supports, easing the transition from correctional facilities, and interrupting patterns of frequent hospital emergency department use. Providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients' and family members' ability to manage care and live safely in the community, and enhancing the use of proactive health promotion and self-management.

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

**Key items include:**

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

**Scope of benefit/service**

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

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**Nurse Care Coordinators**

**Description**

**Nurses**

**Description**

**Medical Specialists**

**Description**

**Physicians**

**Description**

**Physicians' Assistants**

**Description**

**Pharmacists**

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**Doctors of Chiropractic**

**Description**

**Licensed Complementary and Alternative Medicine Practitioners**

**Description**

**Dieticians**

**Description**

**Nutritionists**

**Description**

**Other (specify):**

**Name**

See Health Homes Providers Section

**Description**

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 must include, but are not limited to:

- Navigating the health care system to access needed services for individuals and families;
- Assisting with obtaining and adhering to medications and other prescribed treatments;
- Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
- Arranging for transportation to medically necessary services.

A primary focus will be on increasing a member's health and medication literacy, developing a member's ability to self-manage care, promoting family involvement and support, improving access to education, employment supports and supportive housing, and enhancing the individual's effectiveness in revising and updating their own treatment/care plan. Engagement activities should support recovery and resiliency. In the case of children, these individual and family support services are delivered with a wrap-around approach to ensure individual needs are met to ensure maximum wellness and access to health care. New Mexico funds one the Evidenced-Based Practices for treating trauma, Dialectical Behavior Therapy (DBT)

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

**Key items include:**

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

**Scope of benefit/service**

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

**Nurse Care Coordinators**

**Description**

**Nurses**

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**Description**

**Other (specify):**

**Name**

See Health Homes Providers Section

**Description**

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

**Referral to community and social support services, if relevant**

**Definition:**



The CareLink NM Health Home provider will identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement. Common linkages include continuation of healthcare benefits eligibility, disability benefits, housing, legal services, educational supports; employment supports, and other personal needs consistent with recovery goals and the treatment plan. The care provider or care coordinator will make and follow up on referrals to community services, link clients with natural supports and assure that these connections are solid and effective.

New Mexico has a number of active grants and programs that CareLink NM will refer to and coordinate services for such as: "Now is the Time" Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Health Conditions to be known in New Mexico as Healthy Transitions New Mexico (HTNM). HTNM is working to improve access to treatment and support services for youth and young adults ages 16 - 25. The population consists of those that either have, or are at risk of developing a serious mental health condition. The goal is to create safe avenues to improved emotional and behavioral functioning so that youth and young adults can progress into adult roles and responsibilities and lead full and productive lives. A SAMSHA Communities of Care grant that allows us to building local Warp Around teams which assist is coordinated care.

NM funds one the Evidenced-Based Practices for treating trauma, Dialectical Behavior Therapy (DBT), and  
The development and adoptions of a Youth-version of the Certified Peer Support Worker curriculum

**Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.**

Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC analytics and the BHSDStar web based data collection tools will be used to create HIT linkages for this project. These resources will be available to CareLink NM Health Home providers for minimal additional cost to the State in order to support the beneficiary and the CareLink NM Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services. PRISM will provide insights to the CareLink NM providers as it relates to utilization history and the BHSDStar system will be used for current assessment information such as registration, assessment, and CareLink NM Plans.

Key items include:

- o Daily census of emergency room and urgent/planned/pre-certified admission activities identified by the MCO/hospital will be provided to the CareLink NM Health Home;
- o Beneficiary and Care Coordinator prioritized action items;
- o Goals identified as a part of the CareLink NM Plan;
- o Progress information related to identified health action goals and progress on care plan outcomes; and
- o Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment.

The HSD will begin using MMIS data elements already in place for the purpose of CareLink NM Health Home enrollment tracking over time and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

Scope of benefit/service

**The benefit/service can only be provided by certain provider types.**

**Behavioral Health Professionals or Specialists**

**Description**

**Nurse Care Coordinators**

**Description**

**Nurses**

**Description**

**Medical Specialists**

**Description**

**Physicians**

**Description**

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**Doctors of Chiropractic**

**Description**

**Licensed Complementary and Alternative Medicine Practitioners**

**Description**

**Dieticians**

**Description**

**Nutritionists**

**Description**

**Other (specify):**

**Name**

See Health Homes Provider Section

**Description**

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 Patient Flow

**Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:**  
Please see Attachment 4 for beneficiary patient flow.

**Medically Needy eligibility groups**

- All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
- All Medically Needy receive the same services.**
- There is more than one benefit structure for Medically Needy eligibility groups.**

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Attachment 3.1-H Page Number:*

## Health Homes Monitoring, Quality Measurement and Evaluation

### Monitoring

**Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:**

The HSD will use MMIS claims data and the current Technical Specifications for the Core Set of Health Care Quality Measures for Plan All-Cause Readmissions to track participating CareLink NM Health Home member hospital readmissions within 30 days of an inpatient hospital stay. In addition, the State will supplement this information for CareLink NM Health Homes by providing access to monitor member hospitalization through their existing PRISM system.

In addition, MCOs will work with the CareLink NM Health Home designated providers to ensure data and detailed census information regarding upcoming planned admissions and/or outpatient procedures that are precertified by the MCO will be shared across the spectrum of care. These will prove critical in planning for additional supports that beneficiary's may need.

Data source: MMIS data

Frequency: Annual measurement

Specifications:

Participating CareLink NM Health Home members who had an acute inpatient stay during the measurement year that was followed by an unplanned acute readmission for any SMI/ SED diagnosis within 30 days of discharge.

**Denominator:**

The count of an Index Hospital Stay on or between January 1 and December 1 of the measurement year for participating CareLink NM Health Home members.

**Numerator:**

The count of a readmission for a participating CareLink NM Health Home member within 30 days of a discharge from Index Hospital Stay.

**Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.**

The State will identify and flag the people that affirmatively enroll in a CareLink NM Health Home. We would work to evaluate these flagged individuals and look at cost drivers that the CareLink NM Health Home can impact to get to an expected savings calculation for the program.

The HSD will use data collected through the MMIS, MCOs, and the OMNICAID data warehouse to monitor and establish a baseline and data point for use in the measurement of savings as expenditures and investments as a comparison to the baseline, as well as for the ROI for the program.

**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 solution designed specifically for the CareLink NM Health Home, and will be required to participate in the State HIE planning initiatives and work with the HSD as well as the MCOs to provide seamless integration of the systems data.

**Quality Measurement**

- The State provides assurance that it will require 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.**

**States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:**

**Evaluations**

- The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

**Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:**

**Hospital Admissions**

Measure:	
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<p><b>30-day All Cause Readmissions</b></p> <p>Measure Specification, including a description of the numerator and denominator.                  New Mexico Human Services Department (HSD) will use MMIS claims data and the current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual for Plan All-Cause Readmissions to track participating CareLink NM Health Home member hospital readmissions within 30 days of an inpatient hospital stay. In addition, the State will supplement this information with analytics available through their existing PRISM system.</p> <p>The current specifications:                  Participating CareLink NM Health Home members who had an acute inpatient stay during the measurement year that was followed by an unplanned acute readmission for any SMI/ SED diagnosis within 30 days of discharge.</p> <p>Numerator:                  The count of a readmission for a participating CareLink NM Health Home member within 30 days of a discharge from Index Hospital Stay.</p> <p>Denominator:                  The count of an Index Hospital Stay on or between January 1 and December 1 of the measurement year for participating CareLink NM Health Home members.</p> <p>Data Sources:                  MMIS data</p> <p>Frequency of Data Collection:</p> <p> <input type="radio"/> Monthly  <input type="radio"/> Quarterly  <input checked="" type="radio"/> Annually  <input type="radio"/> Continuously  <input type="radio"/> Other                 </p>
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<p><b>Emergency Room Visits</b></p> <p>Measure:                  Emergency Room Visits</p> <p>Measure Specification, including a description of the numerator and denominator.                  The rate of emergency department (ED) visits per 1,000 enrollee months among CareLink NM Health Home enrollees. HSD will use the most current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid CareLink NM Health Home Programs for the Measure AMB-HH: Ambulatory Care-Emergency Department Visits.</p> <p>Numerator:                  The total number of ED visits for participating CareLink NM Health Home members during the measurement year.</p> <p>Denominator:                  The number of participating CareLink NM Health Home members during the measurement year.</p> <p>Data Sources:                  MMIS</p> <p>Frequency of Data Collection:</p> <p> <input type="radio"/> Monthly  <input type="radio"/> Quarterly  <input checked="" type="radio"/> Annually  <input type="radio"/> Continuously                 </p>
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<b>Other</b>	
<input type="text"/>	

**Skilled Nursing Facility Admissions**

<p><b>Measure:</b>                  Skilled Nursing Facility Admissions</p> <p><b>Measure Specification, including a description of the numerator and denominator.</b>                  The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. HSD will use the most current Technical Specifications for the Core Set of Health Care Quality measures for Medicaid CareLink NM Health Home Programs for the Measure NFU-HH: Nursing Facility Utilization.</p> <p><b>Numerator:</b>                  The total number of Skilled Nursing Facility admissions for participating CareLink NM Health Home members during the measurement year.</p> <p><b>Denominator:</b>                  The number of participating CareLink NM Health Home members during the measurement year.</p> <p><b>Data Sources:</b>                  MMIS</p> <p><b>Frequency of Data Collection:</b></p> <p> <input type="radio"/> Monthly  <input type="radio"/> Quarterly  <input checked="" type="radio"/> Annually  <input type="radio"/> Continuously  <input type="radio"/> Other                 </p>	
<input type="text"/>	

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

**Hospital Admission Rates**

Hospital admissions data will be collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under capitated managed care. Member month data will be collected from eligibility files. Baseline analytics supported by OMNICAID and PRISM, MMIS and enrollment data will be used to establish the baseline for these measures at the program onset for annual comparison of programmatic success.

**Chronic Disease Management**

HSD intends to use the OMNICAID data to establish a baseline for the program prior to implementing CareLink NM Health Home, which will include diagnosis/procedure codes, pharmacy and service utilization collected from claims data for those services provided under fee-for-service and encounter data for those services provided under capitated managed care.

**Coordination of Care for Individuals with Chronic Conditions**

Due to the current statewide initiative to provide Care Coordination to all New Mexicans under the Centennial Care program, we have a unique opportunity to measure the same populations in a pre and post implementation manner. Centennial Care – Care Coordination focuses primarily on beneficiary goals and is exclusive to managed care enrollees. The CareLink NM Health Home program will augment the MCO program by providing more intensive community managed “boots on the ground” supports and services for the qualifying SMI/SED beneficiaries.

**Assessment of Program Implementation**

HSD will conduct reviews with all selected CareLink NM Health Homes to establish their readiness. During programmatic go-live, the State will assess the indicators of program implementation from enrollment data, beneficiary engagement, claims/encounter data, client assessment data and interim progress reports from the operating

CareLink NM Health Home. This multidisciplinary team will include staff from the Medical Assistance Division as well as NM's Medicaid Authority and single state agency for mental health and substance use, the Behavioral Health Services Division.

#### Processes and Lessons Learned

HSD is phasing enrollment geographically to ensure ability to evaluate processes and apply lessons learned. New Mexico will establish a Steering Committee that includes stakeholders and state staff to provide oversight of the program. Process and lessons learned are collected through key informant participation and interim progress reports.

#### Assessment of Quality Improvements and Clinical Outcomes

Quality improvement indicators will be collected from enrollment data, claims/encounter data, and client assessment data. As detailed in the quality measures section, New Mexico has identified a list of quality and outcomes measures that apply lessons learned from previous care management pilots that served high cost/high risk individuals. The outcome measures are intended to measure at varying levels and will take into account both quality and cost outcomes.

HSD will use the CORE measures and specifications as provided for in the CareLink NM Health Home Core Set Measurement in the CareLink NM Health Home Technical Specifications and Resource Manual guidance documents. We believe that while additional state specific measures may prove to be helpful in the future, our phased in geographical approach will allow us the time to continue to work with stakeholders while keeping the initial measurement burden at a lesser level due to the focus needed on beneficiary engagement and ensuring operational stability.

The following measures will be required of all CareLink NM Health Home providers:

1. Measure ABA-HH: Adult Body Mass Index (BMI) Assessment
2. Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan
3. Measure PCR-HH: Plan All-Cause Readmission Rate
4. Measure FUH-HH: Follow-Up After Hospitalization for Mental Illness
5. Measure CBP-HH: Controlling High Blood Pressure
6. Measure CTR-HH: Care Transition – Timely Transmission of Transition Record
7. Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
8. Measure PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

#### Estimates of Cost Savings

- The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

The State expects savings for CareLink NM Health Home enrollees through reductions in the use of emergency room visits and inpatient admissions. In addition to reducing, certain activities the CareLink NM Health Home will help enrollees address other health care needs through identification, management and treatment of these conditions resulting in overall better health, reduced health care complications.

*Transmittal Number: NM-15-0014 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:*

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.