Records / Submission Packages - Your State

NM - Submission Package - NM2019MS0009O - (NM-21-0005) - Health Homes

Summary Reviewable Units News Related Actions

CMS-10434 OMB 0938-1188

Package Information

Package ID	NM2019MS0009O	**Submission Type**	Official
Program Name	MIGRATED_HH.CareLink NM	**State**	NM
SPA ID	NM-21-0005	**Region**	Dallas, TX
Version Number	1	**Package Status**	Submitted
Submitted By	Donna Lopez	**Submission Date**	2/15/2021
		Regulatory Clock	90 days remain
		Review Status	Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2019MS0009O
SPA ID NM-21-0005
Submission Type Official
Initial Submission Date 2/15/2021
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A
Reviewable Unit Instructions

State Information

State/Territory Name: New Mexico
Medicaid Agency Name: NM Human Services Department, Medical Assistance Division

Submission Component

(•) State Plan Amendment
(•) Medicaid
( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

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SPA ID and Effective Date

SPA ID NM-21-0005

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	1/1/2021	18-002
Health Homes Population and Enrollment Criteria	1/1/2021	18-002
Health Homes Providers	1/1/2021	18-002
Health Homes Payment Methodologies	1/1/2021	18-002
Health Homes Services	1/1/2021	18-002
Health Homes Monitoring, Quality Measurement and Evaluation	1/1/2021	18-002

Submission - Summary

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Executive Summary

Summary Description Including Goals and Objectives

In April 2016 New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH) to provide coordinated care in two rural New Mexico counties. In April 2018, CMS approved the expansion of Health Home services in eight additional counties, including rural and urban counties and a Native American Pueblo (SPA ID NM-18-0002, approved by CMS on 7/3/2018). Health Homes (HH) are designed to serve individuals with chronic conditions in the categories of serious mental illness for adults (SMI) and severe emotional disturbance (SED) for children and adolescents. The expansion included a high-fidelity wraparound model with two providers for New Mexico's most vulnerable youth. The HH delivery model 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 referrals for community and social services and supports.

HSD would like to add substance use disorder (SUD) as an additional eligibility criterion for HH services. This addition is in keeping with New Mexico's Centennial Care 2.0 1115 Medicaid Demonstration extension application, approved by CMS in December 2018. That demonstration project (11W-00285/6) included the addition of SUD services to allow the state to better address opioid use disorder and other SUD.

As noted in the SUD Implementation Plan proposal for the demonstration waiver, New Mexico has made progress in slowing overdose trends, however New Mexico continues to rank first in the nation for alcohol-related deaths, and third in suicide. Adding SUD eligibility criteria to Health Homes aligns with existing goals of HH and support the State's efforts to:

1. Increase rates of identification, initiation and engagement in treatment for Opioid Use Disorder (OUD) and other SUD;
2. Increase adherence to retention in treatment for OUD and other SUD;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD;
6. Improved care coordination and transitions between levels of care.
7. Increase provision of medically appropriate interventions.

Levels of care for the continuum of services are based on the American Society of Addiction Medicine (ASAM) recommendations.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$1483369
Second	2022	$1978062

Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Name	Date Created

Submission - Summary

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Governor's Office Review

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

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
- [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

MIGRATED_HH.CareLink NM

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[ ]	Health Homes Intro	●	APPROVED
[ ]	Health Homes Geographic Limitations	●	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	●	APPROVED
[ ]	Health Homes Providers	●	APPROVED
[ ]	Health Homes Service Delivery Systems	●	APPROVED
[ ]	Health Homes Payment Methodologies	○	APPROVED
[ ]	Health Homes Services	●	APPROVED

☐	Health Homes Monitoring, Quality Measurement and Evaluation	●	APPROVED

1 – 8 of 8

Submission - Public Notice/Process

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Name of Health Homes Program

MIGRATED_HH.CareLink NM

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
20-0001 Health Homes SUD affidavit Alb Journal	12/3/2020 4:42 PM EST	
20-0001 Health Homes SUD affidavit LCSN	12/3/2020 4:42 PM EST	

Submission - Tribal Input

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Name of Health Homes Program:

MIGRATED_HH.CareLink NM

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

(•) Yes
( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

(•) Yes
( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

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

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
4/14/2020	Website posting and email notification

[ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
4/14/2020	Website posting and email notification

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

[ ] All Indian Tribes

Date of consultation:	Method of consultation:
4/14/2020	Website posting and email notification

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

Name	Date Created	
20-0001 Health Homes SUD TN 20-08	12/3/2020 4:57 PM EST	

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

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SAMHSA Consultation

Name of Health Homes Program

MIGRATED_HH.CareLink NM

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

Date of consultation
2/11/2021

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

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Superseded SPA ID 18-002

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Reviewable Unit Instructions

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 2016 New Mexico Human Services Department (HSD), with CMS approval, initiated the CareLink New Mexico Health Home Program (CLNM HH) to provide coordinated care in two rural New Mexico counties. In April 2018, CMS approved the expansion of Health Home services in eight additional counties, including rural and urban counties and a Native American Pueblo (SPA ID NM-18-0002, approved by CMS on 7/3/2018). Health Homes (HH) are designed to serve individuals with chronic conditions in the categories of serious mental illness for adults (SMI) and severe emotional disturbance (SED) for children and adolescents. The expansion included a high-fidelity wraparound model with two providers for New Mexico's most vulnerable youth. The Health Home delivery model 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 referrals for community and social services and supports.

HSD would like to add substance use disorder (SUD) as an additional eligibility criterion for HH services. This addition is in keeping with New Mexico's Centennial Care 2.0 1115 Medicaid Demonstration extension application, approved by CMS in December 2018. That demonstration project (11W-00285/6) included the addition of SUD services to allow the state to better address opioid use disorder and other SUD.
As noted in the SUD Implementation Plan proposal for the demonstration waiver, New Mexico has made progress in slowing overdose trends, however New Mexico continues to rank first in the nation for alcohol-related deaths, and third in suicide. Adding SUD eligibility criteria to Health Homes aligns with existing goals of HH and support the State's efforts to:

1. Increase rates of identification, initiation and engagement in treatment for OUD and other SUD;
2. Increase adherence to retention in treatment for OUD and other SUD;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD;
6. Improved care coordination and transitions between levels of care.
7. Increase provision of medically appropriate interventions.

Levels of care for the continuum of services are based on the American Society of Addiction Medicine (ASAM) recommendations.

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 Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

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Package ID	NM2019MS0009O	**SPA ID**	NM-21-0005
Submission Type	Official	**Initial Submission Date**	2/15/2021
Approval Date	N/A	**Effective Date**	1/1/2021
Superseded SPA ID	18-002		

User-Entered

Reviewable Unit Instructions

Categories of Individuals and Populations Provided Health Homes Services

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

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

Health Homes Population and Enrollment Criteria

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Population Criteria

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

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

Specify the criteria for a serious and persistent mental health condition:

The existing SMI and SED criteria were developed and approved by the Behavioral Health Collaborative, a statutorily-created body that includes 15 cabinet-level agencies as well as the Governor's office. The addition of OUD and other SUD for eligibility for HH services is in accordance with the "Program Description and Implementation" described in the 1115 continuation waiver. The state is also implementing initiatives to improve existing SUD services. SUD diagnosis criteria for children and adolescents are included in the "Criteria for Severe Emotional Disturbance Determination" approved by the Behavioral Health Collaborative described above and found in Attachment A; SUD criteria align with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, described as follows: a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. The term "SUD-eligible individual" means an individual who satisfies all of the following:

1. Is an eligible individual with chronic conditions;
2. Is an individual with a substance use disorder;
3. Has not previously received HH services under any other State plan amendment approved for New Mexico.

All HH providers have been serving adults and children with SMI, SED, and co-occurring diagnoses.

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

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

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

Describe the process used:

Enrollment in CLNM Health Homes is voluntary. Members must affirmatively agree to opt in to the Health Home program by signing the opt-in form, which is retained in members' records. Members are asked to remain in the HH program for one year unless they meet criteria for opting out sooner.

Potentially eligible beneficiaries, both Managed Care and Fee for Service, are identified by Health Home providers through their own electronic health records and community outreach based on partners, referral networks, and practitioners providing primary and behavioral health care services, as well as SUD screening and treatment services.

Historical claims data are used to identify eligible individuals based on SUD diagnoses and Medicaid eligibility. The State will send letters to all eligible fee-for-service beneficiaries and MCO will send letters to all eligible managed care beneficiaries meeting SUD diagnoses. The letter describes the opportunity to enroll in a CLNM HH and advises beneficiaries to contact the HH in their area or wait for the HH to contact them. In addition, new Centennial Care managed care members will be referred by MCO when deemed eligible.

The exception to this process relates to beneficiaries for High-Fidelity Wraparound. Eligibility for this level of care coordination requires an SED diagnosis as well as other criteria that are not identifiable in claims data nor known to MCO. Since SED diagnosis criteria includes "Substance-Related and Addictive Disorders," individuals enrolled in HH through Wraparound are not specifically addressed in this SPA.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

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

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following criteria. Criteria apply to all HH providers, regardless of provider type:
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 Manager(s)/Care Coordinator(s)
- Community Liaison
- Clinical Supervisor(s)
- Certified Peer Support Workers and/or Certified Family Peer Support Workers
- Medical Consultant
- Psychiatric Consultant
- Other optional staff may include but is not limited to: pharmacist, nutritionist, nurse, physical therapist or exercise specialist, traditional practitioners, licensed alcohol and drug abuse counselors (LADAC) and certified alcohol and drug abuse counselors (CADC);

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. Be able to provide primary care services for adults and children or have a 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;
9. Be able to provide Naloxone for in-agency use;
10. Provide Medication-Assisted Treatment (MAT) or have a MOA with a MAT provider;
11. If providing or referring to MAT, services must be accompanied by a provision for or referral to counseling services and behavioral therapy;
12. Provide Intensive Outpatient services or have a MOA with at least one IOP provider.

The provider is required to maintain the following care coordination ratios for all CLNM HH members. The range of ratios of care coordinators to members is dependent on severity of case, as follows, with a recommended average of 1:61:
Lowest level: 1:51-100
Higher level: 1:30-50

☐ 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
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7. Be able to provide primary care services for adults and children or have a MOA with at least one primary care practice in the area that serves children and one that serves adults;
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9. Be able to provide Naloxone for in-agency use;
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☐ Community Health Centers

☐ Community Mental Health Centers

Describe the Provider Qualifications and Standards

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6. Be approved by New Mexico Human Services Department through the application process;
7. Be able to provide primary care services for adults and children or have a MOA with at least one primary care practice in the area that serves children and one that serves adults;
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☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

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5. Be approved by New Mexico Human Services Department

through the application process;
6. Be able to provide primary care services for adults and children or have a MOA with at least one primary care practice in the area that serves children and one that serves adults;
7. Have established member referral protocols with area hospitals, residential treatment facilities, specialty providers, schools, and other community resources;
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11. Provide Intensive Outpatient services or have a MOA with at least one IOP provider.

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☐ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

Each CareLink NM Health Home must meet the following:
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3. Meet the State standards and requirements as a Behavioral Health Organization;
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5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA, and others as defined by the State;
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with a recommended average of 1:61:
Lowest level: 1:51-100
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☐ Other (Specify)

Provider Type	Description
IHS or Tribal 638 Clinics	Each CareLink NM Health Home must meet the following: 1. Registered Medicaid Provider in the State of New Mexico; 2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC Supplement 17-06; 3. Meet the State standards and requirements as a Behavioral Health Organization; 4. Employ the following staff: • CareLink NM Health Home Director • Health Promotion Coordinator • Care Managers/Care Coordinator(s), including a care coordinator to serve the SUD population • Community Liaison • Clinical Supervisor(s) • Certified Peer Support Workers • Certified Family Peer Support Workers • Medical Consultant • Psychiatric Consultant • Other optional staff may include but is not limited to: pharmacist, nutritionist, nurse, physical therapist or exercise specialist, traditional practitioners, licensed alcohol and drug abuse counselors (LADAC) and certified alcohol and drug abuse counselors (CADC); 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. Be able to provide primary care services for adults and children or have a 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,

Provider Type	Description
	schools, and other community resources; 9. Be able to provide Naloxone for in-agency use; 10. Provide Medication-Assisted Treatment or have a MOA with a MAT provider; 11. If providing or referring to MAT, services must be accompanied by a provision for or referral to counseling services and behavioral therapy; 12. Provide Intensive Outpatient services or have a MOA with at least one IOP provider. The provider is required to maintain the following care coordination ratios for all CLNM HH members. The range of ratios of care coordinators to members is dependent on severity of case, as follows, with a recommended average of 1:61: Lowest level: 1:51-100 Higher level: 1:30-50 Kewa Pueblo Health Corporation, the State's Tribal 638 HH provider, serves only Native Americans, but serves all Tribal members.

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The CareLink NM Health Homes serve as the lead entity and have memoranda of agreement (MOA) with partnering primary care practices (adult and child), local hospitals, residential treatment centers, IOP, and MAT service providers, and other specialty providers. The MOA describe standards and protocols for communication, collaboration, referral, follow-up, and other information necessary to effectively deliver services without duplication. An example is a behavioral health entity that has a MOA with a primary care physician or a MAT provider. Centennial Care MCOs are required to contract with all Health Homes to ensure continuity of care and support to MCO members in receiving Health Home services, including members with dual eligibility. This process includes HH establishing MOA with a variety of providers to ensure a sufficient number of primary care providers are available for each MCO. MOA are not required if the partner providing primary care is part of the same organization operating in the same or another location.

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 project team is comprised of the Director of BHSD, an experienced behavioral health clinician, an information technology professional, a registered nurse who leads the Quality Division of HSD, an experienced behavioral health project manager, a Native American liaison, the Behavioral Health Director from New Mexico's Children, Youth and Families Department's Behavioral Health Dept., and assistance from the University of New Mexico's Department of Psychiatry's psychiatrist. Before Health Home providers began delivering services for the SMI- and SED-target population, the team developed and delivered training programs for a year to ensure providers were prepared to deliver services, including the following:

1. A collective learning platform for shared information exchange on relevant topics with the participation of all CLNM providers and access to extensive resource documents. Programming for the eight in-person day long sessions included:

- 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;
- Developing memorandums of agreement; review of evaluation criteria & quality reporting; and population health management;
- Trauma informed care: historical trauma & adult trauma; trauma in children;
- Collaboration with the Centennial Care MCOs; nursing facility level of care;
- Cost reporting, membership forecasting, and the development of the PMPMs;
- Review of CLNM information technology:

i) BHSD STAR: registration/activation; assessment; service plan; service tracking; referrals; quality reporting;
ii) Prism Risk Management system;
iii) Emergency Department Information Exchange (EDIE);
iv) Billing and start up IT activities;

- Readiness criteria and preparing for the onsite review;
- A training specifically on care coordination is currently in development;
- New trainings are being developed for Health Home providers to address specific needs of SUD-eligible members. Trainings for evidence-based and promising practice programs and services will include (but are not limited to) the following: Naloxone use and overdose prevention to include awareness of polysubstance use, harm reduction, SBIRT, and Seeking Safety. Additional trainings for those agencies who wish to implement Intensive Outpatient services within their agency will be provided.

For providers interested in delivering Medication Assisted Treatment, New Mexico Project ECHO's Behavioral Health and Addiction program is a robust system developed and sponsored by the University of New Mexico to connect community providers with specialists at centers of excellence in real-time collaborative sessions. The ECHO program partners with the State's MCO and delivers trainings covering a wide range of behavioral health issues, include MAT. Providers may also present specific cases to the team's addiction specialists for consultation. Attachment B is an announcement from Project ECHO for a health care provider training on opioid services.

2. A Steering Committee comprised of HSD management, MCO management (including medical directors), CYFD Behavioral Health Department management, a Native American Liaison, and University of New Mexico Psychiatry department to oversee the application, administration, oversight, and policy development of the Health Home program and providers. The Steering Committee offers operational support through members' respective organizations;
3. The Children, Youth and Families Department provides the required training for certified Family Peer Support Workers. The Office of Peer Recovery and Engagement at BHSD provides required training for Certified Peer Support Workers;
4. An Operations Committee composed of CLNM providers, MCO representatives, State Information Technology department, and the CLNM project team to confer on operational and IT issues, and to work within the relevant organizations to resolve issues and improve processes.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes 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 with three years' experience with the Health Home population ; b) Health Promotion Coordinator - Relevant bachelors level degree, experience developing and delivering curriculum; c) Care Coordinator - Licensed as a registered nurse or behavioral health practitioner, or have a Bachelor's or Master's level degree and two years of experience or as approved through waiver by HSD; d) Community Liaison - multilingual 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. Either the consulting MD/PCP or the consulting psychiatrist must have the ability to consult with an addiction specialist or UNM's Project ECHO, which connects community providers with specialists at centers of excellence in real-time collaborative sessions;
5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA;
6. The Health Home must be approved by New Mexico through the Health Home application process;
7. The Health Home must have the ability to provide primary care services for adults and children or have a MOA with at least one primary care practice in the area that serves children and one that serves adults;
8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

Name	Date Created	
Attachment A - SMI Criteria Checklist	11/19/2019 12:18 PM EST	
Attachment B - Project ECHO Opioid Recruitment Flyer	11/19/2019 12:18 PM EST	

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

Package Header

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Payment Methodology

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

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

    Describe below

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

    Describe below

    Cost analysis
  - [ ] Incentive Payment Reimbursement

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

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

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

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

Health Homes Payment Methodologies

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Rate Development

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

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

Comprehensive Description

To support Health Homes, a per member per month (PMPM) care management cost was developed separately for each provider based on modeling estimated enrollment, staff salaries and benefits, and administrative costs providers incurred during the first two enrollment phases. The PMPM included an allowance for a 5% per annum dropout rate. The initial enrollment periods for SMI and SED members have been completed; enrollment for members with SUD will not be a phased enrollment, and PMPM will not be recalculated to include this additional criterion.
The State anticipates that the addition of the SUD criterion, and any additional staff required to serve these members and maintain care ratios, will not raise enrollment beyond the initial projections used to calculate existing PMPM. Thus, PMPM and staffing ramp-up projections will not be recalculated for this additional eligibility criterion.

The following sections address the key elements considered in calculating PMPM costs approved in SPA NM-18-0002:

Enrollment Development
The Health Homes approved by the State and the counties they are serving are shown in Table I of Attachment C - Health Homes Payment Methodologies.

1. Each Health Home was asked to develop projections for two separate enrollment phases by month. Projections for the first phase were based upon the number of SMI/SED members providers were already serving. Projections for the second phase were based on the number of individuals within a county with SMI/SED diagnoses that HH projected they could enroll (based upon claims data) through outreach efforts. Outreach included efforts by Health Home staff, establishing referral networks in the community, and referrals made by MCOs. For the addition of SUD, Health Homes were asked to project the number of clients they serve with SUD diagnoses that are not members of the Health Home program, and the number of clients they anticipate enrolling through referral networks;
2. Additional data used is based on members identified through claims data in each of the existing HH counties. Criteria for claims data follows:
   - Primary diagnosis in the SUD spectrum;
   - Full Medicaid eligibility;
   - Residence in a county served by a Health Home;
   - Not enrolled in a Health Home.

Attachment C, Table 3 shows the enrollment estimates for each Health Home for members with SUD diagnoses.

Health Home Salaries, Benefits and Overhead Development
The PMPM costs for each Health Home were driven by the number of full-time equivalent employees needed to manage the care of the enrolled members, their job classifications, and member enrollment projections. Salary and benefit costs used in projections were developed by each Health Home using publicly available sources for similar job classifications and the Health Home staffing qualifications. This methodology was approved in SPA NM-18-002. As noted above, the State does not anticipate the addition of SUD criterion to affect staffing projections and PMPM already developed.

Health Home Operational Staff

The required operational staff will not be changed for the inclusion of SUD criteria, and includes a Health Home director, community liaison, health promotion coordinator, medical consultant, and psychiatric consultant. The addition of SUD will require that either the medical or psychiatric consultant be an addiction specialist or be able to consult with an addiction specialist, or UNM Project ECHO, which connects community providers with specialists at centers of excellence in real-time collaborative sessions. Following are staff required for Health Homes, with necessary qualifications and job descriptions.

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 Director's responsibilities include overall service oversight, financial performance, and quality management. The Director may have an advanced degree with three years' experience with the Health Home population (members with SMI/SED/SUD diagnoses).

Community Liaison
The community liaison coordinates, organizes and plans programs that promote the Health Home with potential members and with health care and specialty providers, including treatment centers and substance abuse counselors, within the community to foster relationships and build referral networks. They develop memoranda of agreements with other providers, oversee referral relationships, and are a resource to care coordinators. Community liaison staff have developed relationships with agencies and individuals rendering SUD treatment services, such as residential treatment centers, MAT and IOP service providers, and will continue outreach efforts in their communities.

Health Promotion Coordinator
The health promotion coordinator designs and implements health education and disease management programs for the improvement and maintenance of health conditions and prevalent 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 educational materials current. Coordinators can provide education on the use of Naloxone and overdose prevention and harm reduction.

Consultant - Physical Health Consultant
The consulting clinician will be available to the care team on a consulting basis for issues related to member physical health conditions. The physical health consultant must be able to consult with an addiction specialist or a specialist through UNM's Project ECHO.

Consultant – Psychiatrist
The consulting psychiatrist will be available to the care team on a consulting basis for issues related to member mental health or substance use. The Psychiatric Consultant must have the ability to consult with an addiction specialist or UNM's Project ECHO.

Care Coordination Staff
The care coordination staff includes care manager supervisors, care coordinators, and peer and family support workers.

Care Coordinators
Care coordination staffing ratios are calculated using 1:51-100 for lower severity members and 1:30-50 for members with higher severity with a recommended average of 1:61. An average of 65% of current Health Home members have lower severity, and 35% higher severity. Qualifications for care coordinators include: a registered nurse with two years of behavioral health care experience, behavioral health clinicians, or a person holding a bachelor's degree and having two years relevant healthcare experience. Care coordinators develop and oversee a member's comprehensive care management and the planning and coordination of all physical, behavioral, and support services.

Peer and Family Support Staff
Peer and family support staff have lived experience with SMI, SED, and/or SUD or have been a parent, spouse, sibling, or significant other of one who has one or more of these conditions. Peer staff work with members to increase empowerment and hope, increase social functioning, increase community engagement, help members navigate treatment and support systems, help improve quality of life, and decrease self-stigma. They support family members in dealing with member behaviors, navigating systems, and supporting family resilience.

Supervisors
Supervisors provide supervision and serve as a clinical review resource for care coordination staff, community liaisons, health promotion coordinators, and peer support staff. The target ratio of supervisor to staff is 1:8. Supervisors are independently-licensed behavioral health practitioners who have direct service experience in working with adult and child populations.

Administrative Costs
The final component in cost development was an allowance for administrative expenses associated with Health Homes' operations and staffing costs. Administrative expenses include rent, utilities, phone, computers, equipment, claims support, internet services, trainings, continuing education, promotions, insurance, office supplies, travel, and other indirect costs that may be required to visit members in their homes or other health care settings. Health Homes provided estimates as a percentage of salaries of

Health Home staff or as estimated dollar amounts.

Projection of PMPM Rates
PMPM cost modeling was completed based on assumptions about enrollment, staff salary and benefits, and administrative overhead as developed by the Health Homes. Tables for projected costs and PMPM rates for Health Home services were included in SPA NM-18-0002 and rates were approved by CMS. The State does not anticipate the addition of SUD to eligibility criteria to impact the staffing or PMPM rates of Health Homes.

A Health Home provider must deliver at least one of the six core services to a member within a month to bill the PMPM; selecting one of these six services in the BHSDStar service tracking system triggers the payment. Service activities are tracked through the BHSDStar system developed specifically for Health Homes. Each of the six core services has a list of activities that may be rendered for a provider to bill for the service. Management reports are available in the Star system for Health Homes and the State to track utilization and compliance with Health Home policy and expectations. Quality indicators that do not require claims data may also be derived from the system. Process and outcome criteria are categorized by the five goals of the program.

Based on tracking the six core services through the Star system, claims are submitted to the State's MMIS system. Rules for submission are as follows:
1. For reimbursement of the PMPM, the G9001 or G9003 code must be billed with one other service code (HCPCS code);
2. Codes for the six services are billed at $0.01 but will pay $0.00;
3. All service codes are billed with the actual dates of service and accurate time units;
4. FQHC provider types billing other services using a UB claim form and a revenue code bill the CLNM codes on a CMS 1500 claim form using HCPCS codes. FQHC obtained a new NPI and facility ID to bill Health Home services;
5. IHS and Tribal 638 facilities bill other services using the OMB rate and bill CLNM codes on a CMS 1500 claim for using HCPCS codes.

Health Home services are available to the following categories of Medicaid participants: individuals with SMI, SED, or SUD receiving services in the counties listed in Attachment C - Tables in this SPA who are fee-for service or managed care Medicaid beneficiaries.

Health Homes Payment Methodologies

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Assurances

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

Describe below how non-duplication of payment will be achieved Under managed care, MCO make monthly payments to Health Homes for enrolled members. Although the PMPM was developed based on staffing and administrative costs of the Health Home, current capitated rates paid by the State to MCOs include care coordination or case management activities as the primary function under the federal authority under which Centennial Care operates. Health Home care coordination activities are similar in scope to Centennial Care coordination activities factored into the current MCO capitated rate. Currently under managed care, members assessed with SUD, SMI or SED diagnoses are assigned to the most intensive levels of care coordination. To ensure there is no duplication of payment, Health Home PMPM payment is evaluated against care coordination funding included in the capitated rated. The State monitors payments between the MCO and the Health Homes by evaluating encounter data submitted by MCO as well as MCO Health Home reporting.

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

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

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

Optional Supporting Material Upload

Name	Date Created	
Attachment C - Tables	11/19/2019 6:31 PM EST	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

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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 comprises the CLNM comprehensive needs assessment (CNA) and the development of an individualized service plan with active participation from the Health Home member, family, caregivers and the Health Home team, and providing care coordination for members' physical and behavioral health, long-term care, and social needs.

The Health Home Comprehensive Needs Assessment
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:
1. Provides all the required data elements specified in the HSD authorized CNA;
2. Assesses preliminary risk conditions and health needs, including alcohol and drug abuse and opioid use;
3. Uses data from the risk management system to help determine care coordination levels;
4. Requires outreach to potential CLNM members within 14 calendar days of receipt of a referral;
5. Must document that a provider contacted and/or met with a member to at least begin assessment within the mandated 14-day timeframe;
6. 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;
7. Need not be completed during the first visit if using the Treat First model. The member may be enrolled in Health Homes and assigned care coordination level eight (pending CNA completion) until a diagnosis of SUD, SMI or SED is determined and accepted by the member. The CNA may be completed over the course of four appointments; when completed, the care coordination level is updated.

The Health Home Service Plan
The service plan 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 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 representative, and service providers. The plan is intended to be supplemented by treatment plans developed by practitioners. The service plan:
1. Requires active participation from members, family, caregivers, and team members;
2. Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, MAT and IOP providers, and other participants involved in a member's care;
3. Identifies additional recommended health screenings;
4. Addresses long-term and physical, behavioral, and social health needs;
5. 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;
6. Specifies treatment and wellness supports that bridge behavioral health and primary care;
7. Includes a backup plan that addresses situations that may arise if a member's providers are unavailable, and provides contact information for people and agencies where the member may seek support. 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;
8. 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;
9. Is shared with members and their providers;
10. Is updated with status and plan changes.

Comprehensive care management services must also include:
1. Assignment of Health Home team roles and responsibilities;
2. Development of treatment guidelines for teams to follow across risk levels or health conditions;
3. Oversight of the implementation of the Health Home service plan which bridges treatment and wellness support across behavioral health, primary care and social health supports;
4. Monitoring of individual health status and service use to determine adherence to or variance from treatment guidelines;
5. 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

BHSDStar web-based data collection tools are used for this project. Registration and activation modules to support care management include the level of care deemed most appropriate for the member. The CNA requires screenings for alcohol abuse and asks members about alcohol and opioid use, general drug use and substance abuse treatments, as well as clinical risk assessments and comprehensive history and information gathering over the course of four appointments. The Star system includes a service plan which is developed with members, inclusive of short- and long-term goals, service requirements, and expected outcomes. Systems were developed to be used on touch screen laptops or tablets for in-home or community use. BHSDStar helps Health Home providers support members, and Care Coordinators identify unmet needs, gaps in care, required clinical protocols, case management, medical and behavioral health services, and social determinants of health.

Through a contract with HSD, CLNM providers have access to analytics from the Predictive Risk Intelligence System (PRISM) owned by Spectrum Informatics, LLC. PRISM data provide insights to CLNM providers related to utilization history for behavioral and physical health services, medication history, hospitalizations and ED use. The system utilizes state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. Care Coordinators access this system while determining a member's care coordination level and developing a service plan and can gain new insights as case management evolves.

HSD has contracted with PreManage Emergency Department Information Exchange (EDIE), and Health Homes receive notifications from participating hospitals when a member has been admitted on an in- or outpatient basis. Care coordinators may be contacted by email, text, or telephone when a member has been admitted to a hospital for services and are able to reach out to members for needed services, including updates to service plans. Approximately 90% of New Mexico hospitals participate in the EDIE program.

Health Homes utilize telehealth services to help support members, and University of New Mexico's Project ECHO to attend training sessions hosted by medical and behavioral health professionals. Seminars support continuing education for all professional levels of providers. In addition to regularly hosted seminars, Project ECHO connects community providers with specialists at centers of excellence in real-time collaborative sessions where providers may consult on specific cases.

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Health Home Provider Team	1. Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner or holds a human services bachelor's 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

Provider Type	Description
	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; 2. 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; 3. A Certified Peer Support Worker (CPSW) or Family Peer Support Worker (FPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professionals. CPSW have successfully navigated their personal behavioral health experiences and are willing to support peers in their recovery process; 4. A Certified Family Support Worker (CFSW) who holds a certification from the New Mexico Credentialing Board for Behavioral Health Professionals as a CFSW. CFSW have successfully navigated their personal behavioral health experiences and are willing to support peers in their recovery process; 5. A Health Promotion Coordinator who assures that disease management and risk prevention programs or referrals to outside programs are available based on specific needs of members; 6. A Community Liaison who builds a network of community resources and makes recommendation for resources outside of the Health Home to meet the needs of individual members; 7. Optional Health Home multidisciplinary team participants: • Nutritionist • Medication assisted treatment providers • Intensive outpatient providers • Exercise Specialist • Pharmacist • Doctors of Chiropractic • Licensed complementary and alternative medicine practitioners. Only Health Home-designated providers are paid for 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 individualized service plans 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' efforts to better understand and actively self-manage his or her health conditions. Care coordinators' activities include, but are not limited to:

1. Outreach and engagement of Health Home members;
2. Communication with members, their family or representative, other providers and team members, including face-to-face visits to address health and safety concerns;
3. 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;
4. Ensuring that services are integrated and compatible as identified in the service plan;
5. Coordinating primary, specialty, and transitional health care from nursing homes, ED, hospitals and residential treatment facilities;
6. Making referrals, assisting in scheduling appointments, and conducting follow-up monitoring;
7. Developing self-management care plans with members;
8. Delivering health education plans tailored to a member's specific conditions;
9. Conducting a face-to-face in-home visit within two weeks of a NFLOC determination;
10. Coordinating with a 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 90% of New Mexico

hospitals are engaged with this system, and others are in process. The Health Homes all have 24 hour call lines, and can specify other modes of real time communication.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

See Other

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

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

Health Promotion

Definition

Prevention and health promotion services are intended to prevent and reduce health risks and provide interventions to promote healthy lifestyles. Examples of prevention and health promotion services include supports for: substance use prevention and/or reduction, harm

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, and improving social networks.
Health promotion activities assist Health Home 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 deliver specific health promotion activities to support self-care needs and goals. Some data are available from New Mexico's data warehouse, from provider's electronic health records, and from 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, family planning and pregnancy support, parenting, and life skills.
- 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, either 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 comorbidities within each county have been developed for chronic conditions prevalent within counties. The most prevalent conditions have been identified using the Elixhauser comorbidity analysis of 31 common diagnoses. (See Attachment D for a sample). Online curricula are available through a MCO for the most prevalent chronic conditions that Health Home may use with members or for members to access directly. BHSDStar service tracking is used to track all counseling and health promotions activities provided to members. Each Health Home provider is able to determine which staff members may access member records in BHSDStar, enabling designated team members to follow-up on members' health status, needs, and services.

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description

Provider Type	Description
Health Home Provider Team	1. Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing and delivering curricula. The Health Promotion Coordinator manages health promotion and risk prevention services and resources appropriate for the Health Home population. Typical programs include substance use prevention and cessation, psychotropic medication management, nutritional counseling and weight management, and diabetes care. This role also explores and manages relationships with outside providers such as the New Mexico Department of Health and MCO for additional referral opportunities not available in the Health Home. The Health Promotion Coordinator is part of the multi-disciplinary treatment team and ensures required services are available within the Health Home or through referral; 2. 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 member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services; 3. 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 as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations; 4. A Certified Peer Support Worker (CPSW) or Family Peer Support Worker (FPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professionals. CPSW and FPSW have successfully navigated their personal behavioral health experiences and are willing to support peers in their recovery process. Only Health Home-designated providers are paid for Health Home services; all non-Health Home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

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

Definition

Health Home staff 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, intended to help members shift from levels of care such as ED services, residential treatment centers, and inpatient hospitalization to outpatient services. Transitional services help reduce barriers to timely access, inappropriate hospitalizations, and time in residential treatment centers (RTC). Health Home staff work with staff in RTC to ensure discharge plans are in place and members continue to adhere to treatment goals and receive appropriate recovery supports. Transitional services help to 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 to ensure service plans incorporate a member's shift from pediatric to adult providers, and address issues such as independent living arrangements. Health Homes proactively work with 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 to ensure members have appropriate medications and adhere to medication schedules;
- Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS), Tribal programs, RTC staff, MAT providers, and others to continue implementing or modifying the service plan as needed;
- Implementing appropriate services and supports to reduce use of hospital ED, domestic violence and other shelters, and residential treatment centers. Services should also support decreased hospital admissions and readmissions, 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 indicated 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 providers, 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

BHSDStar service tracking includes a section for comprehensive transitional care which identifies the type of facility to or from which a member transitions. It also documents Care Coordinator involvement in the planning. Medication reconciliation during transitions and discharge planning are both reported through BHSDStar. Star also tracks seven- and 30- day follow-up visits through the State's claims system, and these data are included in quality reporting.
Each Health Home provider can determine which staff members may access member records in BHSDStar, enabling all designated team members to follow-up on members' health status, needs, and services.
PRISM, a risk management application based on 15 months of rolling claims data affords Health Home providers data on utilization history for behavioral and physical health, prescriptions, ED use and hospitalizations.
Health Homes subscribe to the EDIE (PreManage) system and receive real-time notifications for members being admitted to the hospital. Notifications include hospital visit history and other valuable clinical information. Approximately 90% of New Mexico hospitals are engaged with this system, thus serving most New Mexico providers.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

See Other

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses

Description

See Other

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

Provider Type	Description
Health Home Provider Team	1. Care Coordinator who is a Regulation and Licensing Department (RLD) licensed behavioral health practitioner or holds a human services bachelor's- 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 Health Home member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services; 2. Community liaison who is bilingual and speaks a language used by most non-English speaking members, and who is experienced with the resources in the member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers and works with care coordinators to connect members to needed community services, resources and practitioners; 3. A Certified Peer Support Worker (CPSW) or Family Peer Support Worker (FPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professionals; 4. Physical Health Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO) as described in 8.310.3 NMAC; 5. A Psychiatric Consultant who is a physician licensed to practice

Provider Type	Description
	medicine (MD) or osteopathy (DO) and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC; and 6. A clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by the New Mexico board of nursing and certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as his or her certification permits as described in 8.321.2 NMAC. Only Health Home-designated providers are paid for 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 Health Home 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 and treatments;
- 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 to support individuals in attaining their highest level of health and functionality within their families and communities;
- 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 included in BHSDStar service tracking system under "Individual/Family Support" from which reporting measures can be collected:

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

Each Health Home provider can determine which staff members may access member records in BHSDStar, enabling all designated team members to follow-up on members' health status, needs, and services.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

See Other

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

Description

See Other

☐ Medical Specialists

Description

See Other

☐ Physicians

Description

See Other

☐ Physician's Assistants

☐ Pharmacists

- [ ] Social Workers

Description

See Other

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

Provider Type	Description
Health Home Provider Team	• Health Promotion Coordinator with a bachelor's level degree in a human or health services field and experience in developing curriculum and curriculum delivery. The Health Promotion Coordinator manages health promotion services and resources appropriate for a Health Home member such as interventions related to substance use prevention and cessation, nutritional counseling, and parenting classes; • 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 Health Home member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services; • 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 as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations; • Certified Peer Support Worker (CPSW) or Family Peer Support Worker (FPSW) who holds certification from the New Mexico Credentialing Board for Behavioral Health Professionals. CPSW and FPSW have successfully navigated his or her personal behavioral health experiences and is willing to support peers in the recovery process; • Community liaison who is bilingual and speaks a language used by most non-English speaking members, and who is experienced with resources in the member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers and works with care coordinators to connect members to needed community services, resources and practitioners. Only Health Home-designated providers are paid for Health Home services; all non-Health Home services will continue to be paid to participating Medicaid providers in accordance with the Medicaid State Plan.

Referral to Community and Social Support Services

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 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, educational and employment supports, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, wellness and health promotion services, specialized support groups, substance use prevention and treatment, and culturally-specific programs such as veterans' or IHS and Tribal services;
• Developing referral and communication protocols as outlined in MOA;
• Making referrals and assisting members to establish and maintain eligibility for services;
• Confirming members' and providers' encounters and post-referral follow-up.

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 includes a section entitled "Referral to Community & Social Support Services" from which reporting measures can be collected. The activities within this section are:

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

Each Health Home provider can determine which staff members may access member records in BHSDStar, enabling all designated team members to follow-up on members' health status, needs, and services.
Health Homes use telehealth services to link members to service providers not available within the member's community.

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Health Home Provider Team members	• 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 Health Home 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 as described in 8.321.2 NMAC. The Supervisor must have direct experience in working with both adult and child populations; • Certified Peer Support Worker (CPSW) or Family Peer Support Worker (FPSW) who holds certification from the New Mexico

Provider Type	Description
	Credentialing Board for Behavioral Health Professionals; • A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-English speaking Health Home members, and who is experienced with the resources in the member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with the Health Home care coordinator to connect and integrate the Health Home member to needed community services, resources and practitioners. Only Health Home-designated providers are paid for 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 | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

Package Header

Package ID NM2019MS0009O
SPA ID NM-21-0005
Submission Type Official
Initial Submission Date 2/15/2021
Approval Date N/A
Effective Date 1/1/2021
Superseded SPA ID 18-002
User-Entered
Reviewable Unit Instructions

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

Comorbidity data and the patient flow system are unchanged from the submission and approval of SPA NM-18-0002. The patient flow diagram is attached. Please see Attachment E for Patient Flowchart.

Name	Date Created	
Attachment D - Sample County Comorbidity Data	11/19/2019 12:23 PM EST	
Attachment E - CLNM Patient Flow	11/19/2019 12:23 PM EST	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

Package Header

Package ID	NM2019MS0009O	**SPA ID**	NM-21-0005
Submission Type	Official	**Initial Submission Date**	2/15/2021
Approval Date	N/A	**Effective Date**	1/1/2021
Superseded SPA ID	18-002		
	User-Entered		
Reviewable Unit Instructions			

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 identifies people who affirmatively enroll in a Health Home. For these individuals, we are examining total claims costs from our MMIS data warehouse for the two years preceding Health Home enrollment and comparing them to total costs after enrollment in Health Home. We are categorizing those costs by (1) those for which we ultimately expect to realize 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 three comorbid conditions with those with three or more comorbid conditions. A third contrast will examine costs for those with a substance use disorder compared to those without a SUD diagnosis.

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)

1. CLNM Health Home providers are using certified Electronic Health Records (EHR) for the Health Home program. These systems provide the most current technology to both office and field staff;
2. Designated providers are required to work within the BHSDStar system designed specifically for collecting data for Health Homes members.
3. Health Home providers use the EDIE system to receive notifications when members are admitted to hospitals;
4. Health Home providers use the PRISM risk management system to help inform member's health, medication, and hospital usage history and diagnoses;
5. Providers, particularly those in rural areas, use telehealth services.
6. Providers may access University of New Mexico's Project ECHO program to connect with specialists at centers of excellence in real-time collaborative sessions. Health Home providers may also access Project ECHO training and educational seminars;
7. All Health Home providers have participated in operational initiatives planning and problem-solving initiatives with HSD and MCO to integrate systems data and resolve issues.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | NM2019MS0009O | NM-21-0005 | MIGRATED_HH.CareLink NM

Package Header

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	User-Entered		
Reviewable Unit Instructions			

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: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 range from 1 hour to 80 hours per response (see below), 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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