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



DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGIONVI

July 3, 2018

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

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

Dear Ms. Smith-Leslie:

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

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

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

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

Sincerely,

Bill Brooks

Associate Regional Administrator

1 Buch

Cc: Jennifer Mondragon

CMS-10434 OMB 0938-1188

Package Information

Package ID NM2018MS0003O

Program Name MIGRATED_HH,CareLink NM

SPA ID NM-18-0002

Version Number 2

Submitted By Megan Pfeffer

Package Disposition



Priority Code P2

Submission Type Official

State NM

Region Dallas, TX

Package Status Approved

Submission Date 5/10/2018

Approval Date 7/3/2018 10:26 AM EDT

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850



Date: 07/03/2018

Head of Agency: Brent Earnest

Title/Dept: Cabinet Secretary, NM Human Services Department

Address 1: PO Box 2348

Address 2: 2025 S. Pacheco Street

City: Santa Fe State: NM Zip: 87504

MACPro Package ID: NM2018MS0003O

SPA ID: NM-18-0002

Subject

Approval of State Plan Amendment 18-0002

Dear Brent Earnest

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

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

NM Health Home SPA 18-0002

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

Increased Geographic Coverage

Yes

♠ No

Yes

Increase in Conditions Covered

No

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

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

Sincerely,

Melissa Harris (on behalf of Alissa DeBoy)

Mrs.

Approval Documentation

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

Package Header

Package ID NM2018MS0003O

Submission Type Official

Approval Date 7/3/2018

Superseded SPA ID N/A

SPA ID NM-18-0002

Initial Submission Date 5/10/2018

Effective Date N/A

State Information

State/Territory Name: New Mexico

Medicaid Agency Name: NM Human Services Department,

Medical Assistance Division

Submission Component

State Plan Amendment

Medicaid

♠ CHIP

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID NM-18-0002

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

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

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

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

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

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount	ATTENDED TATE
First	2018.	\$ 5125194	ANTO CO CARACACTOR
Second	2019	\$ 33287414	A Philliphone

Federal Statute / Regulation Citation

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

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

Package Header

Package ID NM2018M50003O

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Approval Date 7/3/2018

Superseded SPA ID N/A

SPA ID NM-18-0002

Initial Submission Date 5/10/2018

Effective Date N/A

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

Health Homes Intro

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date 4/1/2018

Superseded SPA ID NM-15-0014

User-Entered

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

MIGRATED_HH.CareLink NM

Executive Summary

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

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

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

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

General Assurances

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

Health Homes Geographic Limitations

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

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Initial Submission Date 5/10/2018

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Superseded SPA ID NM-15-0014

User-Entered

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

Phase 2

Title of phase

Implementation Date

Phase 2

4/1/2018

Phase-in will be done by the following geographic area

Specify which counties:

By county

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

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

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

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Health Homes Population and Enrollment Criteria

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date 4/1/2018

Ellective Date 4/1/20

Superseded SPA ID NM-15-0014

User-Entered

Categories of Individuals and Populations Provided Health Homes Services

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

Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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

Package Header

Package ID NM2018MS0003O

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Approval Date 7/3/2018

Superseded SPA ID NM-15-0014

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SPA ID NM-18-0002

Initial Submission Date 5/10/2018

Effective Date 4/1/2018

Population Criteria

The state elects to offer Health Homes services to individuals with

Two or more chronic conditions

One chronic condition and the risk of developing another

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

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

Health Homes Population and Enrollment Criteria

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

Package Header

Package ID NM2018M500030

Submission Type Official

Approval Date 7/3/2018

Superseded SPA ID NM-15-0014

User-Entered

SPA ID NM-18-0002

Initial Submission Date 5/10/2018

Effective Date 4/1/2018

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
- (iii) Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

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

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

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

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

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SPA ID NM-18-0002

Initial Submission Date 5/10/2018

Effective Date 4/1/2018

Types of Health Homes Providers

Designated Providers

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

Physicians

Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:

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

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

The range of ratios of care managers to members is dependent on severity of case, and is as follows:

Lowest level: 1:51-100 Higher level: 1:30-50

High Fidelity Wraparound: 1:8-10

Rural Health Clinics

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:

- 1. Registered Medicaid Provider in the State of New Mexico
- 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06
- 3. Meet the State standards and requirements as a Behavioral Health Organization
- 4. Employ the following staff:
- · CareLink NM Health Home Director
- · Health Promotion Coordinator
- · Care Managers/Care Coordinator (s)
- Community Liaison
- Clinical Supervisor (s)

- Certified Peer Support Workers
- · Certified Family Peer Support Workers
- Medical Consultant
- Psychiatric Consultant
- Other optional staff may include but not be limited to: Pharmacist, Nutritionist, Nurse, Physical Therapist or exercise specialist, traditional practitioners
- Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State.
- Be approved by New Mexico Human Services Department through the application process.
- 7. Have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
- 8. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources.

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

The range of ratios of care managers to members is dependent on severity of case, and is as follows:

Lowest level: 1:51-100 Higher level: 1:30-50

High Fidelity Wraparound: 1:8-10

Community Health Centers

Community Mental Health Centers

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:

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

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

The range of ratios of care managers to members is dependent on severity of case, and is as follows:

Lowest level: 1:51-100 Higher level: 1:30-50

High Fidelity Wraparound: 1:8-10

Home Health Agencies

Case Management Agencies

Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:

- 1. Registered Medicaid Provider in the State of New Mexico
- Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06

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

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

The range of ratios of care managers to members is dependent on severity of case, and is as follows:

Lowest level: 1:51-100 Higher level: 1:30-50

High Fidelity Wraparound: 1:8-10

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:

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

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

The range of ratios of care managers to members is dependent on severity of case, and is as follows:

Lowest level: 1:51-100 Higher level: 1:30-50

High Fidelity Wraparound: 1:8-10

MOTHER (Specify)

Provider Type

Description

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

Health Teams

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

Package Header

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Superseded SPA ID NM-15-0014

User-Entered

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

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Supports for Health Homes Providers

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

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

Description

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

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

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Other Health Homes Provider Standards

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

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

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

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Health Homes Service Delivery Systems

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

Fee for Service

PCCM

Risk Based Managed Care

Other Service Delivery System

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Payment Methodology

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

Fee for Service

Individual Rates Per Service

Per Member, Per Month Rates

Fee for Service Rates based on

Severity of each individual's chronic conditions

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

Other

Describe below

Cost analysis

Comprehensive Methodology Included in the Plan

🔀 Fee for Service Rates based on

Severity of each Individual's chronic

conditions

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

Other

Describe below

Cost analysis

Incentive Payment Reimbursement

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

PCCM (description included in Service Delivery section)

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

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

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Agency Rates

Describe the rates used

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

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Rate Development

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

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

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

> Two of the Health Homes are also implementing a high fidelity children's wraparound pilot within their Health Home in addition to serving the members described above. Separate projections and rates are developed for this population of most vulnerable children who meet the following conditions to be part of this service: Children and youth Ages 4-21 with:

- Diagnosis of Serious Emotional Disturbance (SED); AND
- Multi-system involvement, i.e. two or more systems involvement including Juvenile Justice, Protective Services, Special Education or Behavioral Health; AND
- At risk of or in out-of-home placement OR previous out-of-home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; AND
- o Functional impairment in home, school or community (as measured by the Children and Adolescents Needs and Strengths (CANS) or Child and Adolescent Functional Assessment Scale (CAFAS).

Enrollment Development

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

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

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

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

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

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

Health Home Salaries, Benefits, and Overhead Development

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

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

Health Home Operational Staff

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

Health Home Director

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

Community Liaison

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

Health Promotion Coordinator

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

Consultant - Physical Health Consultant

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

Consultant - Psychiatrist

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

Health Home Care Coordination Staff

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

Care Coordinators

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

Peer and Family Support Staff

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

Supervisors

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

Administrative Costs

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

Projections of PMPM Rates

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

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

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

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

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

The HCPC codes are listed in Attachment E Table 8.

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

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Assurances

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

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

- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described
- Mate of the State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

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Health Homes Services

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Service Definitions

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

Comprehensive Care Management

Definition

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

The CLNM Comprehensive Needs Assessment (CNA)

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

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

The CLNM Service Plan

The Service Plan, provided by HSD, maps a member's path toward self-management of physical and behavioral health conditions, and is specifically designed to help members meet needs and achieve goals. The Service Plan is a document intended to be updated frequently to reflect identified needs, communicate services a member will receive, and serve as a shared plan for the member, their family or representatives, and service providers. The plan is intended to be supplemented by treatment plans developed by practitioners. The Service Plan:

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

Comprehensive care management services must also include:

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

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

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

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

olan, and can gain new insights as case management evolves.	spitalization. The Care Coordinators access this system before the development of th	
cope of service		
The service can be provided by the following provider types		
Behavioral Health Professionals or Specialists	Description	
	See Other	
Nurse Practitioner		
Nurse Care Coordinators	Description	
	See Other	
Nurses	Description	
	See Other	
Medical Specialists	Description	
	See Other	
Physicians	Description	
	See Other	
Physician's Assistants		
Pharmacists		
Social Workers	Description	
	See Other	
Doctors of Chiropractic		
Licensed Complementary and alternative Medicine Practitioners	·	
Dieticians		
Nutritionists		
Other (specify)		
Provider Type	Description	tand intraver tumore

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

Care Coordination

Definition

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

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

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

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

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

Scope of service

The service can be provided by the following provider types
Behavioral Health Professionals or Specialists
Nurse Practitioner
Nurse Care Coordinators

Description

See Other

Provider Type	Description	
Curier (specify)		
Other (specify)		
William Nutritionists		
Dieticians Dieticians		
Elicensed Complementary and alternative Medicine Practitioners		
Doctors of Chiropractic		
Social Workers		
Pharmacists		
Physician's Assistants		
Physicians	•	
Medical Specialists		
Nurses		

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

Health Promotion

Definition

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

See Other

Nurse Practitioner

Nurse Care Coordinators

₩ Nurses Description
See Other

Medical Specialists

Description

See Other

Physicians

Description

See Other

Physician's Assistants

Pharmacists

Description

See Other

Social Workers

Description
See Other

Doctors of Chiropractic

Elicensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Description

See Other

Other (specify)

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

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

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

Definition

CLNM providers are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement within different levels of care, settings, or situations. Comprehensive transitional care is bidirectional, diverting members from levels of care such as ED services, residential treatment centers, and inpatient hospitalization, and transitioning members to outpatient services. Transitional services help to reduce barriers to timely access, inappropriate hospitalizations, time in residential treatment centers, and nursing home admissions. Additionally, these services interrupt patterns of frequent ED use and prevent gaps in services which could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care. Providers of transitional services should be mindful of a member's transition from childhood to adulthood. When developing a Service Plan providers should consider a member's shift from pediatric to adult medical providers, or issues such as independent living arrangements. The provider agency will proactively work with CLNM members reaching the age of majority to ensure appropriate supports and services are in place in the member's plan to assist in the successful transition to adulthood.

Comprehensive transitional care activities include, but are not limited to:

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

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

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

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

Scope of service

The service can be provided by the following provider types	
Behavioral Health Professionals or Specialists	Description
	See Other
Nurse Practitioner	
Nurse Care Coordinators	
Nurses	Description
	See Other
Medical Specialists	
Physicians	
Physician's Assistants	
Pharmacists	
Social Workers	
Doctors of Chiropractic	
Elicensed Complementary and alternative Medicine Practitioners	
iii Dieticians	

Nutritionists

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

Individual and Family Support (which includes authorized representatives)

Definition

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types Behavioral Health Professionals or Specialists Cee Other Nurse Practitioner Nurse Care Coordinators Nurses Pescription See Other Medical Specialists Description See Other

•	Physicians	Description
		See Other
	Physician's Assistants	
	Pharmacists	
	Social Workers	Description
		See Other
	Doctors of Chiropractic	
	Licensed Complementary and alternative Medicine Practitioners	
	Dieticians	
	Mutritionists	
	Other (specify)	

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

Referral to Community and Social Support Services

Definition

Referrals to community and social support services help overcome access and service barriers, increase self-management skills, and improve overall health. Providers identify available and effective community-based resources and actively link and manage appropriate referrals.

Linkages support the personal needs of members and are consistent with the Service Plan. Community and social support service referral activities may include, but are not limited to:

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

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

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

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

- Food contact made
- Clothing contact made

Scope of service

	The service can be	provided by	v the following	provider type:
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Behavioral Health Professionals or Specialists

DescriptionSee Other

Nurse Practitioner

Murse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Description

See Other

Description

See Other

Description

See Other

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

Health Homes Services

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Effective Date 4/1/2018

Superseded SPA ID NM-15-0014

User-Entered

Health Homes Patient Flow

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

Please see Attachment G for Patient Flowchart.

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

Health Homes Monitoring, Quality Measurement and Evaluation

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

Submission Type Official

Initial Submission Date 5/10/2018

Approval Date 7/3/2018

Superseded SPA ID NM-15-0014

Effective Date 4/1/2018

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Monitoring

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

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

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

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

Health Homes Monitoring, Quality Measurement and Evaluation

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

Package Header

Package ID NM2018MS0003O

SPA ID NM-18-0002

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Effective Date 4/1/2018

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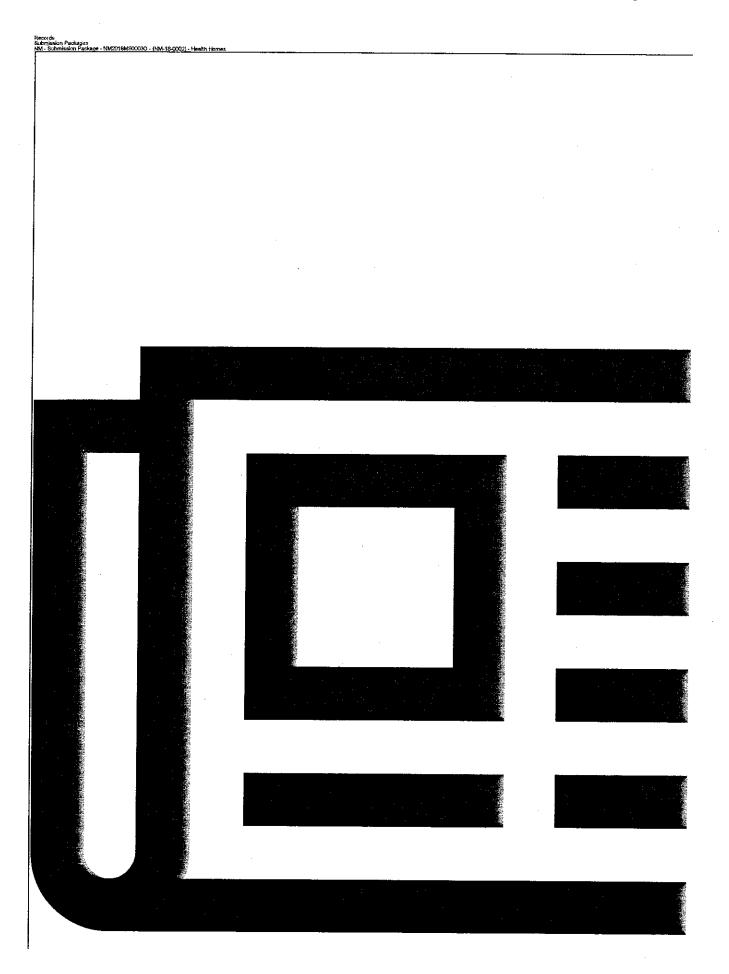
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Quality Measurement and Evaluation

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

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 0938-1188. The time required to complete this information collection is estimated to average 40 hours 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.

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C Yes O No	
HSD is expanding Health Homes in to eight additional counties with seven providers. Within this expansion, HSD will pilot a high 5defity enterpround model with two providers for its most virtual ISS Health Home. Simporely.	runerable children and adolescents. In addition, one of the providers will be the State's first
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an April of 2016 the New Mexico Human Services Department (HSD), with CMS approval, initial Health Homes are designed by individuals with chronic conditions in the categories of serious	ed the CareLink New Mexico Health Home Program (CLNM HH). The first stage of this special library and	statewide program engaged agencies to provide coordinated care in two rural counties. These
Homes in to eight additional counties with seven providers. Within this expension, HSD will pla Health Home service delivery model, called Care Link NM, provides for enhanced care coordin	a high fidelity wraparound model with two providers for our most vulnerable children and tion and integration of primary, acute, behavioral health, long term care services, and so	i adolescents, in addition, one of the providers will be our first Tribul 536 Health Home. The
management, risk prevention, comprehensive transitional care, peer and family supports, and languagement and self-efficacy; 4) improve quality of life for individuals with SMI/SED; and 5) R-	efemal for community and social services and supports. The goals of the program are to fuduce avoidable utilization of emergency department, impatient and residential services, E	 Promote soute and long term health; Prevent risk behaviors; Enhance member and good participations.
Summary Description Including Goels and Objectives In April of 2016 the New Mexico Champa Services Department (HSD), with CMS approval, initial happing like the New Mexico Champa Services Department (HSD), with CMS approval, initial hierarchic Homes are designed for individuals with orbital conditions in the categories of services the Hampard Company of the Compan	Allathrath Almaha an alman theath a theath a physical physical physical physical physical physical physical Al	
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Name of Health Homes Program MGRATED_HH.CareLink NM		
Indicate whether public comment was solicited with respect to this submission. Public notice was not federally required and comment was not solicited.		
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Email to Electronic Mailing List or Similar Mechanism		
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Upload with this application a written summary of public comments received (options)	The state of the s	
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Name of Health Homes Program MIGRATED_HH CareLink NM One or more locion health programs or Urban	: Indian Organizations furnish health care services	in this state			
O _{Yes}	•				
O No This state plan amendment is likely to have a c	direct effect on Indians, Indian health programs of	Urban Indian Ordenizations			
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Complete the following information regardle Solicitation of advice and/or Tribal consulta	n Health Programs end/or Urban Indian Organizat Ing any solicitation of advice and/or tribal con- ation was conducted in the following manner:	ions, as required by section 1902(a)(73) of ti surfation conducted with respect to this s	ne Social Security Act, prior to submission of this ubmission:	SPA	
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States are not required to consult with Indian to	ribal governments, but it such consultation was oc	Anducted voluntarily, provide information abo	ut such consultation below;		
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The state must upload copies of documents innertings were held. Also upload document and describe how the state sucorporated the	s that support the solicitation of advice in acci is with comments received from Indian Health em into the design of its program.	organice with statisticity requirements, incl Programs or Urban indian Organizations	uting any notices tent to indian health Programmed and the state's responses to any issues raise	ams and/or Urban Indian Organizations, as well as attended lists if face-to-face dt. Alternatively indicate the key issues and summarize any comments received bel	
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SAMHSA Consultation Name of Health Homes Program					
MIGRATED_HH.CareLink NM The State provides assurance that if has o	consulted and coordinated with the Substance Abi	me and Mental Health Services Administrati	on (SAMHSA) in addressing issues regarding th	prevention and treatment of mental litness and substance abuse among eligible individua	
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Program Authority 1945 of the Social Security Act The state elects to implement the Health Homes	s state plan option under Section 1945 of the Soc	ial Security Act.	•		
Name of Health Homes Program MIGRATED_HH.CareLink NM					
Executive Summary Provide an executive summary of this Health Ho	omes program including the goals and objectives	of the program, the population, providers, se	rvices and service delivery model used	tal annual to the state of the	
In April of 2010 the New Mexico Human Service Health Homes are designed for individuals with Homes in to eight additional counties with sever	es pepariment (nSD), with CMS approval, rusales chronic conditions in the categories of serious me n providers. Within this expansion, HSD will pilot a	o the Carethik New Mexico health home FT Intal illness for adults (SMI), and severe emo I high fidelity wraparound model with two pro	ogram (CLIVIX IIII). The sist stage of this statew trional disturbance (SED) for children and adoler widers for our most vulnerable children and adol	ice program engaged agences to provide coordinated care in two fural counties. These cents, Based on the positive results in these two counties. HSD is expanding Health Home. The Home is a difficult of the providers will be our first Tribal 636 Health Home. The	
Heatth Home service delivery model, caked Communagement, risk prevention, comprehensive tr	reLink NM, provides for enhanced care coordinations straight to the coordinate rensitional care, peer and family supports, and refer to fill for the indicate set to the straight set of the coordinate with States and Stat	on and integration of primary, acute, behavio erral for community and social services and	ral health, long term care services, and social su supports. The goals of the program are to 1) Pro	ide program angaged agencies to provide coordinated care in two rural counties. These cents, besed on the positive results in these two counties. 1957 is expanding freath the positive of the positive results in these two counties. 1957 is expanding freath poorts. It also includes comprehensive care management, health promotion, disease mole scude and long term health; 27 inversh (six behaviors; 3) Enhance member tall has a number of process and outcome crateria.	
Ganeral Assurances	y of the not thanked data with Own DCD, and O/ Need	oce avoidable datable of energetic) depair	Nive It' II dennes a un resensitival seriannes' Circli A	sel take a trailing of process and conceive careful.	
	individuals will be given a free choice of Health His		Homas agricus		
The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services. The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible inclividuals with utronic conditions who seek or need treatment in a hospital emergency department to					
clessignated Health Homes providers.					
The state provides assurance that FMAP for health Homes services shall be 90% for the first eight facal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate. The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes ervolves will be claimed.					
The state provides assurance that there will be no dublication of services and payment for similar services provided under other Medicaid authorities.					
Health Homes Geographic Limitations					
macrage meacer Package (D NM2018MS00030		NEDYCAID Medicael State Plan Health Homes Nkt20184/S00320 NM-18-0002 MIGRATED_HH, Carel.link NM- Package Nadori Package O			
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\bigcirc Health Homes services will be available sta					
	e following geographic areas				

Title of phase Phase 2
Implementation Date ##/2018 Phase-in will be done by the following geographic mea.
By county Specify which countles: Bernatify Bernatify
De Braca Grant
hirisipo Lea Cusy Roosevelt
Roserveti Sendoval Health Homes services are now available stats-wide
No. The first any additional narretive necessary to fully describe this chase.
The CLMM program is being implemented in a phased approach by county. For papeass of this SPA, the State is requesting approach for the CLMM HIP program is eight additional counties. These counties are a mix of rural, fractier and urban and include: Bernatics, Sendoral, Dusy, De Bass, Rossewell, Lews, Grant and Histology, Of the two counties from the first phase—Curry entrous Health Homes operations, 3, Australian Suspension Plants of implementation or displacement additional counties. We might also look at creating Health Homes with Superactives that only serve, adults and spensions that only serve debition and youth as long as both types are available in each county. (Countility we require that CLNM Health Homes serve both children and adults.) Representative to evalum, authority to serve according to the counting control counting counties control counting.
No. Jens available. No. Sens available. No. Sens available and Conditional Critical No. Sens available and Conditional Critical NESCACAD Medicaid State Plan Haalth Homes NH-2018MS00000 NM-18-0002 MEGRATED_HH.Carathris NM Pachage Haads
Pactogs Hander Package ID NNZO15MSC0030
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NA-15-0014 Exer-Endred
SIPA ID Nobel 1-0-0020 Initial Submission Date
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\$41.2018 Categories of Individuals and Populations Provided Health Homes Services The state will make Health Homes services available to the following categories of Medicaid participants
Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
Medically Needy Eliphiky Groups
Health Hones Population and Enrollment Criteria AEDICALD Medicald State Plan Health Hones NMZ018MS00000 NM-18-0002 MEGRATED_HH.CereLink NM Package Health Plan Health Hones NMZ018MS00000 NM-18-0002 MEGRATED_HH.CereLink NM
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NM-15-0074 Sixe-Entered SPAID
NW-14-00002 hinkial Submission Date
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Postation Citiente The state elects to offer Health Homes services to individuals with
Two or more chronic conditions
Cone of provide condition and the risk of developing another One serious and pensistent mental health condition
Contribution or a serious and necessary marked health morething
The SAH and SED criteria were developed and approved by the Behavioral Health Collaborative, a statutorily created body that includes fifteen cabinet level agencies as well as the Governor's Office, With input from the Behavioral Health Collaborative, as statutorily created body that includes addition, to call the control of the Collaborative and the
Health Homes Population and Englished (Files) American Chief (Files) AMEDICAND Medicaid State Plan Health Homes Introduced Intr
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NM-15-0074 Usel-Entered
SPA ID NM4-9-0002 ritidal Submission Date
8/10/2018 Effective Date (1/2018
Incident of Participants Participation in a Health Homes is voluntary, Indicate the method the state will use to enroll eligible Medicald individuals into a Health Home The property of Participation in a Health Homes is voluntary, Indicate the method the state will use to enroll eligible Medicald individuals into a Health Home
Opt-In to Health Homes provider
Referral and assignment to Health Homes provider with opt-out
Other (describe) Describe the process used
Emotiment from the Guide, in the minimum is voluntary, explore continuous — commands—acro service—are personal trough a data driven process, Benefixianes already receiving outpatient services from the CLNM Hits will be the rigidal group. Phase 1). These identified benefixed will be interviewed at the CLNM Hit to ascertain reteries and to accious their option to opt out after one year's time. Benefixed in small stimmatively agree to remain in the Carefunk NM Heasth Home for her year unless they meet criteria for option to opt out after one year's time. Benefixed in the process, Benefixed in the CLNM Hit to ascertain reteries and to accious the control option to option of the process, Benefixed and The Process and The
dissatisfied with the program and agrees to meet with the agency, the respective MCO or State representative, and others as requested to explain the croumstances related to the request to opt out. Phase I arrothment is projected to test for 6 months. The second group of personal projects in the control of the program and agrees to meet with the agency, the respective MCO or State representative, and others are requested to explain the croumstances related to the request to opt out. Phase I arrothment is projected to test for 6 months. The state will send either to be all the state of
Describe the process used: Fromtiment from the CareLink NM Health Home is voluntary. Eligible beneficiaries – both Managed Care and Fee for Service – are identified through a data driven process. Beneficiaries alwayd prophing outpatient services from the CLNM Hith is assertain interest and to explain their option to opt out after one year unkness. The process used in the CareLink NM health Home for one year unkness they meet criterio to coping outpatients are: I the individual is no longer wheet the collection of coping outpatients are: The individual is no longer wheet the criterio of coping outpatients are: The individual is no longer wheet the criterio of coping outpatients are: The individual is not longer wheet the criterio of the collection of the program and agrees to meet with the agreemy, the respective MOO or State representative, and others are required to explain the critical process (managed on the collection of the coll
nown to the celaims system not to the MCOs. The No CNM agencies have been defined Whaparound will thus reach out to local representatives of linese systems to identify potential beneficiaries. This will begin at startup for these providers so that caseloads can be built. The proposed of Phase 1 and 2 will not be applicable for beneficiaries eligible for Whaparound.
Health Homes Providers MEDICAID Medicaid State Plan Health Homes NMX016MS00000 NM-18-0002 MIGRATED_HH.CereLink NS! Personan Header
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ypes of Health Homes Providers
ndicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards
Li Physicians Li Clinical Practices or Clinical Group Practices
Describe the Provider Clashincations and Standards. And Clashin Mr. Health Internal mast meet the stokewing 1. Fugicitation Mr. Fugicitation
or have an MOA with of least once primary care practice in the area that serves children and one that serves children is not one as a construction of the property of the application process. I. Have the ability to provide primary care practice in the area that serves children and one that serves adults. In the area that serves children is a property of the application process. The provider is required to maintain the following care coordinator ratios for all members of the CereLink NM Health Hottle: The range of ratios of care managers to members a department on severity of case, and is as follows: Lowest level: 1.05-100 Hottle (vet.:
Rural Health Clinics
Describe the Provider Qualifications and Standards and Carellark NM Health Home rivist meet the following: 1. Registered Medicaid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17.05.3, Meet the State of New Mexico as defined in SMAC Supplement 17.05.3, Meet the State of New Mexico as defined in SMAC Supplement 17.05.3, Meet the SMAC Supplement 17.05.3 and
Secretor the Provider Qualiforations and standards such as a final provider of the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17.06.3. Meet the State standards and requirements as a Defavoired Health Community State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as a defined in NMAC Supplement 17.06.3. Meet the State standards and requirements as a Defavoired Health Services (Costs) Community State of New Mexico (Costs) Certification from the
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provider is requir	broyder is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home; The range of ratios of care managers to members is descended on severity of case, and is as follows: I never fewer: 1.51.101 Higher fe				
provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home: The range of ratios of care managers to members is dependent on severity of case, and is as follows: Lowest level: 1.51-100 Higher level: 1.50-50 High Fidelity Minaparound: 1.8-10 [17] [18] [18] [18] [18] [18] [18] [18] [18					
·	Community Health Certers Community Health Certers				
	Community Mental Health Cepters Describe the Provider Qualifications and Standards Each Caractaria M Health Thousand must fine the Community Support Services (ICCSS) Certification from the State of New Mention as defined in NMAC Symptomes 17.05.3 Many than Each Caractaria M Health Thousand must fine the following (I. Registered Medicald Provider in the State of New Mention 2. Have Community Support Services (ICCSS) Certification from the State of New Mention as defined in NMAC Symptomes 17.05.3 Many than 19.05.				
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Waperound; 1:8					
i	perient Agencies				
Community/	Behavioral Health Agencies				
Describe the Pro Each CareUnk N	vider Qualifications and Standards Melbalth Home untut med the following: 1. Registered Medicald Provider in the State of New Menico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Menico as defined in NMAC Supplement 17-063. Meet the				
Morkers • Certifia all data collection	wore (utanications and standards) Mirealth Home must need the following: 1. Registered Medicatid Provider in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06 3. Meet the and requirements as a Dehavioral Health Organization 4. Employ the following staft: - CareLink NM Health Home Director - Health Proposition Coordinator - Care Managers/Geze Coordinator (-) Community Linkson - Clinical Supervisor (5) - Carlified Peer Support def Family Peer Support Workers - Medical Constitation - Psychiatric Constitant - Other Constitant - O				
or have an MOA provider is require	t, Quality and reporting requirements described in this 3-r/s, and curriers as between byte 95 calls on the 20 per section of the project of the application process. 7, have the ability to provide primary care practice in the area that stemes critique and one that serves adults. 8.1 have exhabitished make referred to the primary care practive in the area that serves adults are called the provided primary care practice in the area that serves adults. 8.1 have the make the provided that the discharge that the provided primary care practice in the area that serves adults. 9.1 have the make the provided that the provided primary care practice in the area that the provided primary care to provide primary care practice. 9.1 have the ability to provide primary care services to a server that the provided primary care area to the provided primary care area to the provided primary care area that the provided primary care area to the provided prim				
1 bearing	-TU waitined Health Centers (FOHC)				
State standards a Workers · Certifie	wide dissinctations and standards. Metablishing in the State of New Mexico 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06-3, Meet the and requirements as a Behavioral Health Floring Disport Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06-3, Meet the and requirements as a Behavioral Health Comprehensive (Fig. 1997) for footbase staff may in visible but not be indicated to the standard of the State of Services (Fig. 1997) for Services				
or have an MOA or provider is require	with at least one primary care practice in the area that serves children and one that serves addus. 8. Haive established member reterral protocols with axee hospitates, residential transferrant facilities, specially providers, schools, and other community resources. The ed to markful in the following care coordinator ratios for all members of the Caralink NM Health Home. The range of ratios of care managers to members is dependent on severity of case, and is as follows; Lowest level: 1:51-100 Higher level: 1:30-50 High Fidelity 10.				
Wraparound: 1;8-					
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JHS or Tribal 638 Clinics	Each Care Link NM heads in home must meet the following: 1. Registered Medicaid Provider in the State of New Merica 2. Have Comprehensive Complutery Support Services (CCSS) Certification from the State of New Merica as defined in NMAC Supportment (17-08.3. Meet the State standards and requirements as a Behavioral Health Organization 4. Employ the following staff - Care Link NM health Home Director - Health Promotion Conditioner - Care Management Care Coordinator (s) - Community Liseon - Circled Support Morters - Certified Family Feed Support Workers - Medical Consultant - Project Institute that the limited for Pharmaconic Medical Consultant - Report Morters - Medical Consultant - Report Medical Consultant - Certified Family Feed Support Workers - Medical Consultant - Support Morters - Medical Consultant - Support Morters - Certified Family to meet all disconding order to reduce the Support Workers - Certified Family to meet all disconding order of Certified Family order - Medical Consultant - Certified Family				
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	onders inside State Plan Hraith Homes RM20164500030 NSH-16-0002 MEGRATED_HH. CaraLhix NM				
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34/1/2018 Provider Infraetrus	clure				
She Carel ink NM	structure of provider arrangements for Health Home Services Health Home will serve as the time does not have a memorandum of agreement (NOA) with each partnering primary care practice fadult and chief) and with local hospitals and residential treatment centers. The MOA describes standards and protocols for contributions are contributed to the protocols for contributions and protocols for contributions and protocols for contributions are contributed to the protocols for contributions and protocols for contributions are contributed to the protocols for contrib				
MCO is required to primary care for a	ollaboration, referral, follow up, and other information necessary to effectively deliver services without duplication. An example of this would be a betayloral health entity that would have an MADA with a primary care physician or a podistriction. Each Centervial Care continued with all Carefulns (MM Health Homes to ensure to ensure to ensure continuity of core and support to MCC members in receiving Carefuln (MM Health Homes services assuring of the here are an edequate number of such Centervial Carefuln (MM Health Homes services). This process includes assuring of the here are an edequate number of such MOGe to ensure sufficient and its MCCs. naturity dual eligibit members, MOGE will not be reserved (Int. parting continuity of core and support to MCC members in receiving Carefuln (MM Health Homes services). This process includes assuring of the here are an edequate number of such MOGe to ensure sufficient.				
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SPA ID NM-18-0002					
Initial Submission 5/10/2018	Date				
Effective Date 4/1/2018 Supports for Health	h Homes Providers				
Describe the meth	cols by which his state will support providers of Health Homes services in addressing the following components ven, cost effective, culturally appropriate, and person- and family-centiened Health Homes services whole access to high quality health area services from deep very because of processing the control of the co				
Coordinate and pit	ovide access to preventive and health promotion services, including prevention of mental illness and substance use disorders				
Coordinate and pro logitatric to an adu	ovide access to inential health and substance abuse services on the substance abuse services on the substance abuse services on the substance abuse services at system of health and substance management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as perticipation in discharge planning and facilitating transfer from a strategy of the settings.				
Coordinate and pro Coordinate and pro	ovide access to chronic disease management, including self-management support to Individuals and their familias ovide access to Individual and famility supports, including referral to community, social support, and recovery genices ovide access to Individual and famility supports, including referral to community, social support, and recovery genices				
Develop a person-	centered to see plan for each included to continue and in the seed of the continue and non-chiracial health-case melted needs and services which to see health information to continue according to according to according to the continue according to the				
Establish a continu	sous quasity improvement program, and collect and report on data tract permiss 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				
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ine State's minimu standards and requirums or behaviors	ments and expectations for Health Homes providers are as bolivers. I Registered Medical Provider in the State of New Mexico 2, Heav Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico 3, Meet the State on requirements and expectations for Health Homes delivering purchased. In Providers are supported in the State of New Mexico 2, Health Homes and expectations of the State of New Mexico 1 (Inc.) Expectations are requirements of the State of New Mexico 1 (Inc.) Expectations of the State of New Mexico 1 (Inc.) Expectations of the State of New Mexico 1 (Inc.) Expectations of the State of New Mexico 1 (Inc.) Expectations of the State of New Mexico 1 (Inc.) Expectations of the State of New Mexico 1 (Inc.) Expectations of New Mexico 1 (Inc.) Exp				
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Payments Methodology The State's Health Homes payment methodology will contain the following faatures
☐ Fee for Service
Individual Rates Per Service
Par Member, Per Month Rales
Fee for Service Rates based on
Severity of each individual's chronic conditions
Capabilities of the team of health care professionals, designated provider, or health learn
Coher
Describe betow Cost institys
Comprehensive Methodology Included In the Plan
Fee for Service Rates based on
Severity of each Institutual's other conditions
Capabilities of the team of health care professionals, designated provider, or health team
Cother I and Cothe
Describe below Cool analysis
Conceptive Payment Raimbursement
Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided Described telow.
L. PCCM (description included in Service Delivery section)
and the first transfer at one was never year.
Risk Based Managed Care (description included in Service Delivery section)
Alternative models of payment, other than Fee for Service or PMPM payments (describe below)
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take managing supervisors, care coordinations, and piet and making support winders. The number of employees is dependent on stiffing ratios (menther to staff) and member enrollment. The staffing is based on the excoluent ratios up described above, developed expansibly by anoth Health Home, and begins at the start of Phase 1. Care Coordinations The cancer coordinations artificing ratios are excitations at 1.556 or lower severity, members, with an estimated mit of 55% lower severity and 65% higher severity. These balanciated ratios are based on the experience of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high respond prices, the calculated staffing ratio is 1.9, the median for a suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the product of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the product of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the product of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the first two CLNM Hits and fall within the suggested ratio range of 1.51–100, and 1.30–30. For the high relative to the higher severity members, with an estimated mit of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100. The relative to the first minute of the first two CLNM Hits and fall within the suggested ratio range of 1.51–100. The relative to the first minute of the first minute
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phone, computers, equipment, dams support, internet, training, continuing education, promotions, insurance, office supposes, raviel and other antifect costs that may be required to visit members in their home or health care setting. The freeth home provided their own extinate a for administrative costs for Phases 1 & 2, either as a percent of salaries of Health Home provided their own extinate. Projections of PAIPM Rotes The PAIPM cost modeling as discussed above was completed based on assumptions about enrothment armo-up, past satary and benefits, and administrative overhead as developed by the relatit homes. These costs are developed separately by the
for administrative costs for Phases. 1.8.2, either as a personnel of salesters of health from staff or as estimated data amounts. As the Health from program matures or excelles interested from the Phase of the Pha
ing the care coordinator checks on a daily basis, Management reports are available from this system to Health Home management to tack utilization and complished with HH pokey and expectation. Quality includors that do not require claims data also derive from this system. There are both process and outcome critish categorized by the 5 goals of the program. Based on the tracking of the 5 services through the BHSD Sat system, claims are abunitied to the state's MMIS system, Rules for this submission are: For process and outcome critish and the state of the submission are: For process and outcome critish and the state of the submission are: For process and outcome critish and the state of the submission are: For process and outcome critish and the state of the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and outcome critish and the submission are: For process and the submission are are processed as the submission
anist; - FOHCs that will bill other services utilizing a UE datin form and a revenue code shall bill the CLNN codes on a CNS 1500 claim form using HCPCS codes listed below. FOHC will need to obtain a separate NPI and facility to FO CLNN services. HIS and 658 tribat have below to be used to be the codes of the codes
Sweducial participatura: in provious with said of SEU Receiving services in the Coordinate states above into the Exercit Service of Unit Receivable transported in the Coordinate states above into the Exercit Service of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states above into the Exercit Services of Unit Receivable Services in the Coordinate states are services and the Coordinate states are services and the Coordinate states are services as the Coordinate states are services are services as the Coordinate states are services are services are services as the Coordinate states are services
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Antizons Assumptes
The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are officeed/covered under a different statutory authority, such as 1915(c) waivers or targeted case management. Describe below how non-duplication of payment will be achieved.
Describe below how non-duplication of payment will be achieved. Minder images dare, the MCO will make payment on a morthly basis to the CareLink NM Health Home, it does not the staffing and administrative costs of the CareLink NM Health Home, it cannot capitated care, the MCO will make payment on a morthly basis to the CareLink NM Health Home, it cannot capitated rates paid by the State is the MCO includes care coordination activities as a primary function under the federal administrative under which the Cerebratic Care progress operates. These care coordination activities are similar is stope to the care included the capitated administrative who are assessed as SMM or SED are assigned to the most interestive accordance, to establish the care in the c
that there is no duplication of payment the CareLink NM Health Home PMPIR payment will be eveluated against the care coordination funcing included in the capitaled rates. The State will monitor the payments between the MCO and CareLink NM Health Home through the availables of encounter data submitted by the MCO as well as MCO CareLink NM Health Home reporting.
The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
The State provides assurance that all governmental and private providers are retimbursed according to the same rate schedule, unless otherwise described above. The State provides assurance that it shall retimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).
Optional Supporting Material Uploed NameSortable column, activate to sort ascending Date CleanedSortable column, activate to sort ascending Date CleanedSortable column, activate to sort ascending Date CleanedSortable column, activate to sort ascending
Stachment E - Health Hones Payment Methodologies Tables 1-93/21/2018 11:39 AM EDT
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iurt/2018 Service Delimitions
Provide the state's definitions of the following Health Homes services and the specific activities performed under each service. Commissionsive Care Management Definition
Comprehensive Care Management involves the CLNM Comprehensive Needs Assessment (CNA) and the development of an individualized Service Plan with active participation from the CLNM member, fentily, caregivers and the Health. Home learn. The CLNM Comprehensive Needs Assessment (CNA) The provider appears is responsible for conducting the CNA's obtaining the CNA's obta
is referral; Must document that a provider contacted and/or not with a member to at least begin assessment within the mandated 14-day timetraine; May conduct face-to-face mentings in a member's home. If the member is homeless, the meeting risay be held at a mutually agreed upon location; "Nay enroll a member during the first wint if using the Treat First model. The member would be assigned a "pending" status or assigned care coordination levels until a diagnosis of SMI or SED is finalized and uccepted by the member. The CNA can be the status of the status
Comprehensive Carle Management enrolless the CLIMM comprehensive resources assessment (LVIV) are the interpretation of the climit comprehensive resources assessment (LVIV) are the resource assessment (LVIV) are the resource of the climit comprehensive resources are supported comprehensive resources and an advantage of the resource o
pare provider, specialists, behavioral nears providers, and one percepants of a member's care, retermines occurrence screenings, "accresses projects and providers, end social needs," is organized accounts, included as employed in the percepant of the plan includes as employed should be provided accounts, including self-management. The plan includes as employed should be provided and primary care; includes a backup plan final addresses alumines when regularly-accretioned providers are unavailable, and provides contact information for people and agents elimines indicate information for members receiving home and community-based services where there is a nutring facility level of care [IRICLO].
idelermination. There is no required template; the plan is uploaded as a file into the State's web-trased data collection tool, BHSDStat; * includes a crisis/emergency plan listing steps a member and/or representative will take that differ from the standard emergency protocol in the
givent of an emergency. Those are individualized pints, as bounded into BHSOs are in the interest of an emergency. Those are individualized pints, as bounded into BHSOs are in the interest of an emergency. Those are individualized pints, as bounded into BHSOs are in the interest of an emergency. Those are individualized pints, as bounded in the BHSOs are in the interest of an emergency. The interest of an emergency is a support of the interest of an emergency. The interest of an emergency is a support of the interest of an emergency. The interest of an emergency is a support of the interest of an emergency. The interest of an emergency is a support of the interest of an emergency is a support of the interest of an emergency. The interest of an emergency is a support of the interest of an emergency is a support of the interest of an emergency. The interest of an emergency is a support of the interest of an em
givent of an emergency. Those are inchinistatized plans, uploaded into BHSDSar; is shared with members and their providers; is updated with status and plan changes. Comprehensive care management services must also include: - Assignment of health issuing includes and responsibilities; - Development of unstanter guidelines by health status and services must also include: - Assignment of health issuing of the implementation of the Central NR MP name which bridges treatment and welfaness apport across between the status and service uses to determine of the implementation of the Central NR MP name which bridges treatment and welfaness apport across between the status and service uses to determine of the restment guidelines; and - Development and dissemination of reports that indicate progress toward meeting outcomes for client justification, needed obelvery and codes.
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Fieelth Homes Patient Flow				
	ith Homes system, Submit with the state plan amendment	flow-charts of the typical process a Health	Normes individual Would encounter	
Please see Attachment G for Patient Flowchart.	entra bendemanta i l'artico de la compressa con il confirmation de construcción de la confirmación de la con	Learning of the contraction of t		
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Attachment G - CLNM Patient Flow	9/21/2018 11:46 AM EDT	Σ pdί		
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Monitoring .				
Describe the state's methodology for calculating of	oost saving (and report cost savings annually in Quality Me	rasure Report), include savings that result f	on improved coordination of care and chronic disease management achieved through the Health Homes Program, including data	
sources and measurement specifications, as well	as any savings associated with duel eligibles, and if Medi	care data was available to the state to utiliz	in arriving at its cost-savings estimates	
The State can identify the people who affirmative	ny entrolled in a CareLink NM Health Home, For these, we	can look at total costs from our MMIS data	varehouse for the preceding two years for the same individuals and compare to total costs after enrollment in the HH, We will	
categorize those costs by (1) those we expect to,	in the long run, have savings, such as emergency departs	herr visits, impatient admissions, and reside	ntial treatment; and (2) all other outpatient and pharmaceutical costs we expect to initially increase. We will also analyze cost data with a substance use disorder (SUD) as a comorbidity vs. those without a SUD.	
by contrasting those with lewer than 3 comorbid to	JOHOROUS WITH CHOSE WITH 3 OF THOSE COMOUSIG CONDIDORS, /	A grand contribute will examine costs for mose	with a substance use disorper (SDD) as a comprisinty vs. those without a SDD. oss the core continuum (including the use of wheless patient technology to improve coordination and management of care and	
patient adherence to recommendations made by	Legic Microsoft at Carrainal & Literatus Licentines destaines et in 10 dis	Prove make person's mes conditional and	the core coresiscus (intercest) may use or waterest better sectatority in authore cognitization and management of case and	
Count into this Health Home remaiders will be more	tred to use melitied Electronic Meeth Decorts (EMDs) for	the Carel int NM Health Home program. Ti	ese EHRs must be able to provide state of the ent technologies to both office and field based staff, in addition, the designated	
providers will be required to work within the RHSC	OStar system designed specificaty for the Carel Ink NM H	ealth Home, and will be required to perticip:	te in the State EDIE planning initiatives and work with the HSD as well as the MCOs to provide seamless integration of the	
systems data.	and along and the designer, to an amount that in		and I are noted the benchment a second and the property and the trions of binated sequences are the first	
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Quality Measurement and Evaluation				
The state provides assurance that all Health	Homes providers report to the state on all applicable quali	ty measures as a condition of receiving pay	ment from the state	
The state provides assurance that it will iden	tify measureable goals for its Health Homes model and int	ervention and also identity quality measure	related to each goal to measure its success in achieving the goals	
The state provides assurance that it will repo	rt to CMS information submitted by Health Homes provide	rs to inform evaluations, as well as Reports	to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS	
The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report				
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