Informational Bulletin

August 27, 2015
Re: New Mexico Health Homes Program

Information in this bulletin will provide details about developments in the CareLink NM program and assist you in preparations should you be eligible or interested in becoming a CareLink NM Health Home. As you know Section 2703 of the Affordable Care Act provides an opportunity for States to receive enhanced federal matching funds to implement this community based program for individuals with chronic health conditions. New Mexico has made great strides over the past few years through the delivery of Centennial Care to integrate physical and behavioral health and provide hands-on care coordination to those most in need of an enhanced, higher intensity level of assistance. The CareLink NM Health Homes are a natural next-step.

The Human Services Department (HSD) CareLink NM Health Homes planning group has made significant progress over the past few months having completed the following:

- Conducted extensive outreach to Stakeholders including providers, members, Managed Care Organizations (MCOs), Indian Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), local advocacy groups and subject matter experts;
- Developed a name and logo to clearly identify the program;
- Identified and described the operating requirements for CareLink NM Health Homes including staffing, structure, quality measures, record keeping and payment structure;
- Developed the first draft of the State Plan Amendment (SPA) for submission to the Centers for Medicare and Medicaid Services (CMS); and
- Developed a working draft of an application and readiness pre-assessment for use by entities interested in becoming a CareLink NM Health Home.

HSD completed a formal consultation with the federal government regarding the draft SPA and will submit the Medicaid State Plan Amendment for approval by CMS. HSD is now able to shift the focus to the transition and operations of Phase A of the CareLink NM Health Homes scheduled to go-live January 1, 2016. This process will include:

- Finalizing the provider application and readiness process;
- Initiating regular meetings with interested parties for the purpose of providing technical assistance;
- Identifying potential members to receive services;
- Updating Centennial Care contract language;
- Developing Rules and policy to support program delivery;
- Mapping transition processes; and
- Continuing to develop technology solutions to support data collection and information sharing among providers.

The application and readiness pre assessment tool will be available to all interested providers soon and the State will be utilizing the following timeframes for go-live preparations:

- **September** Application and Pre-Readiness Assessment Tool available
- **September** Finalize Rule and Policy Guidelines
- **October** Initial Health Home Applications Due
  - Begin Training to Applicant Agencies
- **November/December** Schedule readiness assessments for November
  - Notification Letters to members identified as eligible
- **January 1, 2016** First day of Service for CareLink NM Health Home members

The following information is being provided in this letter to assist you in beginning preparations now however, no decisions are final until HSD receives approval from CMS.

**Program Name:**

**Phase A Locations:** Curry County, San Juan County

**Eligible Providers:** CareLink NM Health Homes will be multi-disciplinary teams of behavioral health providers that partner with members to develop and implement a comprehensive plan of care designed to meet all of their physical, behavioral and social health needs. The health care professionals will consist of multiple collaborating entities with the member in the center and CareLink NM Health Home serving as the primary source of care. 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. Each Centennial Care MCO is required to contract with the CareLink NM Health Homes to ensure continuity of care and support MCO members in receiving CareLink NM Health Home services.
Providers who receive a designation as a Phase A CareLink NM Health Home Organization must meet the following Provider Requirements:

- Registered Medicaid Provider in the State of New Mexico.
- Located in Curry County or San Juan County
- Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico
- Meet the standards and requirements as a Behavioral Health Organization as defined in the SPA and in the New Mexico rule.
- Employ the following staff with the requisite qualifications:
  - CareLink NM Health Home Director
  - Health Promotion Coordinator – Relevant bachelors level degree, experience developing and delivering curriculum
  - Care Managers/Care Coordinators – Licensed or Human Services bachelor’s level degree and four years of experience or Human Services Masters level degree and 2 years of experience or as approved through waiver by HSD.
  - Community Liaison – multilingual and experienced with resources in the local community
  - Clinical Supervisor – Independently licensed with experience with adults and children
  - Peer Support Specialists – Certified by the State
  - Medical Consultant
  - Psychiatric Consultant
  - Demonstrate the ability to meet all data collection, quality and reporting requirements

Core services and Definitions:

Comprehensive Care Management
Comprehensive care management services must include:

- Assessment of preliminary risk conditions and health needs;
- Care management plan development, which will include client goals, client preferences that are supported by optimal clinical outcome 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 Care Management 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 used 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.

**Care Coordination and Health Promotion**

Care coordination is individualized, culturally appropriate specified in a Comprehensive Care Management Plan with appropriate linkages, referrals, coordination and follow-up to needed services and supports. The Care Management Plan is developed in active partnership with the member and the member’s family, as appropriate. Care coordination promotes integration and cooperation among service providers across medical and behavioral health needs. It 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 or other reentry processes and communicating with other providers and client/family members.

Health promotion services must include:

- Providing health education specific to an individual’s chronic conditions;
- Developing self-management plans with the individual;
- Educating members about the importance of immunizations 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 attainment and regular physical activity.

Health promotion services also assist clients to participate in the implementation of both their CareLink NM 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.

**Comprehensive Transitional Care**

CareLink NM Health Homes are responsible for taking a lead role in transitional care activities including: coordinating plans of care, reducing hospital admissions, easing the transition to long-term services and supports 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.
**Individual and Family Support Services**

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 and employment supports, and enhancing the individual’s effectiveness in revising and updating their own treatment/care plan. Engagement activities should support recovery and resiliency.

**Referral to Community and Social Support Services**

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 could 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 will make referrals to community services, link clients with natural supports and assure that these connections are solid and effective.

**Use of Health Information Technology to Link Services**

The assessments, care plans, critical planning and transition documents and MCO or Fee for Service (FFS) utilization information will be available via web based tools or they may be shared via secure email or hard copy.

Key items include:

- Daily census of ER and urgent/planned/precertified admission activities identified by the MCO provided to the CareLink NM Health Home;
- Beneficiary and Care Coordinator prioritized action items;
- Goals identified as a part of the care plan;
- Progress information related to identified health action goals and progress on care plan outcomes;
- Data necessary for reporting, programmatic oversight and quality measurement;
- Changes in enrollment in Medicaid, MCO enrollment or CareLink NM Health Home enrollment;
- Risk based information from the Predictive Risk Intelligence System (PRISM): and
- Use BHSDStar web based tools reporting quality and oversight measure and possibly sharing information.
In addition to these Health Information Technology linkages, the HSD will begin using Medicaid Management Information System data elements, some of which are already in place, for the purpose of CareLink NM Health Homes enrollment and plans to move the collected information to its OMNICAID Data Warehouse and its’ BH Warehouse Window for use in its analysis and evaluation.

**Health Promotion Requirements:**

Use consumer-level clinical data to address health promotion programming for an individual’s specific health promotion, self-monitoring and self-care needs and goals (e.g., working with a consumer on his/her individual health promotion goals).

Have systematic strategies to address health promotion for your CareLink NM Health Home population through programs or initiatives (e.g., evidence-based, evidence-informed, best, emerging and/or promising practices related to smoking cessation, nutrition, chronic disease management, etc.).

**Health Information Requirements:**

The assessments, care plans, critical planning and transition documents and MCO or FFS utilization information will be available via web based tools or they may be shared via secure email or hard copy.

We hope that this information is helpful as you prepare to join us in bringing this very important program to Medicaid members. Additional updated and expanded information can be found on the CareLink NM Health Homes website http://www.hsd.state.nm.us/health-homes.aspx CareLink NM Health Home Program comments may be sent to HSD-health.homes@state.nm.us.