Provider Policy Guide

2017

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Introduction

The purpose of the CareLink NM Provider Policy Manual is to provide a reference for the policies established by the New Mexico Human Services Department (HSD) for the administration of the CareLink NM Health Home (CareLink NM) program. The Manual was developed by the Medical Assistance Division (MAD) of HSD to assist in the administration of CareLink NM. Specifically, the Manual is intended to provide direction to the agencies who serve as CareLink NM Providers.

CareLink NM is a set of services authorized by Section 2703 of the Patient Protection and Affordable Care Act (P.L. 111-148, ACA). Care Link NM services are delivered through a designated provider agency (CLNM provider agency) to enhance the integration and coordination of primary, acute, behavioral, social health, and long-term services and supports. The CareLink NM provider agency assists a CareLink NM Member (CLNM Member) by engaging him or her through more direct relationships and intensive care coordination resulting in a comprehensive needs assessment (CNA) and plan of care (CLNM Service Plan). The provider agency also:

- Increases access to health education and promotion activities;
- Monitors the CLNM Member's treatment outcomes and utilization of resources;
- Coordinates appointments with primary care and specialty practitioners;
- Shares information among the Members physical and behavioral health practitioners to reduce the duplication of services, actively manages the transitions between services; and
- Participates as appropriate in the development of the CLNM Member's hospital or residential center discharge plan.

Authority

New Mexico implemented Centennial Care in 2014 to modernize New Mexico's Medicaid program and has developed a Health Home benefit for some of the most vulnerable members of New Mexico's population. The mission of CareLink NM is to promote self-management of care choices through a supportive learning environment, and to provide expanded support services such as case management and care coordination for all physical health, behavioral health, long-term care and other social needs such as housing, transportation, and employment. CareLink NM will provide integrated care for Medicaid recipients and Managed Care Organization (MCO) Members with chronic conditions, targeting a vulnerable population with behavioral health needs. The first phase of CareLink NM is for Medicaid eligible adults with Serious Mental Illness (SMI) and Medicaid eligible children and adolescents with a Severe Emotional Disturbance (SED).

The policies in this Manual will be reviewed on a periodic basis to determine needed changes. HSD reserves the right to change, modify or supersede any of these policies and procedures. As policies are revised, they will be incorporated into the Manual. The CareLink NM Provider Policy Manual may be viewed or downloaded from MAD's home page website at www.hsd.state.nm.us.

The Manual is intended to provide guidance. It will be issued and maintained by HSD. It is the responsibility of all entities affiliated with CareLink NM to review and be familiar with this Manual.

Introduction to the Health Home Model

Overview

HSD is leading the statewide initiative to provide coordinated care by a Health Home through CareLink NM for individuals with the aforementioned chronic conditions and all associated co-morbidities. The CareLink NM service delivery model will enhance integration and coordination of primary, acute, behavioral health, and long-term care services and supports for persons with chronic illness across the lifespan. The CareLink NM model enhances the efforts made through the development and implementation of the Centennial Care program to improve integrated care and enhance Member engagement in managing their health. In New Mexico's health home model, CareLink NM provider agencies will enhance their current operating structure to provide care coordination, partnering with physical health providers and specialty providers. CareLink NM provider agencies will utilize health information technology (HIT) to monitor care and provide comprehensive record management. CareLink NM provider agencies will serve fee-for-service (FFS) recipients and MCO Members already receiving behavioral health services as well as new individuals who elect, and are eligible, to participate.

Core Service Definitions

The CLNM provider agency must demonstrate the ability to provide all core services described in this Manual and meet all data and quality reporting requirements. The provider agency may elect to meet the service needs of CLNM Members by providing integrated physical and behavioral health services through an on-site, co-location model, or through a number of memoranda of agreements (MOA). MOAs are required with at least one primary care practice that serves CLNM Members under 21 years of age, and at least one primary care practice that serves CLNM Members 21 years of age and older. They are also required for local hospitals and residential treatment facilities. Other referral relationships are developed through less formal processes, but are critical for the multi-disciplinary team approach to integrated care.

Services that a provider agency must deliver to CLNM Members consist of six core service categories. These categories include Comprehensive Care Management, Care Coordination, Prevention and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Community and Social Support Service Referrals. The provider agency will also utilize CareLink NM health information technology. The following sections describe the six core service categories in greater detail.

Comprehensive Care Management

Comprehensive Care Management involves a comprehensive needs assessment and the development of an individualized service plan with active participation from the CLNM Member, family, caregivers and the health home team. Comprehensive care management activities include, but are not limited to:

CLNM Comprehensive Needs Assessment (CNA)

The provider agency is responsible for conducting the CareLink NM Needs Assessment for CLNM Members. The Needs Assessment determines needs related to the CLNM Member's physical and behavioral health, long-term care, social and community support resources and family supports.

- Uses the Comprehensive Needs Assessment tool provided by HSD (there is one for children and one for adults)
- Assesses preliminary risk conditions and health needs
- Determines care coordination level along with data from the risk management system
- Requires outreach to potential CLNM Member within 14 calendar days of receipt of referral
- Must be able to produce evidence that provider contacted and/or met with CLNM Member to at least begin assessment within required timeframe
- Initial needs assessment may be face-to-face in CLNM Member's home (if homeless, at a location mutually agreed upon)
- If the agency uses the Treat First clinical model, the CLNM Member may be enrolled upon first visit and placed in a "pending" status, or care coordinator level 8 until a diagnosis of SMI or SED is finalized, and member acceptance has occurred. The CNA can be completed over the course of four appointments and when completed the care coordination level is updated.
- Meets the NCQA standards relevant to the provider agencies

Note: This is not a psychiatric diagnostic evaluation (90791-92) to determine eligibility; it is a screening and assessment of service needs. If no diagnosis from previous records is available a psychiatric diagnostic evaluation must occur coincident with the CNA.

NOTE: For children involved with the NM Children, Youth, and Families Department in Protective Services and/or Juvenile Justice, there may also be a CANS (Child and Adolescent Needs and Strengths). However the Comprehensive Needs Assessment is still required.

Level of Care and CNA Frequency

- Care coordination level determines frequency of needs assessment
- MCO Health Risk Assessment (HRA) determines if CLNM Member requires care coordination level 1 or requires MCO CNA to determine level 2 or 3 (level 2 or 3 denotes a CLNM referral if qualifying diagnoses are present, and a level 1 that has not been reached but that has had BH services with a pertinent diagnosis may also be referred).
- Care coordination levels 6 or 7, assigned by the CLNM provider, have similar but not necessarily the same attributes as MCO care coordination levels 2 and 3; the different numbers are for system tracking purposes
- Level 8 care coordination is a temporary determination used for new admissions until the CNA and level determination are complete
- Level 6 care coordination requires needs assessment at least annually (caseload recommendation is 1:51-100)
- Level 7 care coordination requires needs assessment at least semi-annually (caseload recommendation is 1:30 – 1:50)
- If high fidelity wrap around services for children/adolescents are in place, level 9 caseload recommendation is 1:8 – 1:10.
- If a significant change in a CLNM Member's condition leads to increasing needs, the assessment timeframe is expedited and service changes are instituted within ten (10) calendar days

NOTE: Significant change might include becoming medically complex or fragile; identification of a substance dependency; diagnosis of significant cognitive deficits; or identification of contraindicated pharmaceutical use. In addition, the CareLink NM care coordinator should consider changes in housing, social supports or other non-medical factors that would indicate a need for additional support from the program

Requirements for Care Coordination Level 6

Based on the CareLink NM needs assessment, the CareLink NM provider shall assign care coordination level 6, at a minimum, to Members with one of the following:

- Co-morbid health conditions;
- High emergency room use (3 or more visits in 30 days);

- A mental health condition causing moderate functional impairment;
- Requiring assistance with two (2) or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues; and/or
- Poly-pharmaceutical use (simultaneous use of 6 or more medications from different drug classes and/or simultaneous use of 3 or more medications from the same drug class).

Requirements for Care Coordination Level 7

Based on the comprehensive needs assessment, the CareLink NM provider shall assign care coordination level 7, at a minimum, to Members with one the following:

- Who are medically complex or fragile;
- With excessive emergency room use (4 or more visits in a 12 month period);
- With a mental health condition causing high functional impairment;
- With untreated comorbid substance dependency based on the current DSM or other functional scale determined by the State;
- Requiring assistance with two (2) ADLs or IADLs living in the community at medium to high risk;
- With significant cognitive deficits; and/or
- With contraindicated pharmaceutical use.

CLNM Service Plan

The CareLink NM Service Plan maps a CLNM Member's path towards self-management of his/her condition, and is specifically designed to meet all of his/her needs and achieve his/her goals. The CareLink NM Service Plan is a document that shall be revised over time to consistently address identified needs, communicate the services a member will be receiving and serve as a shared plan for the member, their family and/or representatives and service providers.

- Uses the CareLink NM Plan provided by HSD
- Requires active participation from the CLNM Member, family, caregivers, and others on the team
- Consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, community benefit providers, and other providers
- Addresses all physical health, behavioral health, long-term care, social health, and other needs
- Organized around CLNM Members' goals, preferences and optimal clinical outcomes, including self-management; includes as many short and long term goals as needed

- Specifies treatment and wellness supports that bridge behavioral health and primary care
- Identifies additional health screenings
- Includes a *back-up plan* that addresses situations when regularly scheduled providers are unavailable and includes persons and agencies to contact. This is primarily for CLNM Members receiving Home and Community-Based Services where there is a NFLOC determination. There is no required template; the plan is uploaded as a file into BHSD Star.
- Includes a *crisis/emergency plan* listing steps CLNM Member and/or a representative will take in the event of an emergency that differ from the standard emergency protocol: these are individualized plans, uploaded as a file into BHSD Star.
- This is a service plan, supplemented by treatment plans that are developed by direct practitioners
- Copies provided to CLNM Members and their providers
- Updated as status changes

<u>CLNM Team</u>

- Develops treatment guidelines for health teams that establish clinical pathways across risk levels or health conditions
- Oversees implementation of CLNM Plans
- Monitors individual and population health status and service use to determine adherence to, or variance from, CLNM Plans and best practice guidelines (uses claims-based data sets and other tools to track population based care)
- Reports on progress toward meeting outcomes (client satisfaction, health status, service delivery and costs)

Care Coordination

Care Coordination activities are conducted with CLNM Members; their identified supports; medical and behavioral health; and community providers. Care is coordinated across and between care settings to implement the individualized CLNM service plan, coordinating appropriate linkages, referrals, and follow-up. Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support the CLNM Member's motivation to better understand and actively self-manage his or her health condition. Care coordination activities include, but are not limited to:

- Outreaches and engages CLNM Members
- Communicates with CLNM Member, family, and other providers and team members

- Ensures CLNM Members and their identified supports have access to medical, behavioral health, pharmacology and age-appropriate resiliency and recovery support services, and natural and community supports
- Ensures that these services are integrated and compatible as per the CLNM Service Plan
- Coordinates primary health care, specialty health care and transitional care from emergency departments, hospitals and psychiatric residential treatment facilities
- Assists with scheduling appointments
- Makes referrals and conducts follow-up monitoring
- Develops self-management plans with the CLNM Member
- Delivers health education specific to the CLNM Member's chronic conditions
- Meets the NCQA standards relevant to the provider agencies
- Coordinates with the MCO Care Coordinator when CLNM member has a nursing facility level of care (NFLOC)
- Conducts a face-to-face in home visit within two weeks of a NFLOC determination;
- Conducts a face-to-face visit to address health and safety concerns or other related reasons;

Prevention, Health Promotion, and Disease Management

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

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

- Uses Member-level, clinical data to address CLNM Member's specific health promotion, self-monitoring and self-care needs and goals; some of this can be made available from claims data in the data warehouse and assessment data in BHSDStar
- Develops disease management/self-management plans with the Member
- Delivers health education specific to the CLNM Member's chronic conditions

- Educates CLNM Members about the importance of immunizations and screening for overall general health
- Develops/provides health-promoting lifestyle programs and interventions in areas such as: substance use prevention and/or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, obesity reduction and prevention, increasing physical activity, improving social networks, self-regulation, parenting, life skills, and more.
- Uses evidence-based, evidence-informed, best emerging and/or promising practices for prevention, health promotion, and disease management programs and interventions
- Includes classes or counseling; can be provided on a group or individual basis
- Increases the use of proactive health promotion and self-management.
- Curriculums meet the needs of the population served; are innovative and measurable, and integrate physical and behavioral health concepts
- Tracks success of prevention, health promotion, and disease management programs and interventions, as well as identifies areas of improvement

- Meets the NCQA standards relevant to the provider agencies

NOTE: MCOs and the Department of Health are potential referral source for health promotion when agency and network of providers cannot meet a specific health promotion need.

Comprehensive Transitional Care

Health Homes are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement of CLNM Members between or within different levels of care, settings, or situations. Comprehensive transitional care is bidirectional, diverting CLNM Members from levels of care such as emergency department services, residential treatment, and inpatient hospitalization; and transitioning CLNM Members from these levels of care to outpatient services. Transition services reduce barriers to timely access; reduce inappropriate hospital, residential treatment, and nursing home admissions; interrupt patterns of frequent emergency department use; and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

This category of services should also be mindful of the transition to adulthood. Factors like shifting away from pediatric care providers or other practical concerns, as well as newly independent living arrangements, should be taken into consideration in the CLNM

Member's CareLink NM Plan. The CareLink NM provider agency will proactively work with CLNM Members who are reaching the age of majority to ensure appropriate supports and services are in place in the Member's CareLink NM Plan to assist in the successful transition to adulthood.

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

- Promotes the use of proactive health promotion and self-management
- Participates in all discharge/transition planning activities
- Coordinates with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS) and Tribal programs, and others to continue implementation of the CLNM Service Plan or modify it as appropriate
- Implements appropriate services and supports to reduce hospital emergency department use, hospital admissions and readmissions, homelessness, domestic violence and other shelters, residential treatment, prison, juvenile justice, protective services, treatment foster care, and other settings
- Follows-up with CLNM Members as they change levels of care or providers within the same level of care, to ensure timely access to follow-up care and other needed services and supports
- Shares critical planning and transition documents via web-based tools or via secure email or hard copy
- Facilitates the transition from child to adult services
- Facilitates the transition to long term services and supports

Individual and Family Support Services

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

- Supports the CLNM Member and family in the CLNM Member's recovery and resiliency goals
- Supports families in their knowledge of CLNM Members' disease processes and medication effects
- Enhances CLNM Member's, their family's and other supports' ability to manage care and live safely in the community
- Teaches CLNM Members and families self-advocacy skills and systems navigation

- Provides peer services and peer support groups
- Assist in accessing self-help activities and services
- Navigates the health care system to access needed services for CLNM Members and families
- Assists with obtaining and adhering to medications and other prescribed treatments
- Arranges for transportation to medically necessary services
- Identifies resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community
- Assesses impacts to family related CLNM Member's behaviors, and assisting with obtaining respite services as needed
- Assist with obtaining and adhering to medications and other prescribed treatments
  Identifies resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community

Referral to Community and Social Support Services

Referrals to community and social support services help overcome access and service barriers, increase self- management skills, and improve overall health. Providers identify available and effective community-based resources and actively link and manage appropriate referrals. Linkages reflect the personal needs of the client and are consistent with the CLNM Service Plan. Community and Social Support Service referral activities may include, but are not limited to:

- Identifies and partners with available community-based and telehealth resources such as medical and behavioral health care, Durable Medical Equipment, legal services, housing, respite, educational supports, employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, transportation, personal needs, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and culturally specific programs such as veterans or IHS and Tribal programs.
- Develops referral and communication protocols, outlined in MOAs where required
- MOAs are required with at least one primary care practice that serves CLNM Members under 21 years of age, and at least one primary care practice that serves CLNM Members 21 years of age and older. They are also required for local hospitals and residential treatment facilities. See the section below on "Referrals and Communication."
- Other MOAs could be with agencies with whom the provider agency will work most closely.

- For partnerships that require MOAs, the referral process shall include acknowledgment of the referral and follow-up with the CLNM Member by both participating partners. Once a referral is made, the health care provider also has access to relevant data on the CLNM Member, including his or her CLNM assessment and Service Plan, unless the CLNM Member does not authorize such data exchange.
- Makes referrals and provides assistance to obtain and maintain eligibility for services
- Actively manages appropriate referrals and access to care
- Confirms client and provider's encounters and continuing follow up post referral

Use of Best Practices

The following best practices are fundamental to providing both these core services and all other services and to facilitate the success of CareLink NM:

- Provide quality-driven, cost-effective, culturally appropriate, and person and family centered health homes services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health services;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings to include appropriate follow up from inpatient to other settings, participate in discharge planning and facilitate transfer from pediatric to adult health care system;
- Coordinate and provide access to disease management for chronic illnesses and all co-morbidities, including self-management supports to individuals and to their families;
- Coordinate and provide access to community referrals, social supports and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop and maintain a CareLink NM Plan for each individual that integrates the whole-person model of healthcare needs and services that is culturally sensitive to the individual;
- Demonstrate a capacity to use HIT to link services, facilitate communication between team members, and providers; and
- Establish a continuous quality improvement program and have the ability to collect and report on data to evaluate effectiveness of CLNM Member outcomes.

Use of Health Information Technology to Link Services

The provider agency will be responsible for using HIT to link services as feasible and appropriate. The Comprehensive Needs Assessment, CareLink NM Service Plan, critical planning and transition documents, and MCO or FFS utilization information will be available via BHSDStar, other web-based tools, or they may be shared via secure data exchange, email or hard copy. BHSDStar will be developed in modules and will be used to collect and share information for tracking and care integration. To support use of BHSDStar and other web-based data tools, the provider agency must have computers and an internet connection.

As outlined in the Health Information Technology section later in the Manual, the BHSDStar web-based data collection tool will be used to create participant records that are specific to CareLink NM. BHSDStar will also provide support for the bidirectional data exchange with CLNM agency's EHRs .

Target Populations

The target population of the CareLink NM program is individuals enrolled in Medicaid, including Medicaid recipients in FFS and MCO Members, who are diagnosed with one or more Serious Mental Illness (SMI) or Severe Emotional Disturbance (SED) as defined by the State of New Mexico. The CareLink NM program will be implemented in a phased approach based on geographic location of the CLNM providers. In order to be eligible for enrollment in CareLink NM, an individual must be enrolled in Centennial Care or Medicaid FFS, and have one or more SMI or SED. Once enrolled in the CareLink NM program, participants are referred to as CLNM Members, not to be confused with FFS Recipient or MCO Member which refers to their type of Medicaid participation.

Participation Requirements for Providers

Enrollment as a Medicaid Provider & contracting with the MCOs

Services provided to CLNM Members are furnished by a variety of providers and provider groups. A CareLink NM provider agency must first be enrolled as a New Mexico Medicaid provider and meet all applicable standards. A provider agency must also either update existing contracts with all Medicaid MCOs, or develop a new contract if none exists. The CareLink NM provider agency applicant must also meet the other provider qualifications and standards outlined in this manual, complete a CareLink NM application, and provide services in a county approved for Health Homes by the Centers for Medicare & Medicaid Services (CMS) through a State Plan Amendment (SPA) and pass a readiness review process.

Staffing Requirements

Staffing requirements outline internal staff each provider agency must retain, what their qualifications must be, and for certain staff positions, how many individuals must be retained to meet staff to patient ratios.

The following individuals and practitioners with the corresponding qualifications must be contracted or employed by the provider agency as part of its CareLink NM service delivery:

1. A ***Director*** who is specifically assigned to CareLink NM service oversight and administrative responsibilities.

2. 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, healthy weight management. This position also identifies gaps in disease management programming based on the specific CLNM population.

3. ***Care Coordinators***, who develop and oversee a CLNM Member's comprehensive care management and the planning and coordination of all physical, behavioral, and support services. Care Coordinators:

    a. Are Regulation and Licensing Department (RLD) licensed behavioral health practitioners; or
    b. Hold a bachelor's degree and/or two (2) years of relevant health care experience.

The provider agency must employ enough care coordination staff to meet the recommended ratios and meet the needs of the CLNM Members' receiving CareLink NM service. Recommended ratios for Care Coordinator to CLNM Member are:

Care Coordination Level 6 - chronic conditions not yet stabilized 1:51 – 1:100

Care Coordination Level 7 - multiple chronic conditions with little self-management skills 1:30 – 1:50

Individual caseloads for each Care Coordinator may vary based on the needs of individual CLNM Members and the distance from the practice a Care Coordinator must travel to serve the CLNM Members.

4. 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, including IHS and Tribal programs as appropriate. 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.

5. ***Certified Peer Support Workers*** (CPSW) and ***Family Peer Support Workers*** (FPSW) with lived experience who are certified through the State. While peers and family members will provide a number of individual and family support services, they can also be hired for any positions for which they qualify. Positions can be filled by contract and need not be full time. The New Mexico Credentialing Board for Behavioral Health Professionals (NMCBBHP), info@nmcbbhp.org, the BHSD's Office of Peer Recovery and Engagement (OPRE), opre.bhsd@state.nm.us, and CYFD's Behavioral Health Services (Nicole.MontoyaJones2@state.nm.us) can assist in linking you to peer and family support workers.

6. A ***Supervisor*** of the care coordinators, 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.

7. 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.

8. 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.

For a provider agency that renders both physical health and behavioral health services on-site, additional staff may already be on board. Examples include: nurses, physician's assistants, pharmacists, social workers, nutritionists, dietitians, Tribal practitioners, licensed complementary and alternative medicine practitioners, exercise specialists, and more. These specialized staff could also be considered even if services are not co-located; they are however not required.

Data Requirements

The CareLink NM provider agency is responsible for collecting data that supports care integration, tracking of opt in/opt out affirmation, member authorized data sharing agreement information as well as assessments, CareLink NM Plans and information for a continuous quality improvement program. The data collected must be sufficient to fully inform ongoing quality measurement, an evaluation of 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. There are eight health home quality

indicators mandated by CMS and additional state defined criteria outlined in the quality section of this manual.

Data collection and reporting require use of the web-based tool, BHSDStar, which will collect and record information regarding CareLink NM participants registration in CareLink NM, assessments, the CareLink NM Service Plan, referrals and call tracking, opt in/opt out affirmed status and data sharing agreement information. To support use of this and other web-based data tools, the provider agency must have computers with an internet connection.

Utilizing a combination of the Omnicaid (for FFS claims and encounter data) and BHSDStar (registration and tracking CareLink NM modules), the CareLink NM provider will utilize the following rules:

In BHSDStar:

1. A Medicaid recipient can be in CareLink NM if he/she is in FFS or in Managed Care;
2. A CLNM Member cannot be in more than one CareLink NM Health Home at the same time and cannot have more than one value for Care Coordination at the same time;
3. The MCO is not allowed to enroll a Medicaid recipient into CareLink NM, the CareLink NM provider will complete this task; and
4. If the CLNM Member enrolled into CareLink NM is in Centennial Care, Omnicaid will generate a file to the MCO to show the CLNM Member enrollment in CareLink NM. This is accomplished through a nightly roster update.

In OMNICAID:

The Health Home level will be captured in the Care Coordination Level code field (either Value '6' or '7' or '8' or '9'). The Health Home Type will always be entered as value 'C' for CareLink NM and the Health Home Effective and End Dates on the incoming file from BHSDStar will also be used to fill in the Care Coordination Effective and End dates. There will be basic editing on the incoming file to ensure that the errors below do not occur. If these errors occur, it will cause the incoming record to be rejected and be reported back to BHSDStar on a "reject file" which has all the same elements of the incoming file plus the corresponding error message.

1. The CLNM Member Medicaid ID, Name and DOB do not match the client on Omnicaid; verify the client is correct in the same manner as used by the MCO for the HSD Interface file, by comparing last name and DOB. If either of these matches, then the client is considered to be verified. For the last name verification, the last name is only checked up to the first space. For example, if the Last Name field in Omnicaid contains 'SMITH JR', only 'SMITH' is used in the comparison. The birthday from the

input file (CCYYMMDD) is reformatted and compared to the B_DOB_DT from Omnicaid. If neither of these fields match, an error condition exists and no subsequent errors will be done;

2. The CLNM Member on Omnicaid is not eligible for Medicaid for the dates of service on the incoming file;
3. The incoming Care Coordination Level is a value other than '6' or '7' or '8' or '9' (the only valid entries for the file from STAR);
4. The incoming Health Home Type is anything other than value 'C';
5. The client already has a CareLink NM Health Home entry with dates that overlap the incoming span;
6. The Health Home Effective date is an invalid date or greater than the Health Home End Date;
7. The Health Home Provider NPI on the incoming file is not a valid NPI or the provider does not have the Health Home indicator checked or the provider is not active with status 60 or 70 for the dates on the incoming file;
8. The incoming Health Home span is for a CLNM Member for whom an existing open Health Home type 'A' or 'B' exists, error with the message that the client has existing Health Home value A or B ; and
9. The incoming Health Home span is for a CLNM Member for whom an existing open Health Home type 'C' exists but with a different Health Home Provider and overlapping dates, error with the message that existing Health Home different provider exists.

The incoming file dates will be edited in the following way:

1. The incoming Health Home End Date can be open-ended;
2. If the CLNM Member already has a Care Coordination entry with a Value other than '6' or '7' or '8' or'9' that has an open-ended date, close the existing span one day prior to the effective date on the incoming CareLink span;
3. If the CLNM Member already has a Care Coordination entry with the same Value as on the incoming ('6' or '7' or '8' or '9') and the begin date is prior to the existing date for that Value and Provider ID is the same, update the begin date of the existing Health Home span; and
4. If the incoming contains a Health Home span end date for a CLNM Member with an existing open-ended span, this will cause that span to be end-dated.

For those CLNM Members who receive Medicaid services through the FFS system, the reporting and data exchange will occur directly with Omnicaid. For MCO Members', data exchange will occur either through the Omnicaid roster upload to the MCOs, or for other information exchange directly with the MCOs.

Application Process

In order to enroll as a provider agency, the provider must complete an application that will be reviewed by the CLNM Steering Committee. The CareLink NM application consists of a request for information about the service provider, population served, some behavioral and physical health integration activities, screening and treatment service checklist, a provider and partner outreach and engagement plan, among other requests for information. The applicant must also agree to comply with all Medicaid program requirements. The application can be found at the following link:

http://www.hsd.state.nm.us/uploads/files/CareLink%20NM%20Provider%20Agency%20Application.pdf

Guidelines for submitting the application can be found at the following link:

http://www.hsd.state.nm.us/uploads/files/CLNM%20Application%20Guidelines.pdf

After submitting the formal application, the Steering Committee will review content to ensure it is sufficient and meets the provider and service requirements. If approved, MAD will notify the applicant and will then arrange a readiness review assessment to be conducted by the CLNM Steering Committee.

Readiness Requirements

The Steering Committee will conduct readiness reviews, consisting of pre and post-implementation assessments, with all selected applicants to evaluate their readiness to meet the service requirements of CareLink NM. Following implementation, the Steering Committee will assess the indicators of program implementation from enrollment data, CLNM Member engagement, claims/encounter data, CLNM Member assessment data and interim progress reports from the operating provider agency. The CLNM Steering Committee is comprised of MAD staff, the Behavioral Health Services Division (BHSD), Children, Youth and Family Department (CYFD), UNM psychiatric consultation, and the four MCOs.

As HSD evaluates the outcomes of CareLink NM services and the current delivery system, additional qualifying chronic conditions or other changes to the program may be implemented. The State reserves the right to conduct additional readiness assessments based on program changes or additions over time.

Health Home Operations

Identifying Members

Individuals identified for enrollment in CareLink NM will meet the following criteria:

1. Medicaid enrollee in a "full" program eligibility category (excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries (QMB and SLIMB)), including FFS recipients or MCO Members, who are 18 years of age or older and meet the criteria for SMI; or
2. A Medicaid enrollee in a "full" program eligibility including FFS recipients or MCO Members, who are under age 18, or 21 years of age if services were received prior to age 18, who meets criteria for SED

The criteria for SMI and SED diagnosis can be found in Appendix A of this Policy Manual. Individuals eligible for enrollment in CareLink NM will be identified broadly by HSD, MCOs, the CareLink NM provider agency, community members, and hospital emergency departments (EDs). These processes are outlined in greater detail in the following Enrollment/Disenrollment section.

Enrollment/Disenrollment

Enrollment of Centennial Care Members

MCO Members who meet the eligibility criteria for the program will either be automatically uploaded to the BHSD Star registration system for program and phase 2 start-up or be referred via e-mail to a CLNM HH as new members are identified by the MCO or other referring entity. These eligible individuals must affirmatively agree to opt into CareLink NM no later than 90 calendar days from notification of the automatic upload or referral by signing an opt-in form. Medicaid recipients may also contact participating CareLink NM agencies, their assigned MCO, or HSD to determine if they are eligible for CareLink NM.

Though enrollment can occur at any time within a calendar year, opting out can only occur at the anniversary date of their enrollment except in the following circumstances:

- When being originally registered and interviewed at which time the enrollee may decide they are not interested and can be opted out;
- If they no longer meet the SMI or SED criteria, e.g. have stabilized with no functional impairments;
- Have moved away from the area;
- Have lost their Medicaid eligibility;
- Are dissatisfied with the program and request a panel decision to transfer their care coordination to the MCO or discontinue care coordination if FFS. The panel will

consist of the CLNM agency staff and the relevant MCO.

Method 1:

For Members enrolled in Centennial Care who are eligible for CareLink NM services, and *have already engaged with a CareLink NM provider agency*, the MCO and the CareLink NM provider will identify and contact these individuals for enrollment in CareLink NM. The MCO will send a form letter to the Member, co-branded by both the MCO and MAD, informing the individual of CareLink NM and their enrollment in the program. If the letter is returned to the MCO as not delivered, the MCO will send the returned letter to the CareLink NM provider agency, which is then responsible for making address corrections and resending to Members.

Method 2:

<u>For counties in which there is only one CLNM NM Health Home</u>

For current MCO Members who are potentially eligible for CareLink NM services, but *have not engaged directly with a CareLink NM provider agency*, the MCOs and CareLink NM will work to engage and enroll those eligible for services. In these cases, the MCO will send a letter to Members with a behavioral health diagnosis listed within the SMI/SED criteria living in an eligible county. The letter will inform them of the CareLink NM program, their potential eligibility, and that they will be contacted by the CLNM agency to introduce the program and ascertain their interest in participating. Concurrent to this, the list of potential CLNM members will be uploaded to the BHSD Star system as a "registrant". The CLNM agency will contact the MCO member to arrange an appointment for an evaluation to determine eligibility and interest. For Members identified through this process who express interest in participating, the CLNM agency will opt them in. If unable to contact within 90 days, or the member has expressed disinterest, the CLNM NM provider agency will opt them out. Both of these communications will go through Omnicaid to the MCO on a nightly basis, and the MCO will either transfer care coordination to the CareLink NM provider, or keep care coordination within the MCO, whichever is applicable. For those who do not meet the SMI/SED criteria after evaluation, the CareLink NM provider agency will inform the Member that they will continue to receive care coordination services through the MCO. The CareLink NM provider, upon permission from the MCO member, will transmit the clinical record to the MCO advising them there was no SMI/SED.

For individuals newly enrolled in Centennial Care who have had their HRA conducted and are potential candidates for meeting the CareLink NM qualifications for participation, the MCO will inform the Member they are a potential candidate for the CLNM health home, and will be referred to the CLNM agency for evaluation. They will follow the above process but rather than having an individual automatically uploaded into the BHSD Star system, they will e-mail a referral to the CLNM agency.

<u>For Counties in which there are more than one CLNM Health Home</u>

The MCO will send a letter to Members with a behavioral health diagnosis listed within the SMI/SED criteria living in an eligible county. The letter will inform them of the CareLink NM program, their potential eligibility, and that they will be contacted by the CLNM HH of their choice to introduce the program and ascertain their interest in participating. The letter will contain a brief description and location of each CLNM HH in their county, and request they contact HSD with their choice upon which they will be referred to that CLNM HH. HSD will then place the Member on the list of referrals for the chosen CLNM HH which will be uploaded to BHSD Star as registrants. From that point forward, the above process will be utilized.

Enrollment of FFS Recipients

For Medicaid recipients enrolled in FFS Medicaid who are eligible for CareLink NM services and *have already engaged with a provider agency*, the provider agency will be responsible for identifying and contacting the individual for enrollment in CareLink NM. Their registration information will be uploaded in the registration module by Falling Colors, the BHSDStar IT vendor. The provider agency will not automatically enroll these Medicaid recipients. Instead, the provider agency will conduct outreach to these individuals on the benefits of CareLink NM to encourage opt-ins to the program. The CareLink NM agency will then either opt the registered FFS member in or out of CareLink NM through the activation module.

Medicaid recipients enrolled in FFS Medicaid, who may be eligible for CareLink NM services, but *have not engaged directly with a provider agency*,

<u>For Counties in which there is only one CLNM NM Health Home</u>

HSD will send a letter to recipients with a behavioral health diagnosis listed within the SMI/SED criteria living in an eligible county, informing them of the CareLink NM program, their potential eligibility, and information that they will be contacted by the CLNM HH to introduce the program and ascertain their interest in participating. Concurrent to this the list of potential CLNM members will be uploaded to the BHSD Star system as a "registrant". The CLNM agency will contact the recipient to arrange an appointment for an evaluation to determine eligibility and interest. For recipients identified through this process who express interest in participating, the CLNM HH will opt them in. If unable to contact within 90 days, or the member has expressed disinterest, the CLNM NM HH will opt them out. The individual's "activation status" documented in the BHSDStar "activation module" is transmitted to Star/Omnicaid on a nightly basis.

<u>For Counties in which there are more than one CLNM Health Home</u>

HSD will send a letter to recipients with a behavioral health diagnosis listed within the SMI/SED criteria living in an eligible county, informing them of the CareLink NM program, their potential eligibility, and a unique description of each of the CLNM HHs. The letter will

advise the Member they can be referred to any of the above HHs and can expect a call to determine which they would like to visit for an introductory interview and decision as to whether or not they are interested in membership. They will then be referred to that HH and can expect a call for an appointment. At the time of the first call and selection of the CLNM HH HSD will place them on the registration list for that CLNM for future automatic upload to the BHSD Star system. From that point forward, the above process will be utilized.

"Walk-ins" to a CLNM Health Home

For individuals who are not currently members of a CLNM HH and are being seen for the first time in a CLNM HH, if upon initial screening they are seen to be a potential candidate for the HH, the agency may introduce the program and opt them in if interested. This communication will go to the MCO in the normal way.

Registered Members that cannot be located

Centennial Care enrollees who meet the CareLink NM eligibility criteria and have been automatically registered in CareLink NM have 90 days to affirmatively opt-in to the program. However, there are circumstances that may arise when the provider agency may fail to make contact with the Member to receive an affirmative program opt-in. If after 90 days of good faith efforts to make contact with the Member, the provider agency is unable to locate the Member, the provider agency is to follow the process of opting-out that Member in BHSDStar. The provider agency should also note in BHSDStar that the Member was not able to be located.

If during the enrollment process, the eligible CLNM Member refuses to sign consent forms or data sharing agreements necessary to share confidential information with and among providers, the provider agency should inform the individual that information sharing is necessary for their care management. If the eligible CLNM Member still refuses to sign, the provider agency has the option of opting-out this Member. The provider agency should note the reason for the opt-out in BHSDStar.

A form documenting that CLNM Members have elected to affirmatively agree to opt into CareLink NM must be retained on file in order to receive reimbursement for delivery of CareLink NM services. The activation information can be entered in BHSDStar at any time, and will be automatically transmitted to the Omnicaid system and subsequently to the MCO daily; however, the effective date of enrollment can only be the first day of each month. It is the responsibility of the CareLink NM provider agency to communicate this information to the potential CLNM Member. If the delivery of services, including a diagnostic evaluation to

determine eligibility, occurs before enrollment or before the first day of the month, the CareLink NM agency will bill the MCO or Conduent for each service rendered.

Information from MCO on Enrollment

In cases where the MCO is already providing services to the CLNM Member, the following documents/information may be transferred from the MCO to the CareLink NM via the DMZ file or secure e-mail, or any other secure method the two parties have agreed upon. If this information is unavailable, the MCO is to note the reason such as, "CNA not completed" or "no signed release of information."

Documents to be Provided if existing:

History & Physical
Individualized Service Plans
Health Risk Assessment
Comprehensive Needs Assessments
Functional Assessment
Current MCO Care Plan
Emergency & Back-up Plan
Behavioral Health – Co-management Summary Notes
Client Contact Special Considerations
Care Coordination Plans for Individuals with Special Health Care Needs (ISHCN)
Advance Directive

Member Disenrollment

Every CLNM Member has the right to opt out of, or disenroll from CareLink NM at the end of their anniversary year. Opting out or disenrolling from CareLink NM does not affect access to services for the individual with the exception of CareLink NM specific health home services offered only to participants in the health home program. A form documenting that Medicaid recipients have elected to opt out of CareLink NM must be retained on file. To disenroll, the CLNM Member must contact his/her CareLink NM provider agency who will in turn opt them out in the BHSDStar activation module. The BHSDStar system interface will transmit this information to Omnicaid, which will then transmit the same information to the pertinent MCO. For Medicaid Members who choose to disenroll from CareLink NM, the MCO will resume care coordination activities and change the Member's care coordination level back to a "2" or "3." Additionally, the CareLink NM provider agency will work with the MCO in delivering a "warm transfer" of the individual to the MCO to assume or resume its care coordination activities.

Program Disenrollment

Disenrollment can also occur when a CLNM Member no longer meets the program's eligibility criteria. This may occur because a CLNM Member loses Medicaid eligibility. The CareLink NM agency may discover this by verifying eligibility upon a service appointment. The CLNM Member may or may not notify the provider agency or its provider network of this change. If this information is conveyed to the provider agency by the CLNM Member, or discovered in another way, the provider agency will immediately opt the individual out in BHSDStar with an effective end date of the end of a month. This will be communicated to the MCO through the Omnicaid roster update.

Accessibility to CareLink NM Members—Hours of Operation

Each CareLink NM provider agency shall have a plan for providing necessary care coordination services outside of regular business hours (9:00 AM – to 5:00 PM). The "outside of regular business hour" operations mean compliance with Section 8.321.2 of New Mexico Administrative Code (NMAC). NMAC Section 8.321.2 states that a specialized behavioral health provider "must maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the Medicaid eligible recipient, make referrals as necessary and provide follow-up to the Medicaid eligible recipient." The CLNM Members should be provided with information about how to reach their care coordinator or another qualified member of the CareLink NM team in an emergency situation that may occur evenings or weekends.

HIPAA

The provider agency must comply with applicable provisions of the federal Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191). This includes, but is not limited to, the requirement that the provider agency's management information system (MIS) complies with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. The provider agency must also comply with HIPAA electronic data interchange (EDI) requirements and notification requirements, including those set forth in the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act, P.L. 111-5).

The provider agency shall notify the MCO and HSD of all breaches or potential breaches of unspecified PHI, as defined by the HITECH Act, without unreasonable delay and in no event later than thirty (30) calendar days after discovery of the breach or potential breach. If, in HSD's determination, the CareLink NM provider has not provided notice in the manner or format prescribed by the HITECH Act, then HSD may require the CareLink NM provider to provide such notice.

Disclosure and Confidentiality of Information

Confidentiality

The provider agency, its employees, agents, consultants or advisors must treat all information that is obtained through a CLNM provider's delivery of the services including, but not limited to, information relating to CLNM Members, potential recipients of HSD and the associated providers, as confidential information to the extent that confidential treatment is provided under State and federal law, rules, and regulations.

The provider agency is responsible for understanding the degree to which information obtained through the performance of this service is confidential under State and federal law, rules, and regulations.

The provider agency and all consultants, advisors or agents shall not use any information obtained through performance of this service in any manner except as is necessary for the proper discharge of obligations and securing of rights under this service.

Within sixty (60) calendar days of the effective date of service implementation, the provider agency shall develop and provide to the CareLink NM Steering Committee for review and approval, written policies and procedures for the protection of all records and all other documents deemed confidential.

Any disclosure or transfer of confidential information by the provider agency will be in accordance with applicable law. If the provider agency receives a request for information deemed confidential under this Agreement, the provider agency will immediately notify the MCO or MAD of such request, and will make reasonable efforts to protect the information from public disclosure.

In addition to the requirements expressly stated in this Section, the provider agency shall comply with any policy, rule, or reasonable requirement of HSD that relates to the safeguarding or disclosure of information associated with CLNM Members, the provider agency's operations, or the provider agency's performance of this service.

In the event of the expiration of this service or termination thereof for any reason, all confidential information disclosed to and all copies thereof made by the provider shall be returned to HSD or, at HSD's option, erased or destroyed. The provider agency shall provide HSD with certificates evidencing such destruction.

The provider agency's contracts with practitioners and other providers shall explicitly state expectations about the confidentiality of HSD's confidential information and CLNM Member records.

The provider agency shall afford CLNM Members and/or Representatives the opportunity to approve or deny the release of identifiable personal information by the provider agency to a person or entity outside of the provider, except to duly authorized providers or review organizations, or when such release is required by law, regulation or quality standards.

The obligations of this Section shall not restrict any disclosure by the provider pursuant to any applicable law, or under any court or government agency, provided that the provider shall give prompt notice to HSD of such order.

Disclosure of HSD's Confidential Information

The provider will immediately report to HSD and MCOs as appropriate, any, and all unauthorized disclosures or uses of confidential information of which it or its consultants, or agents is aware or has knowledge. The provider acknowledges that any publication or disclosure of confidential information to others may cause immediate and irreparable harm to HSD and may constitute a violation of State or federal statutes. If the provider, its consultants, or agents should publish or disclose confidential information to others without authorization, HSD will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HSD will have the right to recover from the provider all damages and liabilities caused by or arising from the provider's, its representatives', consultants', or agents' failure to protect confidential information. The provider will defend with counsel approved by HSD, indemnify and hold harmless HSD from all damages, costs, liabilities, and expenses caused by or arising from the providers', representatives', consultants' or agents' failure to protect confidential information. HSD will not unreasonably withhold approval of counsel selected by the CareLink NM Health Home.

The provider will require its consultants, and agents to comply with the terms of this Section.

Member Records

The provider shall comply with the requirements of State and federal statutes, including the HIPAA requirements set forth in this Agreement, regarding the transfer of CLNM Member records.

The provider shall have an appropriate system in effect to protect substance abuse CLNM Member records from inappropriate disclosure in accordance with 42 U.S.C. § 300x-53(b), and 45 C.F.R. § 96.13(e).

If this Agreement is terminated, HSD may require the transfer of CLNM Member records, upon written notice to the provider, to another entity, as consistent with federal and State statutes and applicable releases.

The term "Member record" for this Section means only those administrative, enrollment, case management and other such records maintained by the provider and is not intended to include patient records maintained by participating Contract providers.

Requests for Public Information
When the provider produces reports or other forms of information that the provider believes consist of proprietary or otherwise confidential information, the provider shall clearly mark such information as confidential information or provide written notice to HSD that it considers the information confidential.

If HSD receives a request, filed in accordance with the New Mexico Inspection of Public Records Act (IPRA), NMSA 1978, 14-2-1 et seq. seeking information that has been identified by the provider as proprietary or otherwise confidential, HSD will deliver a copy of the IPRA request to the provider.

Unauthorized Acts
Each Party agrees to:

- Notify the other Parties promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any confidential information or any information identified as confidential or proprietary;
- Promptly furnish to the other parties full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Parties in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of confidential information;
- Cooperate with the other parties in any litigation and investigation against third parties deemed necessary by such party to protect its proprietary rights; and
- Promptly prevent a recurrence of any such unauthorized possession, use, or knowledge of such information.

Information Security
CareLink NM and all its consultants, representatives, providers and agents shall comply with all applicable statutes, rules, and regulations regarding information security, including without limitation the following Centennial Care Agreement Requirements:

7.26.6.1.1	Health and Human Services Enterprise Information Security Standards and Guidelines;
7.26.6.1.2	HIPAA;
7.26.6.1.3	HITECH Act; and
7.26.6.1.4	NMAC 1.12.20 et seq.

Referrals and Communication

The provider agency is required to meet the integrated physical, behavioral, and long-term health needs of its CLNM Members by partnering with physical and behavioral health providers, support service agencies, and long-term care providers. This will require referral

and communication protocols, which in some instances, are to be outlined in MOAs. MOAs are required for at least one primary care practice in the area that serves CLNM Members under 21 years of age, at least one primary care practice that serves CLNM Members 21 years of age and older, and with local hospitals, and residential treatment facilities. MOAs are not required for support services agencies such as food banks. The MOAs and other referral and communication protocols will be submitted to the Steering Committee for review as part of the application or readiness review process or through other means. There are different expectations of referral and communication protocols where MOAs are required and are not required. For partnerships that require MOAs, the referral process shall include acknowledgment of the referral and follow-up with the CLNM Member by both participating partners. Once a referral is made, the health care provider also has access to relevant data on the CLNM Member, including his or her CareLink NM Service Plan, unless the member does not authorize such data exchange.

For example, if a CLNM Member is referred for follow-up primary care, the provider agency will work with the CLNM Member and its partner primary care office to schedule the follow-up care. Once the referral has been finalized, the primary care office will then have access to relevant health data on the CLNM Member and will provide necessary follow-up care. After care is scheduled to occur, the provider agency will confirm that the appointment did take place and check on outstanding care or treatment issues that were brought to light during the appointment. As part of the provider agency's reporting requirements, the communication loop of referrals and follow-up will be tracked.

For partnerships where *MOAs are not required*, there should be a good faith effort by the provider agency to ensure that the support services are delivered. The provider agency must 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 health care benefits eligibility, disability benefits, housing, legal services, educational supports, employment supports, IHS and Tribal programs, Durable Medical Equipment (DME), and other personal needs consistent with recovery goals and the CareLink NM Service Plan. The care provider or care coordinator will make referrals to community services, link clients with natural supports and assure that these connections are solid and effective. For referrals like DME, a care coordinator will work with the Member's physical health providers and MCOs to obtain necessary DME. The care coordinators are responsible for documenting the outcome of the referral including noting that the Member and/or Provider followed up and any additional recommendations resulting from the referral.

Grievances and Appeals

CareLink NM care coordinators will be responsible for assisting CLNM Members with appeals and grievances, including, but not limited to reporting member grievances and

explaining the right of appeal process to members. Communication will be established with the member's MCO and/or HSD for instructions on how to file grievance paperwork, how to file an appeal including applicable timeframes, and what department to contact with grievance and appeals issues. Procedures for grievances and appeals shall follow the requirements described in 8.308.15 NMAC.

Critical Incident Reporting

All providers rendering Medicaid funded services to the HCBS (Home and Community Based Services) population, including CareLink NM provider agencies, are required to report critical incidents. The MCO is required to research and investigate the critical incident and will collaborate with the CareLink NM care coordinator to fulfill this requirement for critical incident reports involving CareLink NM members. New Mexico State statutes and regulations define the expectations and legal requirements for properly reporting recipient involved incidents in a timely and accurate manner. The CareLink NM provider agency is responsible for understanding and complying with these requirements.

To assist CareLink NM provider agencies in understanding and complying with critical incidence reporting, the "Critical Incident Management Guide and Critical Incident Training Guide" is available at the following address: https://criticalincident.hsd.state.nm.us/Default.aspx. For questions about obtaining passwords and access to the reporting portal, email the HSD Critical Incident team at: HSD-QB-CIR@state.nm.us.

MCO Role

The MCO will serve a complementary, but not duplicative, role in the delivery of CareLink NM services. The MCO role begins with identifying and contacting their Members who meet the eligibility criteria and have engaged with the provider entity for enrollment in CareLink NM. The MCO may also refer Members for CareLink NM enrollment that are otherwise eligible, but have not engaged with a provider agency. In addition, MCOs have the following responsibilities:

- Conducting Member initial HRAs including initial recommendation and referral to the CareLink NM provider agencies throughout the year;
- Conducting the Nursing Facility Level of Care (NFLOC) assessment including the Centennial Care Community Benefit Service Questionnaire (CBSQ) with the CLNM Care Coordinator, and providing results to be incorporated into the CLNM Service Plan; (see more on NFLOC below);
- Processing of prior authorization requests from the CareLink NM provider;
- Processing and oversight of all CLNM Member claims and/or encounter data; and

- Establishing per member per month (PMPM) payment agreement on the pass-through of care coordination reimbursements from the State to the provider agency.

The MCOs are also responsible for developing a contract amendment template, which will be used to amend MCO contracts with CareLink NM provider agencies. The contract amendment template is to include the following clarifying information: that CLNM Members are excluded from the MCO care coordination ratio requirements; different timelines are allowed for completing CNAs and CareLink NM Service Plans for CLNM Members; and HRA requirements for the MCO are waived if an HRA has not been completed.

Emergency Department, Inpatient Admissions and Residential Services

CLNM provider agencies are responsible for taking a lead role in transitional care activities including the interruption of patterns of avoidable hospital emergency department (ED) use and inpatient stays followed by an unplanned readmission by CLNM Members. Provider agencies will work with health care providers and CLNM Members to support proactive health promotion and self-management to ensure timely follow up appointments to prevent non-emergent use of the ED and unplanned readmissions. When a CLNM Member uses services in the ED, participating hospitals are required to refer them to provider agencies. This is a requirement of Section 2703 of the ACA. ED and Hospital referral protocols should be established in MOAs with hospitals in the geographic vicinity. The MCOs will provide surrounding Hospital daily census to the CLNM providers to assist in monitoring CLNM Member utilization.

Nursing Facility Level of Care (NFLOC)

In some cases, the CareLink NM provider agency may have CLNM Members who also meet a NFLOC. For CLNM Members who have indicators for community-based long-term services and supports, the CareLink NM care coordinator must ask the CLNM Member if they wish to be evaluated for a NFLOC. The need for a NFLOC will be identified during a CNA. The MCO will identify triggers that would indicate a Member may be eligible for NFLOC and educate the provider agency. If the CLNM Member is interested in a NFLOC evaluation, the CareLink NM care coordinator shall arrange for the evaluation with the assigned MCO. The CareLink NM Care Coordinator will accompany the MCO care coordinator to the appointment with the Member. If an FFS recipient is in need of a NFLOC assessment for long-term services and supports, the State requires that the Member must enroll with an MCO.

Factors that might indicate a NFLOC include the following:

- The individual has a cognitive or physical impairment that limits the individual's ability to complete activities of daily living independently like the inability to get dressed, to bathe or groom; to eat, to acquire or prepare food, to move, to eat, to toilet, or to self-maintain incontinence.

- The individual is unable to self-administer "life preserving" medications.

The MCO will be responsible for completing a NFLOC Assessment, including the Centennial Care Community Benefit Service Questionnaire (CBSQ), for those CLNM Members who qualify for Community Benefit Services. If a NFLOC is established, the MCO will also be responsible for completing the allocation tool, which is used to determine how many hours of personal care services a CLNM Member receives and develop the community benefit care plan. The NFLOC and care plan will be provided to the CareLink NM provider agency for coordination and monitoring of utilization of the Community Benefit Services. When a NFLOC is established, the MCO care coordinator and the CareLink NM care coordinator will conduct the home assessment together. If the Member is eligible for self-directed care, the MCO will retain the self-directed care budget, but the CareLink NM care coordinator will conduct the care management and care coordination.

A NFLOC reassessment shall be conducted (by the MCO) at least annually. In addition, a NFLOC reassessment shall be conducted within five (5) business days of becoming aware of a change in the CLNM Member's functional or medical status. The CareLink NM care coordinator is responsible for tracking these dates and ensuring communication regarding the CLNM Member's needs.

CLNM Members who meet the NFLOC have access to community-based long-term services and supports including:

- Community Benefits, as determined appropriate based on the Needs Assessment.
- CLNM Members eligible for the Community Benefit will have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit.
- CLNM Members selecting the Agency-Based Community Benefit will have a choice of the consumer delegated model or consumer directed model for personal care services.

The CareLink NM care coordinator shall be familiar with these benefits and ensure the CLNM Member's choices are reflected in the CareLink NM Service Plan. While the MCO is responsible for the NFLOC assessment, the CareLink NM care coordinator should also be aware of certain dates. In particular, the MCO is responsible for ensuring that the CNA and NFLOC determination are complete within 60 calendar days of the Primary Freedom of Choice (PFOC). The MCO is also responsible for ensuring that the CNA process is initiated within 120 days of the NFLOC expiration.

Health Information Technology

The BHSDStar web-based data collection tool is used to create HIT linkages for the provider agencies and ancillary care providers. BHSDStar is intended to provide information on CLNM Member registration, care coordination including call tracking and referrals, the Comprehensive Needs Assessment (CNA), the CareLink NM Service Plan, and quality tracking. These resources will be available at no cost in order to support the CareLink NM providers and their Care Coordinators to collect and store data, record any identified unmet needs, gaps in care, or transitional support needs.

In addition to these HIT linkages, HSD will be using Medicaid Management Information System (MMIS) data elements already in place for the purpose of Health Home enrollment. The plan is to move the collected information to HSD's OMNICAID Data Warehouse for use in its analytics and evaluation.

To support use of BHSDStar and other web-based data tools, the provider agency must have computers and an internet connection.

BHSDStar Modules

Registration and activation modules: **see data requirements section**

Client Services Module

This is the module for CLNM staff to track the activities contained within the 6 required core services. It will list, for selection, all activities within each of the 6 services including the time spent conducting such activity. A "reminder" tracking application specific to a CLNM staff person and their assigned clients will assist staff in organizing their activities based on time frames they have set when planning care.

Comprehensive Needs Assessment (CNA)

This is the standardized CareLink NM Needs Assessment that will be automated by BHSDStar, and will have varying levels of security (called permissions) reflective of which providers within the CareLink NM, may have access to the information. Access is based on the status of the relationship (MOA in place) and the Member's consent.

CareLink NM Service Plan

This is the standardized plan of service needs developed by HSD and the MCOs that will be utilized by all CareLink NM health homes, and automated by BHSDStar. It will have varying levels of security (called permissions) reflective of which providers within CareLink NM may have access to the information. Access is based on the status of the relationship (MOA in place) and the Member's consent.

Quality

The provider agency is responsible for collecting and using data that supports a continuous quality improvement program. The data collected must be sufficient to fully inform ongoing quality measurement, an evaluation of coordination of integrated care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. See the Quality Section of this manual for a table of all criteria.

EDIE PreManage

Premanage ED software automatically sends notifications in real-time to the CLNM HH as a patient presents at the ED to give providers immediate perspective on the patient. The content of the notification is specific to the ED including ED visit history, and other valuable clinical and social history information.

It provides the ED with prior ED visit history, and maintains a living care guideline specific to an individual patient as authored by potentially multiple prior treating providers. NM hospitals with emergency rooms are contracting with Collective Medical Technologies (CMT) to support the technical integration and data flow. The 4 NM MCOs are sponsoring this important technical advance with the goal of increased quality of necessary ED visits and the reduction of medically-unnecessary ED readmissions.

PRISM Risk Management

PRISM, a risk management application based on 15 months of rolling claims data affords the CLNM HH options for targeting care management services based on predictive risk scores and utilization data. The Care Coordinator can review the relationship between PRISM's predictive risk scores and alternative methods of targeting based on prior emergency department (ED) or inpatient (IP) utilization patterns. Considerations include further prioritizing engagement within the target population, or use of predictive risk scores to differentiate levels of care coordination intensity, with corresponding staffing ratio targets.

Meaningful Use

A core service of the CareLink NM program is the use of HIT to link services for CLNM Members. To facilitate use of HIT, meaningful use practices defined by the Office of the National Coordinator (ONC), are to be adopted. Meaningful use, defined by ONC, is the use of certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities;
- Engage patients and families;
- Improve care coordination, and population and public health; and

- Maintain privacy and security of patient health information.

Provider agencies will adopt meaningful use of HIT to help achieve the following goals:

- To improve clinical outcomes;
- To improve population health outcomes;
- To increase transparency and efficiency;
- To empower individuals; and
- To improve research data on health systems.

Health Home Reimbursement

PMPM

CareLink NM providers are reimbursed through a per-member per-month (PMPM) payment methodology which is specific to each CLNM agency. CareLink NM dedicated services include the six core service categories that are not duplicative of Centennial Care services. A CareLink NM provider agency will bill for the approved list of CareLink NM core services using the CMS 1500. Additional Medicaid covered services provided to a CLNM Member are billed and reimbursed separately from the approved list of CLMN core services.

The PMPM rate will be updated annually based upon analysis, including claims experience. HSD reserves the right to update the PMPM rate at times other than those identified in this manual. The PMPM reimbursement is paid for each CLNM Member, regardless of whether the CLNM Member is enrolled in an MCO or in FFS Medicaid. The CareLink NM provider agency is responsible for verifying that the CLNM Members have affirmatively agreed to participate and have opted into CareLink NM services, documentation of which is a signed statement in the CLNM Member's file, in order to receive reimbursement.

The codes for the CareLink NM approved services are listed below. Each month, the G9001code and one or more of the six CareLink NM core services listed must be rendered and claimed in order to receive a PMPM payment for that month.

CareLink NM Health Care Common Procedure Coding System (HCPCS) codes

Code	Modifier	Carelink NM Code Description	Units
S0280		**Comprehensive Care Management (CCM)** The identification of high risk individuals ensuring the individual and family are active participants in the comprehensive needs assessment and service planning. Monitoring of the implementation of the CareLink NM Service Plan and 1) its evolution into individual health status and self-management, 2) utilization of services, and 3) prioritization of transitional care activities. Assigns "ownership" of an individual's care to the appropriate CareLink NM team.	15 minutes
T1016	U1	**Care Coordination (CC)** An assigned team lead coordinates the team, both in-house and with local community providers, in the implementation of the CareLink NM Service Plan. Reinforces treatment strategies that increase the individual's motivation to actively self-manage his or her chronic health conditions.	15 minutes
T1016	U2	**Comprehensive Transitional Care** Maximizing the ability of the individual to live safely in the community and minimizing the utilization of out-of- home placement and hospital emergency departments. Assuring the continuation of the treatment plan across all levels of care such as early discharge planning and proactive prevention of avoidable readmissions. Requires effective point-of-service exchange of information including medication reconciliation and access.	15 minutes

Code	Modifier	Carelink NM Code Description	Units
T1016	U3	**Individual and Family Support** 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 may involve peer and family supports, Tribal programs, targeted support groups, and formal self-care programs.	15 minutes
T1016	U4	**Referral to Community and Social Support Services** The identification of available community-based resources and the active management of appropriate referrals. Engagement with other community and social supports, and follow up post-engagement. Example linkages are disability benefits, housing, IHS and Tribal programs, legal services, and other personal needs consistent with recovery goals and treatment plans.	15 minutes
T1016	U5	**Prevention and 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.	15 minutes
G9001		**Coordinated care fee**	**Capitation PMPM ***

Billing Instructions

- The G9001 code must be billed with one of the other service codes, noted above, on the same claim for reimbursement of the PMPM to occur.
- The six services codes shall be billed with a $0.01 price indicated, but will pay $0.00.
- All service codes are to be billed with the actual date of occurrence, and the correct units of time.
- The facility NPI may be used in the rendering provider field as well as in the billing provider field.
- FQHCs that will be billing other services utilizing a UB claim form and a revenue code shall bill the CareLink NM codes on a CMS 1500 claim form utilizing the above HCPCS codes. They will obtain a separate NPI and facility ID for the CareLink NM services.
- IHS and 638 tribal facilities will be billing other services utilizing the OMB rate, and shall bill the CareLink NM codes on a CMS 1500 claim form utilizing the above HCPCS codes.

Enrolling or Disenrolling an Individual as a CareLink NM Member in BHSDStar

The data elements that will be required and communicated from BHSDStar via interface to Omnicaid are:

- Client_System ID (This is automatically recorded when entering the Medicaid ID)
- Client_Hlth_Home_Effective date_Date (the beginning of a month only)
- Client_Hlth_Home_End_Dt (12/31/9999 until they are being disenrolled)
- Client_Hlth_Home_Prov_NPI
- Client_Hlth_Home_Care Coordination Level_Cd (6 or 7 or 8)
- Client_Rec_Add_Medicaid ID (This is automatically recorded based on the CareLink NM user shall bill the CareLink NM codes
- Client_Rec_Add_Date (This is automatically recorded as the date you are entering the new information)
- Client_Rec_Add_Time (This is automatically recorded as the time you are entering the new information)
- Client_Rec_Update_User_ID (Enter the client Medicaid ID if you are updating a record, such as a new care coordination level, or disenrollment)

- Client_Rec_Update_Date (The date you are entering)
- Client_Rec_Update_Time (The time you are entering)

Non-Compliant Members

In accordance with the Centennial Care contract policy, provider agencies participating in CareLink NM shall follow the same criteria as the MCOs prior to disenrolling a CLNM Member that has been noncompliant with his/her treatment as a result of being unreachable. If a CLNM Member is unable or unwilling to engage, the CareLink NM provider shall send a letter to the CLNM Member's most recently reported address to provide information about CareLink NM and how to contact the care team. Documentation of attempts to reach and engage the Member shall be included in the CLNM Member file.

Quality & Outcomes

Quality and health outcome measurement of CLNM Members are important for many reasons. Quality and health outcome measurement is a federal requirement of the Health Home program. It also provides essential information to the State and eligible providers on program impact to support the underlying goal of improving health, wellbeing and self-management of chronic conditions.

A set of core health measurements will be monitored by HSD to evaluate health outcomes of CLNM Members. The following table should serve as a guide on specific health performance measures that will be required for monitoring. The table outlines core performance measures, whether the data is recorded as a quality of care process, a health outcome, prevention and health promotion criteria , the experience of care, or utilization and cost data.

The following table is organized by the 5 overriding goals of the CLNM HH program:

1. Prevention and Health Promotion;
2. The improvement of acute and long-term health care;
3. The enhancement of member engagement and self-efficacy;
4. The improvement in Member quality of life; and
5. The reduction of avoidable utilization of the emergency department, inpatient and residential services.

For a full description of these criteria including frequency of reporting to the Steering Committee and/or CMS, and recommended quality monitoring by the CLNM agency, and formulas for measurement, see Appendix B.

Much of this information will be captured through the CLNM staff's use of the service module; other information will be reported through claims data. Quality reports will be monitored by the Steering Committee at semi-annual intervals. The Steering Committee will use these reports to monitor CareLink NM program efficacy, and in some instances where large gaps in health outcomes are identified, as the basis of corrective action plans.

Compliance and Oversight

Steering Committee

The Steering Committee is comprised of leaders from MAD, BHSD, CYFD, UNM Psychiatric Consultant, and the four MCOs and is charged with a number of implementation and ongoing monitoring activities. Ongoing monitoring activities include:

- Development and reassessment of risk management strategies;
- NCQA pre-delegation on site audits;
- Semi-annual performance review of standards of care and quality indicators, including recommendation of corrective action plans when necessary;
- Evaluation of audit reports conducted by the MCOs
- Long-term evaluation of return on investments;
- Evaluation of CareLink NM goal progress;
- Ongoing evaluation of general CareLink NM operations; and
- Recommendation of future CareLink NM trajectories to HSD leadership.

Other Monitoring and Auditing

MCOs will monitor the performance of the CLNM Health Homes through access to the BHSD Star system, semi-annual reports and as needed on-site audits. Tools and measures used shall be shared with the Health Homes to facilitate and foster proactive on-going continuous improvement efforts.

A CLNM member file must be maintained for each member served. The CLNM member file must contain the following:

- A scanned copy of the member's signed consent form;
- An initial comprehensive assessment and all reassessments

- An initial CLNM service plan and subsequent updates
- Service tracking of member
- Copies of any releases of information signed by the member
- Medical/behavioral health and social service referrals made

Acronyms

ACA	Patient Protection and Affordable Care Act
BHA	Behavioral Health Agency
BHSD	Behavioral Health Services Division
CCSS	Comprehensive Community Support Services
CLNM	CareLink NM
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNA	Comprehensive Needs Assessment
CRA	Comprehensive Risk Assessment
CSA	Core Service Agency
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HIPAA	Health Information Portability and Accountability Act
HIT	Health Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HSD	New Mexico Human Services Department
ICF/MR/DD	An individual with mental retardation or developmental disabilities with an intermediate care facilities level of care.
IHS	Indian Health Services
IPRA	New Mexico Inspection of Public Records Act
MAD	Medical Assistance Division
MCO	Managed Care Organization
MIS	Management Information System
MMIS	Medicaid Management Information System
NMAC	New Mexico Administrative Code
NMSA	New Mexico Statutes Annotated
PHI	Protected Health Information
PMPM	Per-Member Per-Month
PPA	Provider Participation Agreement
SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
UR	Utilization Review

Health Home Appendices

Appendix A – SMI/SED criteria

Appendix B – Evaluation Criteria

APPENDIX A

Serious Mental Illness (SMI)
CRITERIA CHECKLIST

Serious Mental Illness (SMI) determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

☐ 1. **Age:** Must be an adult 18 years of age or older.

☐ 2. **Diagnoses:** Have one of the diagnoses as defined under the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

☐ 4. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Person must meet SMI criteria and at least one of the following in A or B:

☐ A. Symptom Severity and Other Risk Factors

☐ Significant current danger to self or others or presence of active symptoms of a SMI.
☐ Three or more emergency room visits or at least one psychiatric hospitalization within the last year.
☐ Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions, emotional/behavior/cognitive conditions.
☐ Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

☐ B. Co-Occurring Disorders

☐ Substance Use Disorder (SUD) diagnosis and any mental illness that affects functionality.
☐ SMI or SUD and potentially life-threatening chronic medical condition (e.g., diabetes, HIV/AIDS, hepatitis).
☐ SMI or SUD and Developmental Disability.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention –Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	314.01	F90.1	Attention –Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	314.01	F90.2	Attention –Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	314.01	F90.8	Attention –Deficit/Hyperactivity Disorder: Other Specified Attention –Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	314.01	F90.0	Attention –Deficit/Hyperactivity Disorder: Unidentified Attention –Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition– With mixed features
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)–with depressive features
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) -with major depressive-like episodes
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5*.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom)Disorder. Specify: with attacks of seizures; or with special sensory loss

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder –with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa - Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa– Binge-eating/Purging type
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	312.89	F91.8	Other Specified Disruptive Impulse-Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	312.9	F91.9	Unspecified Disruptive, Impulse Control and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	301.83	F60.3	Borderline Personality Disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix B
Substance Use Disorder (SUD) Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use Disorder - Moderate , Severe
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder –Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown)Substance-Related and Addictive Disorders - Moderate, Severe

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

Severe Emotional Disturbance (SED) determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

☐ A. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ B. The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. [*Dear State Director letter*, July 11, 2013, from CMS, SAMHSA, ACF.] In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

☐ Abandoned or neglected;

☐ Sexually abused;

☐ Sexually exploited;

☐ Physically abused;

☐ Emotionally abused; or

☐ Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an ex parte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

☐ 3. **Functional Impairment:**

The child/adolescent must have a Functional Impairment in two of the listed capacities:

☐ *Functioning in self-care:*

Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*

Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*

Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified
by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, in- ability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*

Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*

The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Mood and anxiety symptoms*

The disturbance is excessive and causes clinically significant distress and which substantially interferes with or limits the child's role or functioning in family, school, or community activities

☐ *Trauma symptoms:*

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience
a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention –Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	314.01	F90.1	Attention –Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	314.01	F90.2	Attention –Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	314.01	F90.8	Attention –Deficit/Hyperactivity Disorder: Other Specified Attention –Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	314.01	F90.0	Attention –Deficit/Hyperactivity Disorder: Unidentified Attention –Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition– With mixed features
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)–with depressive features
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) -with major depressive-like episodes
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5*.

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom)Disorder. Specify: with attacks of seizures; or with special sensory loss

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix A
Serious Mental Illness (SMI) -Severe Emotional Disturbance (SED) Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder –with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa - Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa– Binge-eating/Purging type
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	312.89	F91.8	Other Specified Disruptive Impulse-Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	312.9	F91.9	Unspecified Disruptive, Impulse Control and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	301.83	F60.3	Borderline Personality Disorder

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

Appendix B
Substance Use Disorder (SUD) Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use Disorder - Moderate , Severe
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder –Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown)Substance-Related and Addictive Disorders - Moderate, Severe

Sources*: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and *Desk Reference to the Diagnostic Criteria from DSM-5.*

APPENDIX B

CLNM Evaluation Criteria

Domains to be evaluated:

1. Clinical & social determinants of health outcomes (OC)
2. Experience of care (EOC)
3. Quality of care (QOC)
4. Utilization of services (SU)
5. Cost of care ($)

Goal I: Health Promotion/Prevention

Screen for common chronic conditions and risk behaviors in individuals with SMI or SED

Intermediate Actions	Adult/child/both	Reporting Frequency	Measure	Value	Outcomes/Measure Description	Data source	Quality Monitoring
Screening for recommended immunizations	B	Annual	% of members all ages current on immunizations	+/-	(QOC) N: # of members screened D: # of member months Exclusion: religious or medical exemption signed	Star service	Annual
Screening for alcohol use	B (8 & >)	Annual	% of members screened	+/-	(QOC) N: # of members screened D: # if member months	Star assessment auto fill –	Annual
Screening for tobacco use	B (8 & >)	Annual	% of Members screened	+/-	(QOC) N: # of members screened: D: # if member months	Star assessment	Annual
Other substance use screening	B (Children 8 & above)	Annual	% of Members screened for substance use	+/-	(QOC) N: # of members age 8 & > screened for substance use D: # of HH members ages 8 & >	Star service auto fill	Quarterly
Suicide risk assessment	B	Semi-annual	% of members screened for suicide risk	+/-	(QO)) N: # of members screened D: # of HH members – all ages	Star service auto fill	Quarterly
Major depressive disorder (MDD) suicide screening	B	Semi-annual	% of members with depressive disorder screened for suicide risk	+/-	(QOC) N: # of members, all ages, with depressive disorder screened for suicide risk	Star service auto fill	monthly

					D: # of member months for individuals with depressive disorder		
Screening for clinical depression **CMS criterion coupled with follow up plan**	B	Semi-annual	% of members 12 yrs & > receiving the screen at an OP visit	+/-	(QOC) N: # of HH members 12 yrs & > screened ea quarter utilizing age-appropriate standardized depression screening tool, D: Participating HH members aged 12 yrs & older with an OP visit during the measurement year Exclusion: those with a current dx of depressive disorder	Star service auto fill	Quarterly
Weight assessment (BMI) – adults **CMS criterion**	A	Annual	% of HH members 18-74 yrs who had their BMI documented during the measurement year or the year prior to measurement year	BMI value	(QOC) HEDIS N: HH members 18-74 yrs who had BMI documented in STAR during measurement year or year prior D: All HH Members 18 to 74 yrs	Star service auto fill	Bi-Annual
Weight Assessment Children – (BMI)	C	Semi-annual	% of members 3-17 yrs who had evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	BMI value	(QOC) HEDIS N: BMI percentile during measurement year documented in Star D: All HH children/adolescents members stratified by 3 -11 yrs and 12-17 yrs.	Star service auto fill	Quarterly
Diabetes screening for adults that are overweight or obese	A	annual	% of adults 40 to 70 years old that are overweight or obese that had a glucose test or HbA1c	HbA1c or glucose value	(QOC) N: 40 – 70 yr old members that had a glucose or HbA1c test D: 40 to 70 yr old HH members that are overweight or obese	Star service auto fill	Annual
Diabetes screening for people who are on atypical anti-psychotics	B	Semi-annual	% of members 18 & > having a glucose test or an Hba1c during the measurement year	HbA1c or glucose value	(QOC) N: Members 18 yrs &> that are on atypical anti-psychotics that had a Glucose test or HbA1c recorded in STAR	Star service auto fill	Quarterly

(HbA1C)					D: All HH members 18 Yrs & > on atypical anti-psychotics		
Eye exam for people with diabetes and SMI	A	annual	% of Members with diagnosis of type 1 or type 2 diabetes mellitus who had the eye exam	y/n	(QOC)	Star service auto fill & claims	annual
Foot exam care for people with diabetes and SMI	A	Annual	% of Members with diagnosis of type 1 or type 2 diabetes mellitus who had the foot exam	y/n	(QOC)	Star service auto fill	quarterly
Physical examination within 1 month of admission to HH or transfer of records current within the last 12 months	B	Annual	% of members w physical exam w/in 1 month of HH admission or other documentation of physical exam in the past year	Date of exam	(QOC) Numerator = HH members added to HH rolls in the measurement year with physical exam within 1 month of admission or other documentation of physical examination in the measurement year Denominator = all HH members with SMI or SED within the measurement year and added to the HH rolls in the measurement year Exclusions: Active diagnosis of pregnancy during the measurement year or the year prior to the measurement year.	Star service auto fill	Admission + 1 month
Serum lipid profile for adults with SMI who are on atypical anti-psychotics	A	Annual	% of members 18-74 who had serum lipid profile done	Actual value	(QOC) N: An LDL-C test performed on members 18 yrs to 74 on atypical anti-psychotics during the measurement year D: HH members aged 18 to 74 on atypical anti-psychotics	Star service auto fill	Annual

Screening for cervical cancer	A	Annual	% of and women 21 to 64 meeting the criteria	+/-	(QOC) HEDIS N: 1) women 21-64 yrs who had cervical cytology every 3 years 2) 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years D: All HH women 21-64 years	Star assessment auto fill	Every 3 yrs
Screening for breast cancer	A	Annual	% of women 50-74 who had a mammogram to screen for breast cancer in measurement yr or 2 yrs prior	+/-	(QOC) HEDIS N: 1 or more mammograms any time on or between 10/01 2 years prior to measurement year and 12/31 of measurement year D: All HH women 50-74 yrs	Star assessment auto fill	Every 3 yrs
Screening for colon cancer	A	Annual	% of members 50-75 yrs who had appropriate screening for colorectal cancer in measurement yr & 1 yr prior	+/-	(QOC) HEDIS N: One or more screenings documented in Star 1) Fecal occult blood test (FOBT) during measurement year 2) Flexible sigmoidoscopy in measurement yr or 4 yrs prior 3) Colonoscopy during measurement year or 9 years prior	Star service auto fill	Annual for # 1
Screening for chronic infectious diseases: HIV	B (11 yrs & older)	Annual	% of members 11 yrs & > screened	+/-	(QOC) American Association of Pediatrics N: Members 11 yrs & > screened for HIV D: All HH members 11 yrs & >	Star service auto fill	Annual
Screening for chronic infectious	B (11 yrs & older)	Annual	% of members 11 yrs & > screened	+/-	(QOC) American Association of Pediatrics	Star service auto fill	Annual

diseases: Hepatitis B					N: Members 11 yrs & > screened for HIV D: All HH members 11 yrs & >		
Screening for chronic infectious diseases: Hepatitis C	B (11 yrs & older)	Annual	% of members 11 yrs & > screened	+/-	((QOC) American Association of Pediatrics N: Members 11 yrs & > screened for HIV D: All HH members 11 yrs & >	Star service auto fill	Annual
Metabolic monitoring for children & adolescents on antipsychotics	c	Annual	% of HH members 1 – 17yrs (in 3 age stratifications, i.e. 1-5 yrs; 6-11 yrs; 12-17 yrs & total) who had 2 or more anti-psychotic prescriptions and had metabolic testing	2 actual values	(QOC) <u>HEDIS</u> N: Both of the following during the measurement year 1) At least one test for blood glucose or HbA1c 2) At least one test for LDL-C or cholesterol other than LDL D: Members with at least 2 antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year	Star service auto fill	Annual
Child abuse screening	B	Annual	% of members screened for past or present child abuse within the measurement year	+/-	(QOC) N: HH members all ages screened for child abuse, past or present , within the measurement year D: All HH members	Star assessment or service auto fill	Annual
Intimate Partner Violence screening	B	Annual	% of members screened for domestic violence within the measurement year	+/-	(QOC) N: HH members all ages screened for domestic violence, past or present , within the measurement year D: All HH members	Star assessment or service auto fill	Annual

Goal II:
Improve acute and long-term health of individuals with SMI/SED

Intermediate Actions	Adult/ child/ both	Reporting Frequency	Measure	Value	Outcomes/Measure Description	Data source	Quality Monitoring
Control of diabetes for individuals having had a hemoglobin A1c (HbA1c) > 9.0%	B	Semi-annual	% of Members with dx of type 1 or type 2 diabetes with adequate diabetic control (<8.0% HbA1c)		(OC) Numerator (STAR)= HH members with a dx of type 1 or type 2 diabetes mellitus whose most recent HbA1c during the measurement year was <8.0% Denominator (claims) = HH members with a diagnosis of type 1 or type 2 diabetes mellitus during the measurement year. Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure: Patients with a diagnosis of polycystic ovaries. Patients with gestational or steroid-induced diabetes.	Star service auto fill for numerator; STAR CNA for denominator	Quarterly
Follow up plan for positive suicide risk screening	B	Semi-annual	% of members with a plan documented in care plan	y/n	(QOC)N: HH Members, all ages, who had a positive suicide risk screen for which a follow-up plan was documented in the CLNM care plan on the date of the positive screen	Star service & care plan auto fill	Monthly

					D: All HH members with a positive suicide risk screening		
Follow up plan for positive depression screen **CMS criterion coupled with screening**	B	Semi-annual	% of members 12 yrs & > w a plan documented on date of positive depression screen	y/n	(QOC) N: # of HH members that received a positive value for depression screening, for which a follow-up plan is documented on the date of the positive screen D: D: Participating HH members with an OP visit during the measurement year	Star care plan auto fill	Monthly
Treatment plan for BMI > 30	B	Semi-annual	% of Members with BMI > 30 who have a treatment plan for addressing obesity		(QOC) Numerator: HH Members with documented BMI >30 and treatment plan for obesity Denominator: All HH members with BMI > 30 within the measurement year	Star Service auto fill	Quarterly
Treatment plan for BMI < 17.5	B	Semi-annual	% of Members with BMI < 17.5 who have a treatment plan for addressing weight & nutrition		(QOC) Numerator: Pts with documented BMI <17.5 and treatment plan for weight & nutrition Denominator: All HH members with a documented BMI <17.5 within the measurement year	Star Service auto fill	Quarterly
Controlling high blood pressure (Source: NCQA) **CMS criterion**	A	Annual	% of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year	Actual value	(OC) HEDIS N: Patients whose most recent blood pressure (BP) is adequately controlled during the measurement year (after the diagnosis of hypertension) based on the following criteria: -Patients 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.	MCO	Quarterly through STAR

					-Patients 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. -Patients 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg. **Denominator Statement:** All patients 18-85 years of age as of December 31 of the measurement year with SMI AND a diagnosis of hypertension **Exclusions:** All patients who meet one or more of the following criteria should be excluded from the measure: - A diagnosis of pregnancy		
Initiation and engagement of alcohol and other drug dependence treatment **CMS criterion**	B	Semi-annual to Steering	% of Members 13 yrs & > with a new episode of alcohol or other drug (AOD) dependence who 1) initiated treatment through an IP AOD admission, OP visit, Intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis 2) initiation of treatment and had 2 or more additional services with a diagnosis of AOD within 30 days of the initiation visit engagement of AOD	y/n	(QOC) - HEDIS N: Rate 1: HH members 13 yrs & > that had an initiation of AOD treatment through an IP admission, OP visit, Intensive OP encounter or partial hospitalization with 14 days of diagnosis; Rate 2: HH members 13 yrs & > who initiated treatment and who had 2 or more additional services with a diagnosis of AOD within 30 days of the initiation visit. D: HH members 13 yrs & > with an AOD diagnosis	MCO annual	Monthly through STAR

			treatment				
Tobacco cessation follow-up	B	Semi-annual	% of members 8 yrs & > reporting a reduction or cessation of smoking	y/n	(OC) N: HH Members 8 yrs & > reporting a reduction or cessation of smoking D: HH Members 8 yrs & > reporting use of tobacco	Star service for positive auto fill	quarterly
Care transition record transmitted to health care professional **CMS criterion**	B	Annual	% of pts of all ages discharged from IP facility, observation, nursing facility or rehabilitation facility to home or any other site of care for whom a transition record was transmitted to the facility or PCP or health professional designated for follow-up care within 24 hours of discharge.	Date	(QOC) N: Discharges of HH members for whom a transition record was transmitted to the facility or PCP or other health care professional designated for follow-up care within 24 hours of discharge. D: HH members of all ages discharged from an IP facility, observation, nursing facility or rehabilitation facility to home/self-care or any other site of care	Star service auto fill	Monthly
Follow up after hospitalization for mental illness 7 days **CMS criterion**	B	annual	% of discharges for members age 6 and older who were hospitalized for treatment of mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge	y/n	(QOC) HEDIS N: An OP visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge D: HH members who have been discharged from an acute IP setting with a mental illness diagnosis	MCO	Monthly through referrals or facility EHR
Follow up after hospitalization for mental illness 30 days **CMS**	B	Annual	% of discharges for members who were hospitalized for treatment of mental	y/n	(QOC) HEDIS N: An OP visit, intensive outpatient encounter, or partial hospitalization with	MCO	Monthly through STAR referrals or

criterion			health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge		a mental health practitioner within 30 days after discharge D: HH members who have been discharged from an acute IP setting with a mental illness diagnosis		facility EHR
Care coordinator involved in discharge planning for IP admissions, residential, NF, or correctional facility	B	Annual	% of discharges for with active participation of HH staff	y/n	(QOC) N: All HH members discharged from group home, RTC, ARTC, TFC, IP admission, nursing facility, or correctional facility in which the care coordinator participated D: All HH members discharged from group home, RTC, ARTC, TFC, IP admission, nursing facility, or correctional facility	Star service auto fill	quarterly
Antidepressant medication management (AMM)	A	annual	% of HH members 18 & > who were treated with antidepressants, had a dx of major depressive disorder (MDD) and who remained on an anti-depressant medication for at least 84 days (12 weeks)	y/n	(OC) HEDIS (Identify the earliest prescription dispensing date for the anti-depressant medication - IPSD) N: *Effective acute phase treatment*: At least 84 days (12 weeks) of continuous treatment with anti-depressant medication through 114 days after the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. *Effective continuation phase treatment:* At least 180 days (6 months) of continuous treatment with antidepressant medication beginning on	MCO	Monthly

					the IPSD through 231 days after the IPSD (232 total days). Continuous treatment allows gaps of up to 51 days. D: HH members 18 & > with MDD diagnosis, treated with anti-depressants		
Quarterly medication reconciliation with adolescents, adults and PCP	B	Semi-annual	% of Members for whom medications were reconciled by a prescribing practitioner, clinical pharmacist or registered nurse	y/n	(QOC) N: All members with more than 1 prescribing practitioner for whom medication reconciliation was conducted D: HH members of all ages that have more than 1 prescribing practitioner	Star service auto fill	Quarterly
Annual check of NM prescription monitoring program for prescribed opiates or benzodiazepines	B	Annual	% of HH members taking opiates, benzodiazepines, or documented illicit drugs for which an annual check of the prescription monitoring program occurred	y/n	(QOC) N: All HH members taking opiates, benzodiazepines, or documented illicit drugs for which an annual check of the prescription monitoring program occurred D: : All HH members taking opiates, benzodiazepines, or documented illicit drugs	Star service auto fill	Annual
Multidisciplinary care management meetings	B	Semi-annual	% of Members that had a multi-discliplinary care team meeting	date	(QOC) N: HH members, all ages, with active OP visits or transitions of care settings for which 2 multi-disciplinary team meetings were held within the measurement year D: HH members, all ages, with active OP visits or transitions of care settings within the measurement year	Star service auto fill	Quarterly
Completed visits for referral	B	Semi-annual	Composite % of all visits for members for whom referrals have been made and the referral appt. was kept	y/n	(QOC) N: composite referrals for HH members, all ages, where the referral appointment was kept D: All referrals made within the	Star Service	Quarterly

					measurement quarter		
Coordinate with School (with parental permission) related to setting of care transitions	C	Semi-annual	Composite % of setting of care transitions for youth in which the school was contacted	y/n	(QOC) N: composite # of care setting transitions for HH members, 4 years to 18 yrs, where the HH coordinated with the school D: All transitions in care settings for HH members 4 yrs to 18 years old	Star service transitional care auto fill	Quarterly
Care Coordinator *involvement in* setting of care transitions	B	Semi-annual	Composite % **of** setting of care transitions in which the CC was involved	y/n	(QOC) composite # of care setting transitions for HH members, any age, where the Care Coordinator was involved D: All transitions in care settings for HH members, any age	Star service transitional care auto fill	Quarterly

Goal III:
Enhance member engagement and self-efficacy (power or capacity to produce a desired effect)

Intermediate Actions	Adult/ child/ both	Frequency standard	Measure	Value	Outcomes/Measure Description	Data Source	Quality Monitoring
Peer Support	B	annual	% of members reporting positive experience w peer support	y/n	(QOC & EOC) N: All HH members, any age, receiving peer support reporting a positive experience D: All HH members, any age, receiving peer support	Star & Survey	annual
Family Support	B	annual	% of family members reporting positive experience w family	y/n	(QOC & EOC) N: All family or identified supportive individuals of HH members, all ages, that	Star & Survey	annual

			support services		reported a positive supportive experience within the measurement year D: All family or identified supportive individuals of HH members, all ages		
Care planning with HH member/family	B	annual	% of member and/or family reporting inclusion in goal development and care planning	y/n	(EOC) N: HH members and/or family reporting inclusion in goal development and care planning D: HH members of any age	Survey	annual
Education	B	annual	% of members, all ages, and/or family who report having adequate or higher level of knowledge re. reason, symptomology, and remediation of side effects of prescribed medications	y/n	(QOC) N: HH members, all ages, and/or family who report having adequate or higher level of knowledge re. reason, symptomology, and remediation of side effects of prescribed medications D: HH members, all ages, taking prescribed medications	Star assessment auto filled for denominator& survey for numerator	annual
Education: Adherence to Antipsychotic Medications for Individuals with Schizophrenia Source: CMS	A	Annual	Percentage of individuals 18 & above with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).		(OC) HEDIS: Numerator Statement: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications. Denominator Statement: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).	MCO	Quarterly from STAR

					Exclusions: Individuals with any diagnosis of dementia during the measurement period.		
Adherence to mood stabilizers for individuals with bipolar disorder	A	Semi-annual to Steering	% of patients with bipolar I disorder who received & took a mood stabilizer medication during the measurement period		(OC) N: HH members 18 years & > with bipolar I disorder who took their mood stabilizer medication D: HH members 18 years & > with bipolar I disorder who received a mood stabilizer medication	STAR	Quarterly from STAR – reported adherence
Antidepressant medication management		Semi-annual	% of Members 18 yrs and > who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment	y/n	(OC) HEDIS N: HH members 18 yrs & > who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase of at least 84 days (12 weeks) and recovery phase of treatment of at least 180 days (6 months) D: HH members 18 yrs & > who had a new diagnosis of depression and were treated with an antidepressant medication	MCO annual	Quarterly – reported adherence
Knowledge of condition(s)		annual	% of Members, all ages, and/or family who report having adequate or higher level of knowledge of condition(s)	y/n	(EOC) N: HH members, all ages, and/or family who report having adequate or higher level of knowledge of condition(s) D: All HH members	Survey	annual

Goal IV:
Improve quality of life for Members with SMI/SED (Recovery & Resiliency)

Intermediate Actions	Adult child both	Reporting Frequency	Measure	Outcomes/Measure Description	Data Source	Quality Monitoring
Achievement in goals & activities identified by member	B	Annual	% of Members reporting positive progress in identified goals & activities	(OC & EOC) N: HH members of all ages and families reporting positive progress in identified goals & activities D: All HH members	Survey	Annual
Skills development	B	Annual	% of members reporting learned coping skills that work	((QOC & EOC) N: HH members, any age, and/or family report having learned coping skills that work D: HH members, any age	survey	Annual

Goal V:
Reduce avoidable utilization of emergency department, inpatient and residential services (Right time, right place, right service)

Intermediate Actions	Adult/ child/ both	Reporting Frequency	Measure	Outcomes/Measure Description	Data Source	Quality Monitoring
Hospitalizations for chronic conditions in adult patients with SMI **CMS criterion**	A	annual	Prevention Quality Indicator (PQI) 92: Chronic Condition Composite: The total # of hospital admissions for	(OC & $ & SU) Agency for Healthcare Research & Quality (AHRQ) Numerator: Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate	MCO	Annual

			ambulatory care sensitive chronic conditions per 100,000 enrollee months for HH members 18 yrs & >. Includes adult hospital admissions for diabetes with short-term complications, long-term complication, uncontrolled diabetes without complications, and diabetes with lower extremity amputation; COPD; asthma; hypertension; heart failure; or angina without a cardiac procedure.	• PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #13 Angina Without Procedure Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Denominator All HH members with SMI 18 years of age or older as of December 31 of the measurement year		
Re-admission after hospitalization **CMS criterion**	A	Annual	Plan – **all cause readmission Rate**: For HH members 18 & >, the # of acute IP stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days	($ & SU) – NCQA & HEDIS N: At least one acute re-admission for a HH member 18 yrs & > within 30 days of a discharge from index hospital stay D: The count of an index hospital stay (IHS) on or between 1/1 and 12/31 of the measurement year	MCO	Annual
Follow up after hospitalization for mental illness **CMS criterion**	B	Annual	% of discharges ages 6 & > 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	(QOC) HEDIS Numerator – 2 measures: 1) An OP visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days after discharge; 2) An OP visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge; Denominator – HH members 6 & > who have been discharged	MCO	Annual

			practitioner within 7 days and 30 days of discharge	from an acute IP setting with specific mental illness diagnoses		
Retention of OP services after hospitalization for mental illness (SMI/SED)	B	Annual	% of discharges who had at least 5 qualifying visits within 90 days of discharge	(QOC) N: HH members, any age, hospitalized for mental illness and discharged that had at least 5 qualifying visits within 90 days of discharge D: HH members, any age, hospitalized for mental illness and discharged	MCO	Annual
Follow up after residential treatment	C	Annual	% of discharges from residential treatment to a lower level of care followed up with 2 visits within 30 days.	(QOC) N: Composite # of discharges from residential treatment to a lower level of care followed up with 2 visits within 30 days. D: Composite # of discharges from residential treatment	MCO	Annual
Utilization	B	Annual	% of Members with 2 or more ED visits within 6 months for a behavioral health condition including substance abuse	($, SU) N: HH members, any age, with 2 or more ED visits within 6 months for a behavioral health condition including substance abuse D: HH members, any age	MCO	Annual