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State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 15-0014

This file contains the following documents in the order listed:

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

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

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

March 21, 2016

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

Dear Ms. Smith-Leslie:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number (TN) 15-0014. With the approval of TN 15-0014, the Centers for Medicare and Medicaid Services (CMS) has approved the State's Health Home service delivery model known as "CareLink NM" as authorized under Section 2703 of the Patient Protection and Affordable Care Act. This program will provide coordinated care under State Plan authority for individuals with the chronic conditions of Serious Mental Illness and Severe Emotional Disturbance.

Transmittal Number 15-0014 is approved with an effective date of April 1, 2016, as requested. A signed and dated copy of the Transmittal No. 15-0014 summary is included, along with the approved plan pages. All other state plan documents relating to this state plan amendment (SPA) are housed in CMS' Medicaid Model Data Lab (MMDL) portal.

If you have any questions, please contact Stacey Shuman at (214) 767-6479.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Bill Bob Farrell, DMCH
Ford Blunt, DMCH
Justin Myrowitz, CMS Baltimore
Mary Pat Farkas, CMS Baltimore
Jennifer Mondragon, NM HSD/MAD

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

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

Submission Summary

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

NM-15-0014

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

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Socia**

Name of Health Homes Program:

CareLink NM

State Information

State/Territory name:	**New Mexico**
Medicaid agency:	New Mexico Human Services Department

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Tallie Tolen
Title:	Special Projects Manager
Telephone number:	(505) 476-7013
Email:	tallie.tolen@state.nm.us

The primary contact for this submission package.

Name:	Nancy Smith
Title:	Staff manager, Nursing

Telephone number:	(505) 827-3161
Email:	Nancy.Smith2@state.nm.us

The secondary contact for this submission package.

Name:	Megan Pfeffer
Title:	Chief, Quality Bureau
Telephone number:	(505) 827-7722
Email:	Megan. Pfeffer@state.nm.us

The tertiary contact for this submission package.

Name:	Maria Roybal-Varela
Title:	Director's Office
Telephone number:	(505) 827-3106
Email:	Maria.Roybal-Varela@state.nm.us

Proposed Effective Date

04/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
The New Mexico Human Services (HSD) is leading the statewide initiative to provide coordinated care through a Health Home for individuals with the chronic conditions of Serious Mental Illness and Severe Emotional Disturbance. This request is being made as a State Plan authority and is separate from the current 1115 demonstration. Our CareLink NM Health Home service delivery model, known as “CareLink NM”, will enhance integration and coordination of primary, acute, behavioral health, and long-term care services and supports for persons with chronic illnesses across the lifespan. CareLink NM enhances the efforts made through the development and implementation of the Centennial Care program to improve integrated care and enhance member engagement in managing their health. CareLink NM will be available as a community-based component of Centennial Care (care coordination will be delegated to the community level provider by the MCO) and as a first time care coordination opportunity for fee for service beneficiaries. CareLink NM Health Homes will be multi-disciplinary teams of behavioral health providers that partner with members to develop and implement a care/service plan (CareLink NM Plan) designed to meet all of the opted-in beneficiaries physical, behavioral and social health needs. The health care professionals will consist of multiple entities (behavioral health and physical health entities) collaborating with the beneficiary at the center with CareLink NM as the source of care coordination, replacing the Centennial Care “care coordination” for managed care members. CareLink NM will lead all care coordination from the community level whether with and not duplicate services currently offered by Centennial Care.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 1104020.00
Second Year	2017	$ 3703488.00

Federal Statute/Regulation Citation

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

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

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

DATE RECEIVED: 29 December, 2015
DATE APPROVED: 21 March, 2016
EFFECTIVE DATE: 1 April, 2016
SIGNATURE OF REGIONAL OFFICIAL: [redacted]
PRINTED TITLE AND NAME: Bill Brooks, Associate Regional Administrator, Division of Medicaid and Children's Health (DMCH)

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

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☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Socia**

Name of Health Homes Program:

CareLink NM

State: New Mexico
Date Received: 29 December, 2015
Date Approved: 21 March, 2016
Effective Date: 1 April, 2016
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State Information

State/Territory name: **New Mexico**

Medicaid agency: New Mexico Human Services Department

Authorized Submitter and Key Contacts

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Name: Tallie Tolen

Title: Special Projects Manager

Telephone number: (505) 476-7013

Email: tallie.tolen@state.nm.us

The primary contact for this submission package.

Name: Nancy Smith

Title:	Staff manager, Nursing
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- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

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

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Submission - Public Notice

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

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

Indicate how public notice was solicited:

Newspaper	
Name: Albuquerque Journal North Date of Publication: 10/30/2015 (mm/dd/yyyy) Locations Covered: Northern and middle New Mexico	
Name: Las Cruces Sun News Date of Publication: 10/30/2015 (mm/dd/yyyy) Locations Covered: Southern New Mexico	

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

Date of Publication: (mm/dd/yyyy)

State: New Mexico
Date Received: 29 December, 2015
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Email to Electronic Mailing List or Similar Mechanism.

Date of Email or other electronic notification: (mm/dd/yyyy)

Description:

Select the type of website:

Website of the State Medicaid Agency or Responsible Agency

Date of Posting: 10/29/2015 (mm/dd/yyyy)

Website URL: http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opp

Website for State Regulations

Date of Posting: (mm/dd/yyyy)

Website URL:

Other

ublic Hea

Date	Time	Location
Jun 12, 2015	**9:00 am -10:30 am**	**Albuquerque, NM**
Jun 19, 2015	**11:00 am -12:30 pm**	**Albuquerque, NM**

Date	Time	Location
Mar 13, 2015	11:00 am to 1:30 pm	Behavioral Health Services Division, Santa Fe, NM
Mar 17, 2015	10:00 am to 12:00 pm	Behavioral Health Services Division, Santa Fe, NM
Jul 1, 2015	5:00pm-7:00pm	Clovis, NM
Jul 2, 2015	9:00 am -11:00 am	Clovis, NM
Jul 9, 2015	5:00pm-7:00pm	Farmington, NM
Apr 2, 2015	11:00 am to 1:00 pm	Medical Assistance Division, Santa Fe, NM
May 11, 2015	1:00 pm- 4:30 pm	Santa Fe, NM
Apr 7, 0015	8:00-5:00	Santa Fe, NM
Jul 9, 2015	10:00 am to 12:00 pm	Window Rock, AZ

☐ **Other method**

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

☑

Challenges regarding accessible services in rural and frontier areas should be considered in developing assistance to member with a focus on transportation. Peer Support shou integral part of the model.

Summarize Response

In working together in partnership with stakeholders to develop proposal, HSD has considered and incorporated solutions to address program.

☐ **Quality**

State: New Mexico
Date Received: 29 December, 2015
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Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☑ **yment methodolo**

Commenters fell that the payment to CareLink NM Providers should be adequate to build initial operations and sustain the level of service expected.

Summarize Response

In working together in partnership with stakeholders to develop proposal, HSD has considered and incorporated solutions to address development of the rates as possible.

☐

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

State: New Mexico
Date Received: 29 December, 2015
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☑

Commenters recommended that the State should take careful steps to ensure the CareLink NM Health Homes do not negatively interrupt progress made in building patient centered medical homes (PCMH) practices. In addition, the requirements for staff should consider the limited capacity to hire qualified individuals and re agencies to receive the best pay. Also, care should be taken to reduce confusion among memb about what a CareLink NM Health Home is and does. The uniform needs assessmen upon information already collected and reduce burden to members and staff.

Summarize Response

The state addressed these concerns by working with community providers in the planning understanding the regional challenges in staff availability, incorporating training for Sta provider and MCO staff training to ensure consistent responses to member, and has collaborate with providers and MCOs to establish a standardized care/service plan (CareLink NM Plan)

☐ **Other Issue**

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Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☑ **State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizatio**

☑ **e State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

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

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: All NM Tribes Date of consultation: 10/05/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to the Governors of all Tribes in NM on 10/05/2105 soliciting feedback on the proposed CareLink NM Program. Tribes had a total of 60 days to provide feedback and request a formal consultation. No feedback was received as a result of the letters and no consultaion was requested.	

☑ **ndian Health Program**

Indian Health Programs	
Name of Indian Health Programs: All IHS, and Tribal 638 including programs that border NM. Date of consultation: 10/05/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to the Indian Health Programs in NM (including border areas outside of the state) on 10/05/2105 soliciting feedback on the proposed CareLink NM Program. Programs had a total of 60 days to provide feedback and request a formal consultation. No feedback as a result of the letter was received and no consultaion was requested.	

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☑ **Summarize Com**

State: New Mexico
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New Mexico expects that the CareLink NM Health Home will have a direct effect on Native Americans. The IHS facilities have not expressed an immediate interest in serving as a CareLink NM Health Home at this time, however they are eligible to become a CareLink NM Health Home should they chose to do so. Feedback received from a meeting with IHS representatives, included a desire to include traditional services; a suggestion to use simple language to ensure beneficiaries understand this is optional and in addition to their Medicaid coverage, to have Navajo translators available, have the schools involved, understand and plan that transportation will be a big issue and most importantly develop trust with the beneficiaries. In addition, the State sent an official tribal letter on 10/15/2015, and no requests were received following the 60-day tribal consult period.

Summarize Response

The state requires the CareLink NM providers to provide both culturally and language appropriate service to beneficiaries. The CareLink NM Steering committee will provide oversight of all health home provider outreach activities to strive for the best beneficiary engagement and outcomes.

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

State: New Mexico
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☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

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Submission - SAMHSA Consultation

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

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

Health Homes Population Criteria and Enrollment

Population Criteria

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

☐ **Two or more chronic conditions**

Specify the conditions included:

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

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

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

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:

☑ **More serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
The SMI and SED criteria were developed and approved by the Behavioral Health Collaborative to initially identify core service agency members as well as members who are eligible to receive certain services comprehensive community support services (CCSS). The criteria were revised to add addi
criteria to the SED definition, discussed with the Behavioral Health Planning Council's Children and Adolescent Subcommittee (CASC), and approved by the Collaborative. The third revision was designed to update th criteria to coincide with DSM-V and the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. Our criteria checklist includes symptom severity and other risk factors. This revised set of criteria is used for a variety of services and grants and have been discussed with and approved by the fu Behavioral Health Collaborative.

Geographic Limitations

☐ **Health Homes services will be available statewide**

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

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If no, specify the geographic limitations:

◉ **By county**

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

○ **By region**

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

○ **By city/municipality**

Specify which cities/municipalities:

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○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

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

○ **Opt-In to Health Homes provider**

Describe the process used:

◉ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:
For MCO members with a claims history with the CareLink NM providers, the MCO will work with the providers and the State to identify members living in the geographical area who have a claims relationship with the CareLink NM providers. These members will be automatically opted into the health home, but will be required to affirm opting in by signing an opt-in and data sharing agreement with the health home. These members will receive a combined letter from the MCO and the State.

The State of New Mexico operates both a managed care (MCO members) and Fee-For-Service (FFS beneficiaries) delivery systems. FFS beneficiaries and MCO members with no claims history with the CareLink NM provider will not be auto assigned or automatically opted into the health home. Native Americans will be allowed to opt in to the health home but will not be automatically opted-in. For MCO members without a claims history with the CareLink NM providers, a letter will be generated by the MCO and the State to ensure the member is aware of the opportunity and has the information needed to engage in the program. These members will remain opted out until such time that they engage and opt in. FFS beneficiaries will receive a letter from the State announcing the program with the details of how to engage in the health home opportunity. These members will remain opted out until such time that they engage and opt in.

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

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○ **Other**

Describe:

☑ **Assurance that eligible individuals will be given a free choice**

☑ **Assurance that it will not prevent individuals who are dually eligible for Medicare an Medicaid from receiving Health Homes**

☑ **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 co seek or need treatment in a hospital emergency department to desi**

☑ **e State provides assurance that it will have the systems in enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular people with a particular chronic conditi**

☑ **be no duplication of services and payment for similar services under other Medica**

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Health Homes Providers

Types of Health Homes Providers

☑

Indicate the Health Homes Designated Providers the State includes in its program and the provi qualifications a

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☑ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

Each CareLink NM Health Home must meet the following:

1. Registered Medicaid Provider in the State of New Mexico.
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held

Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
a. CareLink NM Health Home Director
b. Health Promotion Coordinator
c. Care Managers/Care Coordinator
d. Community Liaison
e. Clinical Supervisor
f. Peer Support Specialists
g. Medical Consultant
h. Psychiatric Consultant
5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA.
6. The CareLink NM Health Home must be approved by New Mexico through the application process.
7. The CareLink NM Health Home must have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

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

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

☑ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:
Each CareLink NM Health Home must meet the following:

1. Registered Medicaid Provider in the State of New Mexico.
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
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c. Care Managers/Care Coordinator
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e. Clinical Supervisor
f. Peer Support Specialists
g. Medical Consultant
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5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA.
6. The CareLink NM Health Home must be approved by New Mexico through the application process.
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The provider is required to maintain the following care coordinator ratios for all members of the CareLink NM Health Home:

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

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **have been determined by the State and app**

qualified as a hea

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

Each CareLink NM Health Home must meet the following:

1. Registered Medicaid Provider in the State of New Mexico.
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
   a. CareLink NM Health Home Director
   b. Health Promotion Coordinator
   c. Care Managers/Care Coordinator
   d. Community Liaison
   e. Clinical Supervisor
   f. Peer Support Specialists
   g. Medical Consultant
   h. Psychiatric Consultant
5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA.
6. The CareLink NM Health Home must be approved by New Mexico through the application process.

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7. The CareLink NM Health Home must have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

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

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

☑ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:
Each CareLink NM Health Home must meet the following:

1. Registered Medicaid Provider in the State of New Mexico.
2. Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – This is typically held Core Service Agencies (CSA), FQHCs and Indian Health Services Clinics.
3. Meet the State standards and requirements as a Behavioral Health Organization
4. Employ the following staff:
a. CareLink NM Health Home Director
b. Health Promotion Coordinator
c. Care Managers/Care Coordinator
d. Community Liaison
e. Clinical Supervisor
f. Peer Support Specialists
g. Medical Consultant
h. Psychiatric Consultant
5. Demonstrate the ability to meet all data collection, quality and reporting requirements described in this SPA.
6. The CareLink NM Health Home must be approved by New Mexico through the application process.
7. The CareLink NM Health Home must have the ability to provide primary care services for adults and children, or have an MOA with at least one primary care practice in the area that serves children and one that serves adults.
8. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities.

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

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

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

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☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

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

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

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☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

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☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

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

Description:

Providers will use community experience to address behavioral needs and integrate physical & social health needs to promote comprehensive holistic care.State supports providers through initial/ongoing training for staff,technical & MCOdata driven support.The State ensures all 11 functional requirements are met.They requirements are addressed in the six core services of the program.Comprehensive Care Management (CCM),Care Coordination(CC),Health Promotion ensure all requirements are met CCM services include:Initial and ongoing assessment of risk conditions & health needs; developing the person-centered CareLink NM Plan to include member goals,supporting tx adherence; identify health needs;assigns health team;develop treatment plan for risk/health conditions;conducting outreach and engagement;oversight of CareLink NM Plan for BH/PH;use claims-based data sets,registries, health status & utilization variances from treatment guidelines & development of outcomes & satisfaction reports, health status,costs.CC is the execution of individuals culturally appr CareLink NM Plan with linkages,referrals,coordination,follow-up to services/supports.CareLink NM Plan is developed with member/family.Promotes integration &cooperation of service providers,reinforces treatment strategies that support the members motivation to understand & manage health conditions.CC & health promotion include,appointment scheduling;referrals & follow-up;hospital discharge planning & communicating with providers,members,caregivers;delivers health education specific to the chronic conditions;developing plans with the member;educating aboutimmunizations/ screening for health;caregiver counseling; healthy lifestyle

choices; resiliency/ recovery, independent living,smoking interventions;nutritional counseling,obesity reduction/prevention; physical activity;services assist members to participate in their treatment/medical services plan & place emphasis on,understanding,self-management chronic health conditions.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

New Mexico's CareLink NM Health Homes will be multi-disciplinary teams of behavioral health providers that partner with members to develop and implement a comprehensive care plan designed to meet all of their physical, behavioral and social health needs. The health care professionals will consist of multiple entities collaborating with the member at the center and the CareLink NM Health Home will serve as the primary source of care coordination. The CareLink NM Health Home may partner with more than one primary care practice to best meet the needs of the members based on their choice, age, location and primary concerns or needs. The CareLink NM Health Home will serve as the lead entity and have a memorandum of agreement (MOA) with each partnering primary practice that describes standards and protocols for communication and collaboration and other information necessary to effectively deliver services without duplication. An example of this would be a behavioral health entity that would have an MOA with a primary care physician or a pediatrician. Each Centennial Care MCO is required to contract with all CareLink NM Health Homes to ensure continuity of care and support to MCO members in receiving CareLink NM Health Home services. MOAs will not be needed if the partner is a part of the same organization operating in another location. The State will work with its' provider and MCO stakeholders, before the effective date, to finalize the requirements regarding the use of the MOA. The State will ensure members will receive the necessary services.

Provider Standards

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

The State's minimum requirements and expectations for Health Homes providers are as follows and providers must meet the following requirements: Registered Medicaid Provider in the State of New Mexico; Have Comprehensive Community Support Services (CCSS) Certification from the State of New Mexico as defined in NMAC, Title 8, Chapter 321, Part 2, section 8.321.1.14 – this is typically held by Core Service Agencies (CSA), FQHCs and Indian Health Service Clinics; Meet the State standards and requirements as Behavioral Health Organization. Employ the following: a) Health Home Director, b) Health Promotion Coordinator – Relevant bachelors level degree, experience developing and delivering curriculum, c) Care Managers/Care Coordinator – Licensed or Human Services bachelor's level degree and four years of experience or Human services masters' level degree and two years of experience or as approved through waiver by HSD d) Community Liaison – Multi-lingual and experienced with resources in the local community including family and caregiver support services. e) Clinical Supervisor – Licenses professional who has experience with adults and children f) Peer Support Specialists – Certified by the State g) Medical Consultant h) Psychiatric Consultant.

The CareLink NM Health Home must have the ability to provide primary care/pediatric services for adults and children, or have an MOA with at least one primary care/pediatric practice in the area that serves children and one that serves adults. The CareLink NM Health Home must have established member referral protocols with area hospitals and residential treatment facilities. Dependent on the site, primary care will be integrated into the provider structure by either having both primary and BH care occurring at the same physical location or through co-location of providers with MOAs and current member releases of information to share all pertinent health communications between the domains. The State expects that some providers will have both primary and behavioral health entities in the same location or co-located and this will be encouraged with CareLink NM providers, however the State is not stipulating this as a requirement. MCO members are not required to change their PCP. The CareLink NM care coordinator is tasked to make certain that the member's health records are shared amongst the BH and primary provider. To ensure well-being from a holistic perspective the intent is that both providers have the knowledge of the member's needs to create a treatment plan that is most appropriate in consideration of all BH and physical health issues. Multi-disciplinary teams of behavioral health providers should include relevant professionals; any other relevant BH clinical professional that is providing care to the CareLink NM member; any physical health provider, as appropriate; any in-home provider; and any other individual that the member identifies as important to maintaining or improving health and wellbeing. The CareLink NM Plan will be for both physical and behavioral health needs, and will serve as the care and service plan. This is one of the participation requirements of providers enrolled in the CareLink NM program. Integration will begin with the sharing of treatment records.

CareLink NM providers must meet all data collection, quality and reporting requirements for the program. The CareLink NM Health Home must be approved by New Mexico through the application process. The initial

range for care coordination ratios were determined through consultation with current MCOs and potential CLNM providers. The CLNM steering committee will monitor ratios ongoing to ensure they remain appropriate to meet the needs of the population.

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Health Homes Service Delivery Systems

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

☑
☐ **CCM**

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

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

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

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

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

If yes, describe how requirements will be different:

☑ **Risk Based Managed Ca**

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

☐ **The current capitation rate will be reduced.**

☑ **se additional contract requirements on the enrollees**

Provide a summary of the contract language for the additional requirements:
In designing and implementing Centennial Care, New Mexico anticipated the development of a Health Homes program and included relevant language in the CMS approved managed care contracts. The current CMS approved Centennial Care managed care contract includes language addressing Health Homes in the following section: Definitions, 4.4.6.3.3., 4.4.12.2, 4.4.12.5, 4.4.12.16.1, 4.10.2.3, 4.13.2, 4.14.10.3, 4.20.2.26.5, 4.20.2.6.9, 4.21.7.8. In addition, the CLNM provider has independent contracts with the MCOs that describe roles and responsibilities to ensure no duplication of services. The State will publish a policy manual for health homes that will be made available to the public.

The CareLink NM provider will be primarily responsible for all elements of care coordination for the CareLink member. There will be a need for ongoing communication between the MCO and the CareLink NM provider to address any changes to a member's level of care (LOC) or other possible administrative activities deemed more appropriate for completion by the MCO. The CareLink NM steering committee will work with both the MCOs and CareLink NM Providers to ensure the appropriate coordination is maintained and CareLink NM members do not see any lapse in or duplication of services.

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☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

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

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

○ **Yes**

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

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

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

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

○ **No**

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

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

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☐ **Other Service Delivery System:**

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

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

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Health Homes Payment Methodologies

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

☑

☑ **ee for Service Rates based on**

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

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

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

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

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☑

See the description below.

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

The payment rate for the health home will be based on the combined fee for service (FFS) and managed care enrollees anticipated to be served by the health home and the staffing requirements of clinical and non-clinical staff, (health home director, clinical administrative assistants, health educators, and care coordinators), for the health home . These costs will be used to develop per member per month (PMPM) amounts.

The State provides assurance that all costs used to establish the health home rates are limited to the costs for providing the health home services of comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support, and referral to community and social support services. The PMPM is intended for 100% support of the Health Home for the New Mexico Medicaid population.

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

The total costs associated with the salaries of the staff and administrative costs are by the number of enrollees participating and their annual duration. These inputs are used to ca monthly cost per person or per member per month (PMPM). Since SMI/SED including those with a substance abuse diagnosis the population is distinct and th additional levels for severity will not be established for payment purposes. This payment will be utili to reimburse the health home on a monthly basis for care coordination activities regardless of whether t member is enrolled in managed care or FFS. the Health Home PMPM associated with the delivery of any behavioral health services. In the circumstance provider renders a state plan approved service the Health Home will submit a claim to the Stat claims system or managed care organization for the rendered ser

The CY2016 PMPM has been developed for the nine months between 2016 for and is based on marketplace salaries obtained from publically available sala information and enrollment is based on consultation between the State and potential pilot si CY2017 PMPM estimate utilizes the salary information from CY2016 trended at 2.0% to the CY2017 period. The PMPM for CY2017 reflects the continued increase in enrollment in the Health Home. D CY2016, the State will evaluate the salary cost and enrollment in the program to rebase the CY2017 estimated PMPM. The State will review rates at least annually to ensure that they r efficient and ensure the provision of quality care.

The effective date for the Health Home PMPM is April 1, 2016.

FFS Enrollees
For FFS enrollees the monthly payment for care coordination will be triggered by a claim submissi from the Health Home to the State's MMIS claims system. For FFS members, the requirement for health home to submit a claim for payment allows the State to e home service before payment is made. The claims submission also Health Home, and date of service for monitoring and evaluation of health home activities includin support of outcome and quality studies.

For Managed Care
Under managed care, the MCO will make payment on a monthly basis to the Health Home for enrolled members. Although the PMPM developed for the Health Home is done based on the staffing an administrative costs of the Health Home the current capitated rates paid by the State to the MCO incl care coordination or case management activities as a primary function under the State's 111 Demonstration Waiver. These care coordination activities are similar in scope to th that will be performed by the health home and already factored into the current MCO rate. Currently under managed care, members who are assessed as SMI or SED with s disorder are assigned to the most intensive care coordination (Level 3). To ensure that the duplication of payment the Health Home PMPM payment will be evaluated against the care coordinatio funding included in the capitated rates and the capitated payment will be adjusted acco will monitor the payments between the MCO and Health Home through the evaluation of encounter da submitted by the MCO as well as MCO Health Home reporting.

The payments will not be tiered based on the severity of the member's condition. This is because the Health Home is targeted to a distinct population of members who are SMI/SED with substance abuse disorders. The PMPM developed is based on clinical and non-clinical staffing requirements for the Health Home, their salaries and administrative cost and the number and duration of health home participants.

☐ **Incentive payment reimbursement**

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

☐ **PCCM Managed Care (description included in Service Delivery section)**

☑ **ription included in Service Deliv**

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

☐ **Tiered Rates based on:**

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

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

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

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☐ **Rate only reimbursement**

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

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
Under managed care, the MCO will make payment on a monthly basis to the CareLink NM Health Home for enrolled members. Although the PMPM developed for the CareLink NM Health Home is done based on the staffing and administrative costs of the CareLink NM Health Home, the current capitated rates paid by the State to the MCO includes care coordination or case management activities as a primary function under the federal authority under which the Centennial Care program operates. These care coordination activities are similar in scope to the care coordination that will be performed by the CareLink NM Health Home and already factored into the current MCO capitated payment rate. Currently under managed care, members who are assessed as SMI or SED are assigned to the most intensive care coordination. To ensure that there is no duplication of payment the CareLink NM Health Home PMPM payment will be evaluated against the care coordination funding included in the capitated rates. The State will monitor the payments between the MCO and CareLink NM Health Home through the evaluation of encounter data submitted by the MCO as well as MCO CareLink NM Health Home reporting.

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

☑ **urance that all governmental and private providers are reimburse**

☑ **urance that it shall reimburse Health Homes providers directly are employment or contractual arrangements**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

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

☑ **rically Needy eligibility grou**

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Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive Care Management

Definition:
Comprehensive Care Management is the identification of individuals ensuring the individual and family are active participants in comprehensive service planning. Monitoring of the implementation of the CareLink NM plan and 1) its evolution into individual health status and self-management, 2) utilization of services, and 3) prioritization of transitional care activities. Ensures "ownership" of an individual's care to the appropriate CareLink NM team.

Comprehensive care management services must include: Assessment of preliminary risk conditions and health needs; CareLink NM Plan development, which will include client goals, preferences and optimal clinical outcome and identify specific additional health screenings required based on the individual's risk assessment; assignment of health team roles and responsibilities; development of treatment guidelines for health teams to follow across risk levels or health conditions; oversight of the implementation of the CareLink NM Plan which bridges treatment and wellness support across behavioral health and primary care; through claims-based data sets and patient registries, monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
BHSDStar, a web-based data collection tool will be used to create participant records that are specific to CareLink NM. BHSDStar will also eventually provide support for the bidirectional data exchange of the records created in this tool for this project.It will be developed in modules and will be used to collect and share information for tracking and care integration, such as: Tracking of calls, referrals, follow up, and prior authorizations; Tracking of beneficiary's CareLink NM opt in/opt out status and data sharing agreement related to the program; Goals identified as a part of the CareLink NM Plan; Daily census of ER and urgent/planned/pre-authorized admission activities identified by the State and/or the MCO provided to the Health Home; Progress information related to identified health action goals and progress on care plan outcomes; Changes in CareLink NM enrollment in Medicaid or CareLink NM; Completing and monitoring Needs Assessments; and Data collection to support quality indicators measuring program success. At this time we do not anticipate systems based exchange, however this will be considered in the State's HIE initiative.

Scope of benefit/service

☑ **ervice can only be provided by certain provider t**

☑ **Behavioral Health Professionals or Specialists**

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See Other

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Description
See Other

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **o**

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See Other

☐ **octors of Ch**

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **(specify):**

Care Link NM Provider Team

Description
A Care Coordinator, who: is a regulation and licensing department (RLD) licensed behavioral health practitioner; or holds a human services bachelor's level degree and has four years of experience; or holds a human services master's level degree and has two years of 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 coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

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Care Coordination

Definition:
Care coordination is the implementation of the individualized, culturally appropriate Comprehensive CareLink NM Plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. With the member and the member's family, as appropriate, a CareLink NM Plan is developed based on a standardized assessment developed for the CareLink NM. The assessment was developed in partnership with the University of New Mexico, Managed Care Organizations and providers.

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Please see description found in Comprehensive Care Management

Scope of benefit/service

☑ **ervice can only be provided by certain provider t**

☑ **Behavioral Health Professionals or Specialists**

Descriptio

See Other

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☐ **s' Ass**

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☐ **Pharmacists**

Description

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

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☑ **(specify):**

CareLink NM Provider Team

Description
Health Home team members who can provide this service include:

A Care Coordinator, who: is a regulation and licensing department (RLD) licensed behavioral health practitioner; or holds a human services bachelor's level degree and has four years of experience; or holds a human services master's level degree and has two years of 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 coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

Health Promotion

Definition:
Health Promotion – Individual, group and environmental strategies aimed at disseminating information regarding healthy living and ways to improve overall health and reduce the health consequences associated with chronic conditions such as substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing

physical activity. Health promotion services must include: Providing health education specific to an individual's chronic conditions; Developing self-management care plans with the individual; Educating members about the importance of immunizations, other primary prevention activities, and screening for overall general health; Providing support for improving social networks; and Providing health-promoting lifestyle interventions, including, but not limited to: substance use prevention and/or reduction; resiliency and recovery, independent living, smoking prevention and cessation; nutritional counseling, healthy weight management and increasing physical activity.
Health promotion services also assist clients to participate in the implementation of both their treatment and medical services plan and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion reinforces strategies that support the member's motivation to better understand and actively self-manage her or his chronic health condition.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Please see description found in Comprehensive Care Management

Scope of benefit/service

☑ **ervice can only be provided by certain provider t**

☑ **Behavioral Health Professionals or Specialists**

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Licensed Complementary and Alternative Medicine Practitioners

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Nutritionists

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Care Link NM Provider Team

Description
Health Home team members who can provide this service include:

A 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 CLNM Member such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management.

A Care Coordinator, who: is a regulation and licensing department (RLD) licensed behavioral health practitioner; or holds a human services bachelor's level degree and has four years of experience; or holds a human services master's level degree and has two years of 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 coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

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

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

Each provider agency, in the application or through other means, will document a provider and partner outreach and engagement plan, which is a foundation for transitional care services. CareLink NM providers will either have existing relationships with hospitals or will establish data sharing agreements with hospitals in their county to support beneficiaries.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Please see description found in Comprehensive Care Management

Scope of benefit/service

☑ **ervice can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

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☑ **(specify):**

Care Link NM Provider Team

Description
A Care Coordinator and Supervisor of the care coordinator, as described in Health Promotion above.

A, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English-speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with a CLNM Member's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources, and practitioners.
A Physical Health Consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC.

A Psychiatric Consultant who is a physician (MD or DO) licensed by the Board of

Medical Examiners or Board of Osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC.

Individual and family support, which includes authorized representatives

Definition:
Assisting the individual in attainment of the highest level of health and functioning within the family and in broader community contexts. Individual engagements support recovery and resiliency, and involve peer and family supports, targeted support groups, and formal self-care programs.

Individual and family support services must include, but are not limited to: Peer support specialists as required by NMAC; Navigating the health care system to access needed services for individuals and families; Assisting with obtaining and adhering to medications and other prescribed treatments; Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and Arranging for transportation to medically necessary services.
A primary focus will be on increasing a member's health and medication literacy, developing a member's ability to self-manage care, promoting family involvement and support, improving access to education and employment supports, and enhancing the individual's effectiveness in revising and updating their own treatment/care plan. Engagement activities should support recovery and resiliency. In the case of children, these individual and family support services are delivered with a wrap-around approach to ensure individual needs are met to ensure maximum wellness and access to health care. This includes engaging parents and school-based services as necessary. New Mexico funds one the Evidenced-Based Practices for treating trauma, Dialectical Behavior Therapy (DBT).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Please see description found in Comprehensive Care Management

Scope of benefit/service

☑ **ervice can only be provided by certain provider t**

☑ **Behavioral Health Professionals or Specialists**

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☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
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☐ **Doctors of Chiropractic**

Description

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

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☐ **Nutritionists**

Description

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☑ **(specify):**

Care Link NM Provider Team

Description
Health Home team members who can provide this service include:

A 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 CLNM Member such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management.

A Care Coordinator, who: is a regulation and licensing department (RLD) licensed behavioral health practitioner; or holds a human services bachelor's level degree and has four years of experience; or holds a human services master's level degree and has two years of 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 coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

Referral to community and social support services, if relevant

Definition:
The CareLink NM Health Home provider will identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement. Common linkages include continuation of healthcare benefits eligibility, disability benefits, housing, legal services, educational supports; employment supports, and other personal needs consistent with recovery goals and the treatment plan. The care coordinator will make and follow up on referrals to community services, link clients with natural supports and assure that these connections are solid and effective. Natural Supports are supports not paid for with Medicaid funds that assist the individual to attain the goals as identified on the Care Plan. Individuals who provide natural supports are not paid staff members of a service provider, but they may be planned, facilitated, or coordinated in partnership with a provider.

New Mexico has a number of active grants and programs that CareLink NM will refer to and coordinate services for such as: "Now is the Time" Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Health Conditions to be known in New Mexico as Healthy Transitions New Mexico (HTNM). The population consists of those that either have, or are at risk of developing a serious mental health condition. The goal is to create safe avenues to improved emotional and behavioral functioning so that youth and young adults can

progress into adult roles and responsibilities and lead full and productive lives.
A SAMSHA Communities of Care grant that allows us to build local Wrap Around teams which assist is coordinated care. NM funds one the Evidenced-Based Practices for treating trauma, Dialectical Behavior Therapy (DBT), and the development and adoptions of a Youth-version of the Certified Peer Support Worker curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Please see description found in Comprehensive Care Management

Scope of benefit/service

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☑ **Behavioral Health Professionals or Specialists**

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Description
See Other

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **(specify):**

Care Link NM Provider Team

Description
Health Home team members who can provide this service include:

A Care Coordinator, who: is a regulation and licensing department (RLD) licensed behavioral health practitioner; or holds a human services bachelor's level degree and has four years of experience; or holds a human services master's level degree and has two years of 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 coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in

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working with both adult and child populations.

A Certified Peer Support Worker (CPSW) who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.

A Community Liaison who is bilingual and speaks a language which is utilized by a majority of non-fluent English-speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with a CLNM Member's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources, and practitioners.

Health Homes Patient Flow

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

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☐ **Medically Needy eligibility groups**

○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
The HSD will use MMIS claims data and the current Technical Specifications for the Core Set of Health Care Quality Measures for Plan All-Cause Readmissions to track participating CareLink NM Health Home member hospital readmissions within 30 days of an inpatient hospital stay.

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

additional supports that beneficiary's may need.

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

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

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

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The State will identify and flag the people that affirmatively enroll in a CareLink NM Health Home. We would work to evaluate these flagged individuals and look at cost drivers that the CareLink NM Health Home can impact to get to an expected savings calculation for the program.

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

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
CareLink NM Health Home providers will be required to use certified Electronic Health Records (EHRs) for the CareLink NM Health Home program. These EHRs must be able to provide state of the art technologies to both office and field based staff. In addition, the designated providers will be required to work within the BHSDStar solution designed specifically for the CareLink NM Health Home, and will be required to participate in the State HIE planning initiatives and work with the HSD as well as the MCOs to provide seamless integration of the systems data.

Quality Measurement

☑ **urance that it will require that all Health Homes providers report to t State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **urance that it will identify measureable goals for its Health Homes and intervention and also identify quality measures related to each goal to measure its succe achieving the go**

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

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Evaluations

☑ **urance that it will report to CMS information submitted by providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of th Affordable Care Act and as des**

Describe how the State will collect information from Health Hom the effect of the program o

Hospital Admission

Measure:

30-day All Cause Readmissions

Measure Specification, including a description of the numerator and denominator.
New Mexico Human Services Department (HSD) will use MMIS claims data and the current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual for Plan All-Cause Readmissions to track participating CareLink NM Health Home member hospital readmissions within 30 days of an inpatient hospital stay.

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

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

Denominator:
The count of an Index Hospital Stay on or between January 1 and December 1 of the measurement year for participating CareLink NM Health Home members.
Data Sources:
MMIS data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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Emergency Room Visits

Measure:

Emergency Room Visits

Measure Specification, including a description of the numerator and denominator.
The rate of emergency department (ED) visits per 1,000 enrollee months among CareLink NM Health Home enrollees. HSD will use the most current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid CareLink NM Health Home Programs for the Measure AMB-HH: Ambulatory Care-Emergency Department Visits.

Numerator:
The total number of ED visits for participating CareLink NM Health Home members during the measurement year.

Denominator:
The number of participating CareLink NM Health Home members during the measurement year.

Data Sources:
MMIS
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annualy**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:
Skilled Nursing Facility Admissions
Measure Specification, including a description of the numerator and denominator.
The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. HSD will use the most current Technical Specifications for the Core Set of Health Care Quality measures for Medicaid CareLink NM Health Home Programs for the Measure NFU-HH: Nursing Facility Utilization.

Numerator:
The total number of Skilled Nursing Facility admissions for participating CareLink NM Health Home members during the measurement year.

Denominator:
The number of participating CareLink NM Health Home members during the measurement year.
Data Sources:
MMIS
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annualy**
- ○ **Continuously**
- ○ **Other**

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

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

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

Coordination of Care for Individuals with Chronic Conditions
Due to the current statewide initiative to provide Care Coordination to all New Mexicans under the Centennial Care program, we have a unique opportunity to measure the same populations in a pre and post implementation manner.

Centennial Care – Care Coordination focuses primarily on beneficiary goals and is exclusive to managed care enrollees. The CareLink NM Health Home program will augment the MCO program by providing more intensive community managed "boots on the ground" supports and services for the qualifying SMI/SED beneficiaries.

Assessment of Program Implementation
HSD will conduct reviews with all selected CareLink NM Health Homes to establish their readiness. During programmatic go-live, the State will assess the indicators of program implementation from enrollment data, beneficiary engagement, claims/encounter data, client assessment data and interim progress reports from the operating CareLink NM Health Home. This multidisciplinary team will include staff from the Medical Assistance Division as well as NM's Medicaid Authority and single state agency for mental health and substance use, the Behavioral Health Services Division.

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

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

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

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

Estimates of Cost Savings

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

If no, describe how cost-savings will be estimated.
The State expects savings for CareLink NM Health Home enrollees through reductions in the use of emergency room visits and inpatient admissions. In addition to reducing, certain activities the CareLink NM Health Home will help enrollees address other health care needs through identification, management and treatment of these conditions resulting in overall better health, reduced health care complications.

PRA Disclosure Statement

Health Homes Administrative Component

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Health Homes Administrative Component

Name of Health Homes Program:
CareLink NM

State: New Mexico
Date Received: 29 December, 2015
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Monitoring

Provide an estimate of the number of individuals to be served by the Health Homes program during the first year of operation:

1000

Provide an estimate of the cost-savings that will be achieved from implementation of the Health Homes program during the first year of operation:

$ 310378.00

Describe how this cost-saving estimate was calculated, whether it accounted for savings associated with dual eligibles, and if Medicare data was available to the State to utilize in arriving at its cost-savings estimates:
The Health Homes program is intended to begin in January 2016 with enrollment ramping up throughout the year. Due to the member ramp up and the small number of individuals who will be enrolled the cost savings for the first Federal Fiscal Year of operation are also limited.

The approach to estimating the cost savings included analyzing historical expenditures and utilization for both mental health / substance abuse and acute care service expenditures for likely SMI and SED members. Since identifying SMI and SED members includes diagnosis as well as Global Assessment of Functioning (GAF) and other psychosocial information a proxy population was identified relying on only diagnosis codes and the utilization of both mental health / substance abuse and acute care services. The cost by major service category (inpatient, emergency room, residential treatment center, etc….) was arrayed and reductions were assumed for services including inpatient admissions, reductions in the use of residential treatment centers and use of emergency room and emergency transportation. Also reflected were increases associated with services including improved adherence to medications, increased use of acute care physicians and behavioral health professionals. Additionally, the Health Homes program will shift a portion of Health Homes cost estimate from care coordination currently performed by the managed care organizations and included in their current capitated payment. The portion of the estimated Health Homes program cost already included in the managed care capitation will be directed to the Health Homes and incremental cost associated with the Health Homes will be added to the MCO capitation payments. Dual eligibles were not included in the savings estimate.

Quality Measurement

CMS Recommended Core Measures

For each Health Homes core measure, indicate the data source, the measure specification, and how HIT will be utilized in reporting on the measure.

Health Homes Core Measure		
Measure ABA-HH: Adult Body Mass Index (BMI) Assessment		
Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan		

Health Homes Core Measure		
Measure PCR-HH: Plan All-Cause Readmission Rate		
Measure FUH-HH: Follow-Up After hospitalization for Mental Illness		
Measure CBP-HH: Controlling High Blood Pressure		
Measure CTR-HH: Care Transition - Timely Transmission of Transition Record		
Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Measure PQ192-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite		

Health Homes Administrative Component: Core Measure Detail

Measure
Measure ABA-HH: Adult Body Mass Index (BMI) Assessment

Measure Specification, including a description of the numerator and denominator.
The percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: the eligible population of participating Health Home members.
Numerator: Health Home enrollees for whom BMI was documented during the measurement year or the year prior to the measurement year. For Health Home enrollees younger than 19 years of age on the date of service, BMI percentile (BMI Percentile Value Set) also meets criteria.

Data Sources:
Data Sources: MMIS claims, Medical Record Review.

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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How Health IT will be utilized
The Health Homes program is intended to begin in January 2016 with enrollment ramping up throughout the year. Due to the member ramp up and the small number of individuals who will be enrolled the cost savings for the first Federal Fiscal Year of operation are also limited.

The approach to estimating the cost savings included analyzing historical expenditures and utilization for both mental health / substance abuse and acute care service expenditures for

likely SMI and SED members. Since identifying SMI and SED members includes diagnosis as well as Global Assessment of Functioning (GAF) and other psychosocial information a proxy population was identified relying on only diagnosis codes and the utilization of both mental health / substance abuse and acute care services. The cost by major service category (inpatient, emergency room, residential treatment center, etc….) was arrayed and reductions were assumed for services including inpatient admissions, reductions in the use of residential treatment centers and use of emergency room and emergency transportation. Also reflected were increases associated with services including improved adherence to medications, increased use of acute care physicians and behavioral health professionals. Additionally, the Health Homes program will shift a portion of Health Homes cost estimate from care coordination currently performed by the managed care organizations and included in their current capitated payment. The portion of the estimated Health Homes program cost already included in the managed care capitation will be directed to the Health Homes and incremental cost associated with the Health Homes will be added to the MCO capitation payments. Dual eligible were not included in the savings estimate.

Health Homes Administrative Component: Core Measure Detail

Measure
Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan

Measure Specification, including a description of the numerator and denominator.
The percentage of Health home enrollees age 12 and older who were screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: participating Health Home members with an outpatient visit during the measurement year.
Numerator: Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen.

Data Sources:
MMIS Claims

Frequency of Data Collection:

State: New Mexico
Date Received: 29 December, 2015
Date Approved: 21 March, 2016
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- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
BHSDStar, a web-based data collection tool will be used to create participant records that are specific to CareLink NM. BHSDStar will also eventually provide support for the

bidirectional data exchange of the records created in this tool for this project.It will be developed in modules and will be used to collect and share information for tracking and care integration, such as: Tracking of calls, referrals, follow up, and prior authorizations; Tracking of beneficiary's CareLink NM opt in/opt out status and data sharing agreement related to the program; Goals identified as a part of the CareLink NM Plan; Daily census of ER and urgent/planned/pre-authorized admission activities identified by the State and/or the MCO provided to the Health Home; Progress information related to identified health action goals and progress on care plan outcomes; Changes in CareLink NM enrollment in Medicaid or CareLink NM; Completing and monitoring Needs Assessments; and Data collection to support quality indicators measuring program success.In addition to these BHSDStar tools, HSD will use their existing Predictive Risk Intelligence System (PRISM) web-based clinical decision support predictive modeling tool to provide critical insights via a claims-based view of the health service experiences of the CareLink NM beneficiaries. The key features of the PRISM application include: A claims-based view of the health service experiences of CareLink NM participants which contains comprehensive longitudinal health information derived from paid claims, managed care encounters, and utilization data; Integration of medical and behavioral health data to provide a comprehensive view of patient risk factors, service utilization and health outcomes; Uses state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. At this time we do not anticipate systems based exchange, however this will be considered in the State's HIE initiative.

Health Homes Administrative Component: Core Measure Detail

Measure
Measure PCR-HH: Plan All-Cause Readmission Rate

Measure Specification, including a description of the numerator and denominator.
For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: The count of an Index Hospital Stay (IHS) on or between January 1 and December 1 of the measurement year for participating Health Home members.
Numerator: At least one acute readmission for a participating Health Home member within 30 days of a discharge from Index Hospital Stay.

Data Sources:
MMIS Claims

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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Health Homes Administrative Component: Core Measure Detail

Measure
Measure FUH-HH: Follow-Up After hospitalization for Mental Illness

Measure Specification, including a description of the numerator and denominator.
The percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:
• The percentage of discharges for which the patient received follow-up within 30 days of discharge.
• The percentage of discharges for which the patient received follow-up within 7 days of discharge.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: participating Health Home members who have been discharged from an acute inpatient setting with specific mental illness diagnoses.
Numerator 1: an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days after discharge.
Numerator 2: an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge.

Data Sources:
MMIS Claims

Frequency of Data Collection:

○ **Monthly**

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- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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Health Homes Administrative Component: Core Measure Detail

Measure
Measure CBP-HH: Controlling High Blood Pressure

Measure Specification, including a description of the numerator and denominator.
The percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:
• Health Home enrollees ages 18-59 whose BP was <140/90 mm Hg.
• Health Home enrollees ages 60-85 with a diagnosis of diabetes whose BP was <140/90 mm Hg.
• Health Home enrollees ages 60-85 without a diagnosis of diabetes whose BP was <150/90 mm Hg.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: participating Health Home members whose diagnosis of hypertension is documented in the medical record on or before June 30 of the measurement year.
Numerator: the number of Health Home enrollees in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

• Health Home enrollees ages 18-59 as of December 31 of the measurement year whose BP was <140/90 mm Hg.
• Health Home enrollees ages 60-85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.
• Health Home enrollees ages 60-85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

Data Sources:
MMIS claims, Medical Record Review

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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Health Homes Administrative Component: Core Measure Detail

Measure
Measure CTR-HH: Care Transition - Timely Transmission of Transition Record

Measure Specification, including a description of the numerator and denominator.

The percentage of Health Home enrollees of all ages discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician or other health care professional designated for follow-up care, within 24 hours of discharge.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: participating Health Home members discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care, among enrollees of all ages.
Numerator: discharges of enrollees for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Data Sources:
MMIS claims, Medical Record Review

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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Health Homes Administrative Component: Core Measure Detail

Measure
Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Specification, including a description of the numerator and denominator.
The percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:
• Initiation of AOD Treatment: The percentage Health Home enrollees who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
• Initiated treatment: The percentage of Health Home enrollees who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: participating Health Home members with an AOD diagnosis
Numerator:
Rate 1: Health Home enrollees that had an Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalizaiton within 14 days of diagnosis.
Rate 2: Health Home enrollees that had an Engagement of AOD treatment with two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partical hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter.

Data Sources:
MMIS Claims

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

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collection to support quality indicators measuring program success.In addition to these BHSDStar tools, HSD will use their existing Predictive Risk Intelligence System (PRISM) web-based clinical decision support predictive modeling tool to provide critical insights via a claims-based view of the health service experiences of the CareLink NM beneficiaries. The key features of the PRISM application include: A claims-based view of the health service experiences of CareLink NM participants which contains comprehensive longitudinal health information derived from paid claims, managed care encounters, and utilization data; Integration of medical and behavioral health data to provide a comprehensive view of patient risk factors, service utilization and health outcomes; Uses state-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. At this time we do not anticipate systems based exchange, however this will be considered in the State's HIE initiative.

Health Homes Administrative Component: Core Measure Detail

Measure
Measure PQ192-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Measure Specification, including a description of the numerator and denominator.
The total number of hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months for Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; or angina without a cardiac procedure.
New Mexico HSD will follow current Technical Specifications for the Core Set of Health Care Quality Measures for Medicaid Health Home Programs Manual.
Denominator: The total number of months of Health Home enrollment for members 18 years during the measurement year.
Numerator: discharges for patients ages 18 and older, who meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQI):
PQI 1: Diabetes Short-Term Complications Admission
PQI 3: Diabetes Long-Term Complications Admission
PQI 5: COPD or Asthma in Older Adults Admission
PQI 7: Hypertension Admission
PQI 8: Heart Failure Admission
PQI 13: Angina without Procedure Admission
PQI 14: Uncontrolled Diabetes Admission
PQI 15: Asthma in Younger Adults Admission
PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

Data Sources:
MMIS Claims

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**

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○ **Continuously**

○ **Other**

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State Goals and Quality Measures

In addition to the CMS recommended core measures, identify the goals and define the measures the State will use to assess its Health Homes model of service delivery:

Health Home Goal		

PRA Disclosure Statement

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

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