

Provider
Policy
Manual

2018

CareLink NM

HEALTH HOMES



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Introduction

The purpose of this 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 (CLNM) program. The Manual was developed by the Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD) of HSD to assist in the administration of the CLNM program, and is intended to provide direction to the agencies who serve as CLNM providers.

The CareLink NM program provides services authorized by Section 2703 of the Patient Protection and Affordable Care Act (P.L. 111-148, ACA). Services are delivered through a designated provider agency to enhance the integration and coordination of primary, acute, behavioral, social, and long-term services and supports for individuals with Serious Mental Illness (SMI) and Severe Emotional Disturbance (SED). The CLNM provider agency assists a CLNM member (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 (service plan). The goals of the CLNM Health Homes are to:

1. Promote acute and long term health;
2. Prevent risk behaviors;
3. Enhance member engagement and self-efficacy;
4. Improve quality of life for individuals with SMI/SED; and
5. Reduce avoidable utilization of emergency department, inpatient and residential services

Authority

New Mexico implemented Centennial Care in 2014 to modernize New Mexico's Medicaid program and developed the CLNM Health Home benefit for some of the State's most vulnerable residents. The mission of CLNM is to promote self-management of care choices through a supportive learning environment. CLNM services also provide expanded supports such as case management and care coordination for physical and behavioral health, long-term care, and social needs such as housing, transportation, and employment. CLNM provides 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 CLNM is for Medicaid-eligible adults with SMI, and Medicaid-eligible children and adolescents with a SED. HSD is leading the statewide initiative to provide coordinated care by a CLNM provider for individuals with the aforementioned chronic conditions and all associated comorbidities.

The policies in this Manual will be reviewed periodically by Human Services Division. HSD reserves the right to modify or supersede any policies and procedures. The CLNM Provider Policy Manual may be viewed or downloaded from MAD's home page website at <http://www.hsd.state.nm.us/providers/health-home-policy-manual.aspx>

It is the responsibility of all entities affiliated with CLNM to review and be familiar with the contents of this Manual.

Introduction to the CareLink Health Home Model

Overview

The CareLink NM service delivery model enhances integration and coordination of primary, acute, behavioral health, and long-term care services and supports across the lifespan for persons with chronic illness. The CLNM model builds on efforts made through the development and implementation of the Centennial Care program to improve integrated care and member engagement in managing their health. In New Mexico's health home model, CLNM provider agencies (providers) enhances their current operating structure to provide care coordination by partnering with physical health providers and specialty providers. CLNM providers will utilize health information technology (HIT) to monitor care and provide comprehensive records management. Providers serve fee-for-service (FFS) recipients and MCO members already receiving behavioral health services as well as new individuals who are eligible and to participate in the program.

Core Service Definitions

CLNM providers must demonstrate the ability to deliver all core services and meet all data and quality reporting requirements described in this Manual. Providers may elect to meet the service needs of members by providing integrated physical and behavioral health services through an on-site, co-location model, or through a number of memoranda of agreements (MOAs). MOAs are required with at least one primary care practice that serves members less than 21 years of age and at least one primary care practice that serves members 21 years of age and older. Agreements 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.

Providers must deliver services in six core categories to members: Comprehensive Care Management, Care Coordination, Prevention and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Community and Social Support Service Referrals. Providers also utilize CLNM health information technology. Following are descriptions of the core service categories:

Comprehensive Care Management

Comprehensive Care Management involves a comprehensive needs assessment and the development of an individualized comprehensive service plan with active participation from the CLNM member, family, caregivers and the health home team. Comprehensive care management services must also include:

- Assessment of preliminary risk conditions and health needs;
- Comprehensive service plan development, to include client goals, preferences, and optimal clinical outcomes, and identify specific additional health screenings required based on the individual's risk assessment;
- Assignment of health team roles and responsibilities;
- Development of treatment guidelines for health teams to follow across risk levels or health conditions;
- Oversight of the implementation of the comprehensive service plan which bridges treatment and wellness support across behavioral health, primary care and social health supports;
- Monitoring individual health status and service use through claims-based data sets to determine adherence to or variance from treatment guidelines; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Comprehensive care management activities include a needs assessment, as described below.

CLNM Comprehensive Needs Assessment (CNA)

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

Note: The CNA is not a psychiatric diagnostic evaluation (90791-92) to determine eligibility; it is a screening and assessment tool to establish service needs. If no diagnosis from previous records is available, a psychiatric diagnostic evaluation must also be completed. The CNA provides all the required data elements specified in the HSD authorized CNA (one version for children and one for adults).

The CNA:

- Provides all the required data elements specified in the HSD authorized CNA;
- Assesses preliminary risk conditions and health needs;
- Uses data from the risk management system to help determine care coordination levels;

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

Note: For children involved with the NM Children, Youth, and Families Department in Protective Services and/or Juvenile Justice, a Child and Adolescent Needs and Strengths assessment may also be indicated, however the CNA is still required.

Levels of Care and CNA Frequency

A MCO's Health Risk Assessment (HRA) is used to determine the need for a CNA. A CNA determines if care level 2 or 3 is appropriate. Level 2 or 3 determinations denote a CLNM referral if qualifying diagnoses are present. A member who has been determined to require level 1 care and has had BH services with a pertinent diagnosis, but whom a provider has not been able to contact, may also be referred.

Note: If a *significant change* in a member's condition leads to increasing service needs, the assessment timeframe is expedited and service changes are instituted within ten calendar days. "Significant change" might include a member becoming medically complex or fragile, identification of a substance dependency, diagnosis of significant cognitive deficits, or identification of contraindicated pharmaceutical use. In addition, the CLNM care coordinator should consider changes in a member's housing, social supports or other nonmedical services that would provide additional supports.

The following establishes guidelines for frequency of needs assessments based upon care coordination levels, and outlines caseload recommendations by level:

- Care coordination levels 6 or 7, assigned by the CLNM provider, have similar attributes as MCO care coordination levels 2 and 3. The variation in numbering systems is 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 a needs assessment at least annually (caseload recommendation is 1:51-100);

- Level 7 care coordination requires a needs assessment at least semi-annually (caseload recommendation is 1:30 – 1:50);
- Level 9 for high fidelity Wraparound services for children/adolescents for designated Wraparound providers only, following a review process. Level 9 caseload recommendation is 1:8 – 1:10.

Care Coordination Level 6 Requirements

Based on results obtained from the CNA, the provider shall assign care coordination level 6, minimally, to members with one of the following:

- A comorbid health condition;
- High emergency department (ED) use, defined as three or more visits within 30 calendar days;
- A mental health condition causing moderate functional impairment;
- Requirement for assistance with two or more activities of daily living (ADL) or instrumental activities of daily living (IADL) who live in the community at low risk;
- Mild cognitive deficits requiring prompting or cues;
- Poly-pharmaceutical use, defined as simultaneous use of six or more medications from different drug classes and/or simultaneous use of three or more medications from the same drug class.

Care Coordination Level 7 Requirements

Based on the results of the CNA, the provider shall assign care coordination level 7, at a minimum, to members with one of the following:

- Determination of medical complexity or fragility;
- Excessive ED use (four or more visits within a 12 month period);
- A mental health condition causing high functional impairment;
- Untreated comorbid substance dependency based on the current DSM or other functional scale determined by the State;
- Requirement of assistance with two ADL or IADL and living in the community at medium to high risk;
- Significant cognitive deficits;
- Contraindicated pharmaceutical use.

Care Coordination Level 9 Requirements

A Level 9 is indicated for children and youth ages 4-21 with:

- Diagnosis of Serious Emotional Disturbance (SED); **and**
- Multi-system involvement, i.e. two or more systems involvement including Juvenile Justice, Protective Services, Special Education or Behavioral Health; **and**

- At risk of or in out-of- home placement OR previous out of home placement, incarceration, or acute hospitalization within a two year period prior to evaluation; **and**
- Functional impairment in home, school or community (as measured by the Children and Adolescents Needs and Strengths (CANS) or Child and Adolescent Functional Assessment Scale (CAFAS)).

CLNM Service Plan

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

- Requires active participation from members, family, caregivers, and team members;
- Requires consultation with interdisciplinary team experts, primary care provider, specialists, behavioral health providers, and other participants in a member’s care;
- Identifies additional recommended health screenings;
- Addresses long-term and physical, behavioral, and social health needs;
- Is organized around a member’s goals, preferences and optimal clinical outcomes, including self-management. The plan includes as many short- and long-term goals as needed;
- Specifies treatment and wellness supports that bridge behavioral health and primary care;
- Includes a *backup plan* that addresses situations when regularly-scheduled providers are unavailable, and provides contact information for people and agencies identified in the backup plan. This is primarily for members receiving home- and community-based services where there is a nursing facility level of care (NFLOC) determination. There is no required template; the plan is uploaded as a file into the State’s web-based data collection tool, BHSDStar (please refer to the “Health Information Technology” section of this manual on page 36 for information on BHSDStar);
- Includes a *crisis/emergency plan* listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency. These are individualized plans, uploaded into BHSDStar;
- Is shared with members and their providers; and
- Is updated with status and plan changes.

CLNM Team Roles

The following list describes the roles of the CLNM team members:

- Develop treatment guidelines for health teams that establish clinical pathways across risk levels or health conditions;
- Oversee the implementation of Service plans;
- Report on progress toward meeting outcomes, e.g. client satisfaction, health status, service delivery, and costs;
- Monitor individual and population health status and service use to determine adherence to or variance from Service plans and best practice guidelines; and
- Use claims-based data sets and other tools to track population-based care.

CLNM Care Coordination

These services are conducted by care coordinators with Members, their identified supports, medical, behavioral health, and community providers. Care is coordinated across care settings to implement the individualized, culturally appropriate, comprehensive service plan. Care is coordinated through appropriate linkages, referrals, and follow-up to promote integration and cooperation among service providers and reinforces treatment strategies that support Members' motivation to better understand and actively self-manage his or her health conditions. Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients' and family members' ability to manage care ad live safely in the community, and enhancing the use of proactive health promotion and self-management. Specific activities include but are not limited to:

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

- Coordinating with the MCO care coordinator when a member has a NFLOC determination; and
- Interrupting patterns of frequent hospital emergency department use and reducing hospital admissions.

Prevention, Health Promotion, and Disease Management

These services are designed to prevent and reduce health risks and provide health promoting lifestyle interventions associated with CLNM-member populations. Services address an array of health challenges including substance use prevention and or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention and early intervention, STD prevention and early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, obesity reduction and prevention.

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

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

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

Comprehensive Transitional Care

CLNM providers are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement within different levels of care, settings, or situations and is bidirectional, diverting members from levels of care such as ED services, residential treatment centers, and inpatient hospitalization, and transitioning members to outpatient services. Transitional services help to reduce barriers to timely access, inappropriate hospitalizations, time in residential treatment centers, and nursing home admissions. Additionally, these services interrupt patterns of frequent ED use and prevent gaps in services which could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care.

Providers of transitional services should be mindful of a member's transition from childhood to adulthood. When developing a service plan providers should consider a member's shift from pediatric to adult medical providers, or issues such as independent living arrangements. The provider agency will proactively work with CLNM members reaching the age of majority to ensure appropriate supports and services are in place in the member's plan to assist in the successful transition to adulthood. Comprehensive transitional care activities include, but are not limited to:

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

Individual and Family Support Services

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

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

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

- Identifying and partnering with community-based and telehealth resources such as medical and behavioral health care, durable medical equipment (DME), legal services, housing, respite, educational and employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, personal needs, wellness and health promotion services, specialized support groups, substance use prevention and treatment, and culturally-specific programs such as veterans' or IHS and Tribal programs;

- Developing referral and communication protocols as outlined in MOA: Referrals for partnerships with a MOA shall include acknowledgment of the referral and follow-up with the member by both participating partners. Once a referral is made, the healthcare provider may have access to relevant data on the Member including his or her CLNM assessment and service plan, unless the member does not authorize a data exchange;
- Making referrals and providing assistance to establish and maintain a member's eligibility for services. Common linkages could include continuation of healthcare and disability benefits, educational supports, and other personal needs consistent with recovery goals and the treatment plan;
- Actively managing appropriate referrals and access to care; and
- Confirming members' and providers' encounters and following up post-referral.

High Fidelity Wraparound

High Fidelity Wraparound is an individualized, intensive, holistic care planning process to improve outcomes for children and youth with complex behavioral health challenges and their families. Wraparound is not a service, but an approach that makes existing services and systems more effective, and helps to identify other services and supports that may be indicated. The intent of this structured approach to service planning and care coordination is to support youth and families to live in their homes and communities.

Core Elements

Wraparound is comprised of the following five core elements:

- *Holistic* - considers the entire context of a family, rather than focusing only on behavior;
- *Strengths-based* - integrates the qualities, interests and talents of a family into a plan of care and emphasizes family voice and choice;
- The component of *vision* that helps a youth and family define their goals, and inspire them to persevere during difficult times;
- *Needs-driven*, to help understand why a behavior is occurring;
- *Team-based* – includes family members and natural supports as well as physical, behavioral health, and social services professionals working collaboratively to creatively address challenges.

Use of Best Practices

The following best practices are fundamental to providing core services, all supportive services, and to facilitating the success of CLNM:

- Provide quality-driven, cost-effective, culturally-appropriate, and person- and family-centered services;

- Coordinate and provide access to high-quality healthcare 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, coordination, and transitional care across settings including facilitating transfer from a pediatric to an adult healthcare system;
- Coordinate and provide the practice and use of trauma informed care to more effectively support youth and adults impacted by toxic stress and trauma;
- Participate in members' discharge planning and including appropriate follow-up from inpatient to other settings;
- Coordinate and provide access to disease management, education and strategies for members with chronic illnesses and comorbidities, including providing self-management supports to members and their families;
- Coordinate and provide access to community referrals, social supports recovery services, and access to long-term care supports and services ;
- Develop and maintain a Service plan for each member to integrate the whole-person model of healthcare needs and services that is culturally appropriate for the individual;
- Demonstrate ability to use HIT to link services and facilitate communication between team members and providers;
- Establish a continuous quality improvement program and have the ability to collect and report on data to evaluate member outcomes.

Use of Health Information Technology to Link Services

The provider agency will be responsible for using HIT to link available, appropriate services. The CNA, Service plan, critical planning and transition documents, and MCO or FFS utilization information will be available to providers via BHSDStar, other web-based tools, or may be shared via secure data exchange, email or hard copy. BHSDStar is 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 of this Manual, the BHSDStar data collection tool will be used to create member records specific to CLNM. BHSDStar will also provide support for the bidirectional data exchange with provider agencies' EHR.

Target Populations

The target population of the CLNM program is individuals enrolled in Medicaid, including Medicaid recipients in FFS and MCO, who are diagnosed with one or more Serious Mental

Illness (SMI) or Severe Emotional Disturbance (SED) as defined by the State of New Mexico (criteria are listed in Appendix B, pages 45, with additional criteria on page 49). The CLNM program is being implemented in stages based on geographic location of providers. In order to be eligible for enrollment in CLNM, an individual must be enrolled in Centennial Care or Medicaid FFS, and have one or more SMI or SED. Once enrolled in this program, participants are referred to as members, but should not be confused with FFS recipient or MCO member, which refers to an individual's type of Medicaid participation.

If approved by HSD or the CLNM Steering Committee, Health Homes may also implement high fidelity children's Wraparound in addition to serving the members described above. Separate member projections and PMPM rates are developed for this population of most vulnerable children and youth ages 4-21 who meet the following conditions to be eligible for this service:

- Diagnosis of Severe Emotional Disturbance (SED) for youth younger than 18, or Serious Mental Illness for youth ages 18-21, *and*
- Multi-system involvement, i.e. involvement with two or more systems including Juvenile Justice, Protective Services, Special Education or Behavioral Health; *and*
- At risk of or in out-of-home placement OR previous out-of-home placement, incarceration, or acute hospitalization within a two-year period prior to evaluation, *and*;
- Functional impairment in home, school or community, as measured by the Children and Adolescents Needs and Strengths (CANS) or Child and Adolescent Functional Assessment Scale (CAFAS).

Health Homes will identify potential Wraparound clients through relationships and referrals through community stakeholders such as local CYFD Juvenile Justice and Protective Services offices, schools, Treatment Foster Care providers, residential treatment centers and MCO.

CLNM Wraparound does not require preauthorization. Rather, in addition to meeting the criteria described above, a committee comprised of staff members from CYFD Wraparound, MCO and the Health Home (and optionally additional people who may inform a youth's circumstances) must approve a candidate's eligibility for Wraparound.

Participation Requirements for Providers

Enrollment as a Medicaid Provider and Contracting With MCOs

Services offered to CLNM members are furnished by a variety of providers and provider groups. A CLNM provider must first be enrolled as a New Mexico Medicaid provider and meet all applicable standards and must either update existing contracts with all Medicaid

MCOs, or develop a new contract if none exists. In order to be designated a CLNM provider applicants must also:

- Must hold a Comprehensive Community Support Services (CCSS) certification or an attestation that the agency has received all required training for certification;
- Meet all provider qualifications and standards outlined in this Manual;
- Complete a CLNM application;
- Provide services in a county approved for Health Homes by the Centers for Medicare & Medicaid Services (CMS) through a State Plan Amendment (SPA);
- Have a full-time Executive Director and full-time Clinical Director who hold one of the following licenses: Board-certified or Board-eligible psychiatrist; psychologist; licensed independent social worker, licensed master social worker, clinical nurse specialist in psychiatric nursing; registered nurse with a master's degree in psychiatric nursing; licensed professional clinical mental health counselor; licensed marriage and family therapist; or licensed, independent school psychologist.
- Administrative infrastructure, financial viability and infrastructure, and IT infrastructure to support the role of CLNM including managed care experience. IT capability must include electronic billing/accounting capacity;
- Have a Quality Improvement program with capacity specifically to address quality issues for care planning and coordination, including process improvement, data collection, and program fidelity;
- Successfully complete a readiness review process.

Provider Application Process

To apply to be a CLNM provider, an agency must complete an application that will be reviewed by the CLNM Steering Committee (please refer to page 42 for information on the Steering Committee). The CLNM application includes the following:

- General information about the service provider;
- Description of population served;
- An overview of behavioral and physical health integration activities;
- A screening and treatment service checklist;
- A plan for provider and partner outreach and engagement;
- General financial and business information;
- Additional relevant information as requested by the Steering Committee.

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>

The Steering Committee will review applications to determine if a provider meets CLNM requirements. If approved, the Medical Assistance Division of Human Services Dept. will notify the applicant and arrange a readiness review assessment to be conducted by members of the CLNM Steering Committee.

Readiness Requirements

The Steering Committee will conduct readiness reviews with all selected applicants to evaluate their capacity to meet CLNM service requirements. The Readiness Review Protocol is comprised of the following twelve sections:

- The Health Home Population;
- Health Home Referral Relationships and Network Management;
- Health Home Services – Comprehensive Care Management;
- Health Home Services – Care Coordination;
- Health Home Services – Prevention, Health Promotion and Disease Management;
- Health Home Services – Comprehensive Transitional Care;
- Health Home Services – Individual and Family Support Services;
- Health Home Services – Referral to Community and Social Support Services;
- Staffing and Other Organizational Matters;
- Systems;
- Integration of Physical and Psychiatric Health Consultants; and
- High Fidelity Wraparound (applicable only to those who wish to provide Wraparound and are approved by HSD or the CLNM Steering Committee).

Additional readiness guidelines and information will be provided to applicants selected for site visits prior to those visits.

Staffing Requirements

Each provider must employ specific staff positions to meet CLNM requirements. Some positions may be hired as contractors rather than employees. Following is a list of essential positions, qualifications, and where applicable, the number of individuals required to comply with staff-to-patient ratios:

1. A **Director** specifically assigned to CLNM 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 curricula development and delivery. The health promotion coordinator manages health promotion and risk prevention services and

resources appropriate for the CLNM population. Typical programs are substance use prevention and cessation, psychotropic medication management, nutritional counseling, healthy weight management, diabetes, pulmonary and hypertensive care. Programs are developed based on the prevalent conditions and comorbidities of the regional population. This role explores and manages relationships with outside providers such as the Department of Health and the MCOs for additional referral opportunities not available in the CLNM Health Home. This position also identifies gaps in disease management programming based on the specific CLNM population.

3. **Care Coordinators**, who are behavioral health practitioners licensed by Regulation and Licensing Department (RLD), or hold a human services bachelor's or master's level degree with two years of behavioral health experience, or is a registered nurse in New Mexico, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a member's comprehensive care management and the planning and coordination of all physical, behavioral, and support services. Care coordinators, working with MCOs, are responsible for researching, investigating, and reporting grievances, appeals, and critical incidents involving a member.

The provider agency must employ a sufficient number of care coordinators to meet the recommended ratios and the needs of members. Recommended ratios for care coordinators to members are based on care coordination levels indicated below:

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

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

Care Coordination Level 8 - Pending evaluation: 1:50

Care Coordination Level 9 - High Fidelity Wrap Around - 1:8 - 1:10

Individual caseloads for care coordinators may vary based on the needs of individual members and distance from the practice a care coordinator must travel to serve members.

4. A bilingual **Community Liaison** who speaks a language used by a majority of non-fluent English-speaking CLNM members, and who is experienced with resources in a member's local community. The community liaison works with an eligible recipient's care coordinator in appropriately connecting and engaging the member with needed community services, resources, and providers, including IHS and Tribal programs.

5. **Certified Peer Support Workers** (CPSW) hold a certification from the New Mexico Credentialing Board for Behavioral Health Professionals as a Certified Peer Support Workers. CPSW have lived experience and have successfully navigated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery processes. CPSW provide a number of individual and family support services and can also be employed on a contract basis or full-time for other positions for which they are qualified. Following is contact information for entities that can help connect providers with peer and family support workers: New Mexico Credentialing Board for Behavioral

Health Professionals (info@nmcbbhp.org); BHSD's Office of Peer Recovery and Engagement (opre.bhsd@state.nm.us).

6. **Family Peer Support Specialists** (FPSS) are trained by CYFD's Behavioral Health Services Division and certified by New Mexico Credentialing Board for Behavioral Health Professionals as a certified family support worker. While FPSS provide support services to individuals and families and can be employed on a contract basis or full-time for other positions for which they are qualified. Following is contact information for entities that can help connect providers with family support specialists: CYFD Behavioral Health Services (cyfd.org/behavioral-health).

6. A **Supervisor** who provides supervision and serves as a clinical review or resource for the care coordination staff, community liaison staff, health promotion coordinator and peer and family support staff. Supervisors are independently licensed behavioral health practitioner as described in 8.321.2 NMAC and have direct service experience in working with both adult and child populations. Physical health and psychiatric consultants must comply with their respective licensing boards' requirements for supervision.

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

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

9. A **Wraparound Facilitator** in Health Homes providing High Fidelity Wraparound. Following an intensive 18-month training and coaching period, Facilitators must be certified by the New Mexico Credentialing Board for Behavioral Health Professionals. The following are essential job functions: strong communication skills to engage youth, children and families; planning skills to organize and guide team members to develop a plan of care; implementation skills to coordinate and allocate resources to implement identified interventions; and analytic skills to assess progress toward goals, assess the appropriateness of a shift into a transition phase and prepare a transition plan for ending formal services and making referrals to community-based resources.

A provider that delivers both physical health and behavioral health services on-site may already employ required staff. Examples include: nurses, physician's assistants, pharmacists, social workers, nutritionists, dietitians, Tribal practitioners, licensed complementary and alternative medicine practitioners and exercise specialists. These

specialized staff members may also provide services even if not co-located, however these services are not required.

Data Requirements

The CLNM provider agency is responsible for collecting data that tracks care integration services, opt in/opt out affirmations, member authorized data sharing agreement information, assessments, CLNM Service plans, and procedures for a continuous quality improvement program. Data must be sufficient to fully inform ongoing quality measurements and include an evaluation of coordination of care and chronic disease management on individual-level clinical outcomes, experience and quality of care outcomes, at the population level. Eight health home quality indicators are mandated by CMS, and additional state-defined criteria are outlined in the quality section of this Manual.

Providers will use the web-based tool, BHSDStar for data collection and reporting. BHSDStar tracks multiple measures on members, including assessments, the CLNM 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. Additional information on entering data into BHSDStar and Omnicaid systems can be found in the HIT Section of this manual on page 36, and in the attachment for data entry in BHSDStar and Omnicaid.

Health Home Operations

Identifying Members

Medicaid, Diagnosis Eligibility

Individuals identified for enrollment in CLNM will meet the following criteria:

1. Be a Medicaid enrollee in a “full” eligibility category (excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries), including FFS recipients or MCO members, who are 18 years of age or older and meet the criteria for SMI; or
2. Be a Medicaid enrollee in a “full” program eligibility category 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.

Note: A Member’s Medicaid eligibility can be checked in the New Mexico Medicaid Portal: <https://nmmedicaid.portal.conduent.com/static/index.htm#ProviderEnrollment>

“Full” Medicaid coverage for CLNM purposes includes most categories of eligibility (COE). For a list of those categories *not* covered, please refer to Appendix F, page 63 of this manual.

The criteria for SMI and SED diagnoses can be found in Appendix B, page 45 of this Manual. Individuals eligible for enrollment in CLNM will be broadly identified by HSD, MCOs, CLNM providers, community members, and ED. Following are additional enrollment considerations:

- A Medicaid recipient can participate in CLNM if he or she is in FFS or Managed Care;
- A member cannot be enrolled with more than one CLNM Health Home simultaneously;
- An MCO is not allowed to enroll a Medicaid recipient into CLNM — the CLNM provider will complete this task.

Identifying Wraparound Members

High Fidelity Wraparound serves youth and adolescents with the most complex behavioral health needs, so Health Homes will need to establish relationships with a different array of providers to identify potential clients. Examples of referral sources include: CYFD Child Protective Services and Juvenile Justice Services, schools, residential treatment centers, and treatment foster care providers. MCO may also provide referrals for clients enrolled in either in- or out-of-state RTC.

To participate in Wraparound, clients must meet the eligibility criteria outlined on page 16 of this manual. Anyone making a referral to a Wraparound provider must complete a Wraparound Referral Form for a prospective client; a formal review conference for each potential client is mandatory. Referral review teams should be comprised of the following members: the individual who made the referral, a representative from the Health Home providing care coordination, staff from CYFD Behavioral Health Services and the relevant MCO, appropriate family members or caregivers, and other stakeholders familiar with the client's situation (e.g. agencies or systems with which the client has been involved). Referral review meetings should be held within 48 hours of the provider's receipt of the Wrap-around Referral Form.

For additional information on High Fidelity Wraparound, please refer to the NM Wraparound Cares High Fidelity Implementation Plan, available from Children Youth & Families Department, (505) 827-8008.

MCO Referral Process

New members may be identified by MCO or other agencies and referred to a CLNM provider. MCO will refer new members to CLNM Health Homes throughout the year either after the health risk assessment or after the comprehensive needs assessment has been conducted if chronic behavioral health issues have been identified or suspected. In counties with more than one CLNM provider, MCO will implement the following procedure to refer clients not enrolled in a Health Home to the most appropriate Health Home. MCO will provide

information on both Health Homes to help clients make an informed choice, and make a referral based on the following criteria:

- Geography;
- Cultural or linguistic preferences;
- Provider specialties (e.g. MST or IOP if indicated);
- Capacity (to avoid putting a client on a wait list).

MCOs will provide all referral information to the appropriate Health Home, which can reach out to the member.

Enrolling Members

Members who meet eligibility criteria for CLNM may either have their records uploaded to the BHSDStar registration system or individually entered into Star by CLNM staff. To upload client records for enrollment, please refer to the BHSDStar User Guide-Vendor CareLink, and the CareLink File Specification sheet for instructions.

Eligible individuals must agree to opt-in to CLNM 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 providers, their assigned MCO, or HSD to determine if they are eligible for CLNM services.

Though enrollment can occur at any time within a calendar year, opting out can only occur on a member's enrollment anniversary date, except in the following circumstances:

- During initial registration interview, when an enrollee may decide they are not interested;
- 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 Medicaid eligibility; or
- Is dissatisfied with the program and requests a panel decision to transfer their care coordination to the MCO or, if FFS, discontinue care coordination. The panel will consist of the CLNM provider staff and the relevant MCO.

If a member is no longer engaged with the Health Home, providers will opt-out the member and notify the MCO that they should resume care coordination.

Enrollment of Centennial Care Members

Phase 1:

For members enrolled in Centennial Care who are eligible for CLNM services, and *have already engaged with a CLNM provider*, the MCO and the provider will identify and contact

individuals for enrollment in CLNM. The MCO will send a form letter cobranded by the MCO and MAD to the individual, informing them of CLNM and their enrollment in the program. If the letter is returned to the MCO as undeliverable, the MCO will send the returned letter to the provider agency, which is responsible for making address corrections and resending enrollment information to members.

Phase 2:

For counties in which there is only one CLNM Health Home

MCOs and providers will work to engage and enroll those current MCO members potentially eligible for CLNM services who *have not engaged directly with a CLNM provider*. In these cases, the MCO will send a letter to members who live in an eligible county and have a behavioral health diagnosis within the SMI/SED criteria. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the provider to describe the program and determine their interest in participating. The lists of potential members will also be sent to each CLNM provider in the appropriate counties.

Providers will contact MCO members to arrange an appointment for an evaluation and to determine eligibility and interest. Providers will opt-in members who express interest in participating. If the provider is unable to contact these individuals, or the member is uninterested in the program, the provider will opt them out if they have been preregistered in BHSDStar. Opt-in determinations will be transmitted through Omnicaid to MCOs on a nightly basis, and MCOs will either transfer care coordination to the CLNM provider or retain care coordination if the member does not opt-in to the Health Home program. Those who do not meet the SMI/SED criteria after evaluation will be advised that they will continue to receive care coordination services through the MCO. Upon permission from the MCO member, the provider will transmit clinical records to the MCO advising them there was no SMI/SED.

For individuals newly enrolled in Centennial Care who have had an HRA and potentially meet qualifications for participation in CLNM, the MCO will inform the member they are a candidate for the CLNM program, and will refer the individual to the provider for evaluation. MCOs will also provide the member's information to the Health Home.

For counties in which there is more than one CLNM Health Home

The MCO will send a letter to members living in an eligible county who have a behavioral health diagnosis within the SMI/SED criteria. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the provider of their choice to introduce the program and ascertain their interest in participating. The letter will contain a brief description and location of each health home in their county, and request they contact HSD to select a provider. HSD staff will refer individuals to the appropriate provider, and place the member on a referral list for the chosen provider. The list may be

uploaded to BHSDStar with new referrals described as registrants, or the CLNM provider may register and opt-in new clients themselves. From that point forward, the enrollment process described above should be followed.

Enrollment of FFS Recipients

For Medicaid recipients enrolled in FFS who are eligible for CLNM services and *have already engaged with a provider agency*, the provider will be responsible for identifying and contacting the individual for enrollment in CLNM. Registration information will be completed in the registration module of the BHSDStar system. Providers will contact Members to describe the benefits of CLNM and encourage participation in the program. The provider will then either opt the registered FFS member in or out of CLNM through the BHSDStar activation module.

Medicaid recipients enrolled in FFS Medicaid who are not engaged with a provider

For counties in which there is one CLNM provider

HSD will send a letter to recipients who live in an eligible county and have a behavioral health diagnosis within the SMI/SED criteria to inform them of the CLNM program and their potential eligibility. The letter will advise individuals that they will be contacted by the area provider to introduce the program and determine their interest in participating. Simultaneously, the list of potential CLNM members will be uploaded to the BHSDStar system and individuals described as “registrant” (care coordination level 8). The provider will contact FFS individuals to arrange an appointment for an evaluation to determine eligibility and interest. Providers will opt in referred individuals identified through this process who wish to participate. If a provider is unable to contact an individual, or the member is uninterested in the program, the provider will opt them out.

An individual’s activation status is documented in the BHSDStar “activation module” and transmitted to BHSDStar/Omnicaid on a nightly basis.

For counties in which there is more than one CLNM provider

HSD will send a letter to recipients who live in an eligible county and have a behavioral health diagnosis within the SMI/SED criteria to inform them of the CLNM program, their potential eligibility, and a description of each CLNM provider in the county. The letter will advise the member they can be referred to any providers on the list, and that they will receive a call to follow-up on their interest in the program and choice of providers. Those interested will be referred to the appropriate provider and advised they will be contacted to schedule an appointment. HSD will provide registration lists to the appropriate providers. From that point forward, the process described on page 23 should be implemented.

Enrollment of Walk-in Clients

Individuals who are not CLNM members and are being seen for the first time by a CLNM

provider should be screened to determine their potential eligibility for the program. The provider may introduce CLNM and opt the individual in if they are interested and eligible. This communication will be provided to the MCO.

Registered Members who cannot be located

Centennial Care enrollees who meet CLNM eligibility criteria and have been automatically registered have 90 days to opt-in to the program. However, circumstances may arise when the provider agency fails to make contact with the member to receive an affirmative program opt-in. If, after 90 days of good faith efforts to contact a member, the provider agency is unable to locate the member, the provider agency is to follow the opt-out process in BHSDStar. The provider agency should also note in BHSDStar that they were unable to contact the member.

If an eligible individual 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 individual still refuses to sign the agreement, the provider agency has the option of opting out this member. The provider agency should note the reason for the opt-out in BHSDStar.

Enrollment Timing/Documentation

A form documenting that CLNM members have affirmatively agreed to opt-in to CLNM must be retained on file in order to receive reimbursement for delivery of CLNM 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 on a daily basis, however, the effective date of enrollment can only be the first day of a month. It is the responsibility of the provider agency to communicate this information to potential CLNM members. If the delivery of services, including a diagnostic evaluation to determine eligibility, occurs before enrollment or before the first day of the month, the CLNM agency will bill the MCO or Conduent for each service rendered.

Information from MCO to provider upon member 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 CLNM via the DMZ file or secure e-mail, or any other secure method the two parties have agreed upon. If the information is unavailable, the MCO is to note the reason such as, "CNA not completed" or "no signed release of information".

Documents to be transferred to providers:

- History and physical
- Individualized service plans
- Health Risk Assessment
- Comprehensive needs assessments
- Functional assessment
- Current MCO care plan
- Emergency and 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 directives

Transitioning a Member who relocates

In the event that a member relocates from a county served by a CLNM provider into a new county served by a different provider, it is important for CLNM providers to remember the following:

- A member can only be enrolled for services at the first of a month;
- Only one PMPM can be billed for a member in any month.

If the first Health Home provided any of the six core services during the month the member transitions, they should bill the PMPM for that month. If the new provider also provides services to the same member, they can bill for other services (e.g. diagnostic evaluation, therapy, and group therapy) using the CMS 1500 form. They cannot bill for any of the six core CLNM services. CLNM providers should notify each other of a Member's relocation so the Member can be opted out of the first Health Home, and opted in to the second.

Disenrolling Members

Every CLNM member has the right to opt out of the program at the end of their enrollment anniversary. Opting out from CLNM does not affect an individual's access to services, with the exception of CLNM-specific services offered only to participants in the health home program. Documentation that Medicaid members have elected to opt out of CLNM must be retained on file. To disenroll, a member must contact the CLNM provider, who will enter the opt-out information in the BHSDStar activation module. The BHSDStar interface will transmit this information through Omnicaid, which will then transmit the information to the pertinent MCO. Medicaid members who choose to disenroll from CLNM will receive care coordination services from the MCO. The MCO will also change the member's care coordination level back to a "2" or "3". Additionally, the CLNM provider will notify the MCO,

and work with them to deliver a “warm transfer” of the individual to the MCO to assume or resume its care coordination activities.

Disenrollment can also occur when a CLNM member no longer meets the program’s eligibility criteria, such as a member losing Medicaid eligibility, which a provider may discover by verifying eligibility during a service appointment. A member may not necessarily notify their provider or provider network of a change in eligibility. Once a provider establishes a member’s ineligibility, the provider will immediately disenroll the individual in BHSDStar with an effective end date of the end of that month. This will be communicated to the MCO through the Omnicaid roster update.

Service Accessibility for CLNM Members—Hours of Operation

Each provider shall have a plan for providing necessary care coordination services outside of regular business hours (9:00 AM – to 5:00 PM). “Outside of regular business hours” operations mean compliance with Section 8.321.2 of New Mexico Administrative Code (NMAC). This section 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.” CLNM members should be provided with information about how to reach their care coordinator or other qualified member of the CLNM 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, data specifications, 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 CLNM provider has not provided notice in the manner or format prescribed by the HITECH Act, HSD may require the provider to provide such notice.

Disclosure and Confidentiality of Information

Confidentiality

The provider agency, its employees, agents, consultants or advisors must treat all information obtained through a CLNM provider’s delivery of 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 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 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 60 calendar days of the effective date of service implementation, the provider shall develop and provide to the CLNM 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 will be in accordance with applicable law. If the provider receives a request for information deemed confidential under this Agreement, the provider 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 delineated in this Section, the provider 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's operations, or the provider'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'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 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 providers', 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 CLNM 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 recurrence 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

CLNM 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;
- 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 cases, are to be outlined in MOAs. MOAs are required for the following: at least one primary care practice in the area that serves members less than 21 years of age; at least one primary care practice that serves members age 21 and older; local hospitals, and residential treatment facilities. MOAs are not required for support services agencies such as food banks.

MOA and other referral and communication protocols will be submitted to the Steering Committee for review as part of the application or readiness review process. For partnerships that require MOA, the referral process shall include acknowledgment of the

referral and follow-up with the member by both participating partners. Once a referral is made, the provider also has access to relevant data on the CLNM member, including his or her Service plan, unless the member does not authorize such data exchange.

For example, if a member is referred for follow-up primary care, the provider will work with the CLNM member and its primary care partner to schedule follow-up care. Once the referral is finalized, the primary care office will have access to relevant health data on the member, and will provide necessary follow-up care. If after-care is scheduled, the provider will confirm that the appointment occurred and check on outstanding care or treatment issues that arose during the appointment. As part of the provider's reporting requirements, the communication loop of referrals and follow-up will continue to be tracked.

For partnerships where *MOA are not required*, a good faith effort should be made by the provider to ensure that 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 activities post-engagement. Common linkages include assistance with continuation of healthcare benefits eligibility, disability benefits, housing, legal services, educational supports, employment supports, IHS and Tribal programs, DME, and other personal needs consistent with recovery goals and the Service plan. The care provider or care coordinator will make referrals to community services, link clients with natural supports and ensure that these connections are solid and effective. For referrals such as DME, a care coordinator will work with the member's physical health providers and MCO to obtain necessary equipment. Care coordinators are responsible for documenting outcomes of referrals, including notation of follow-up activities and any additional recommendations resulting from referrals.

Grievances and Appeals

CLNM care coordinators will be responsible for assisting members with appeals and grievances, including, but not limited to, explaining the right of appeals process and reporting grievances. Coordinators will contact a member's MCO and/or HSD for instructions on the process for filing a grievance or appeal, including timeframes and contact information. Procedures for grievances and appeals shall follow the requirements described in 8.308.15 NMAC.

Critical Incident Reporting

All providers delivering Medicaid-funded services to individuals receiving Home- and Community-Based Services, including CLNM providers, are required to report critical incidents to the State.

MCOs are required to research and investigate critical incidents and will collaborate with care coordinators to fulfill this requirement when a CLNM Member is involved. 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 provider agency is responsible for understanding and complying with these requirements.

To assist providers in understanding and complying with critical incident reporting, guidelines and forms for CI reporting are available at:

<http://www.hsd.state.nm.us/providers/critical-incident-reporting.aspx>

To obtain passwords and access to the reporting portal, email the HSD Critical Incident team at: HSD-QB-CIR@state.nm.us

MCO Role

The MCO shall comply with Section 2703 of the Patient Protection and Affordable Care Act (PPACA) and in accordance with the Medicaid State Plan Amendment to provide a comprehensive system of care coordination for Medicaid-eligible individuals with chronic conditions targeting a vulnerable population with behavioral health care needs through CLNM Health Homes.

The MCO will serve a complementary, but not duplicative, role in the delivery of CLNM services, beginning with identifying and contacting their members who meet CLNM eligibility requirements and referring interested MCO members to providers for enrollment in CLNM. The MCO shall ensure that Health Homes provide the delegated care coordination functions for Members enrolled with a Health Home. Delegated Health Home Care Coordination responsibilities include the following:

- Perform a Comprehensive Needs Assessment (CNA) for Health Home Members who meet the criteria. For members of the Health Home using the Treat First Model, an in-home visit will be required within 6 months;
- Assign Care Coordination levels for each Health Home Member;
- Adhere to Care Coordination activities for level 2 or level 3 as set forth in the HSD Policy Manual;
- Develop and implement Comprehensive Care Plans (CCP) for Members in Care Coordination levels 2 and 3 to monitor, on an ongoing basis, the effectiveness of the care coordination process;
- Develop and implement policies and procedures for ongoing identification of Members who may be eligible for a higher level of care coordination;
- Develop and implement policies and procedures for ongoing care coordination to ensure that Members receive all necessary and appropriate care;
- Monitor and evaluate a Member's emergency room and behavioral health crisis services utilization;
- Participate in the institutional setting's care planning process and discharge planning processes;
- Maintain individual case files for each Member;

- Ensure that Members transition to another MCO in accordance with HSD's protocols; and
- Ensure adequate care coordination staffing requirements, including training required to perform the care coordination activities.

The MCO will provide available member documentation to the Health Home, including but not limited to:

- History and physical;
- Individualized service plan;
- HRA;
- CNA;
- Functional Assessment;
- Comprehensive care plan;
- Emergency and backup plan;
- Behavioral health co-management summary notes; and
- Advance Directive.

Additionally, MCOs are responsible for:

- Conducting initial HRA for members, including initial recommendations and referrals to CLNM providers;
- Processing prior authorization requests from CLNM providers;
- Processing and oversight of all CLNM member claims and/or encounter data;
- Conducting the NFLOC assessment, including the Centennial Care Community Benefit Service Questionnaire (CBSQ) with the CLNM care coordinator, and providing results to Health Homes to be incorporated into Service plan. Please refer to the NFLOC section below for more information; and
- Establishing per-member-per-month (PMPM) payment agreements on the pass through of care coordination reimbursements from the State to the provider agency;
- Appointing one representative and one alternate representative to participate on the CLNM Steering Committee to help provide direction to and oversight of CLNM providers;
- Sponsoring the Emergency Department Information Exchange program (EDIE) so CLNM providers may receive real-time notifications of a Member's admission to an ED;
- Collecting and reporting on CLNM Member outcome measures identified by the CLNM Steering Committee; and
- Assisting CLNM providers in developing MOU with providers and identifying a referral network for CLNM Members.

MCOs are also responsible for developing a contract amendment template to be used to amend MCO contracts with CLNM providers. The contract amendment template should include the following information: that CLNM members are excluded from the MCO care coordination ratio requirements; varying timelines are allowed for completing a CNA and Service plan for CLNM members, and HRA requirements for the MCO are waived if the HRA has not been completed.

Emergency Department, Inpatient Admissions and Residential Services

CLNM providers are responsible for taking a lead role in transitional care activities for members, including interrupting patterns of avoidable hospital ED use, inpatient stays and unplanned readmissions. Provider agencies will work with additional healthcare providers and CLNM members to support proactive health promotion and self-management – activities that help ensure timely follow-up appointments, prevention of non-emergency use of the ED, and unplanned readmissions. When a member uses ED services, participating hospitals are required by Section 2703 of the ACA to refer the patient to a provider agency. Referral protocols should be established in MOA with hospitals in the geographic vicinity. MCOs will provide a daily hospital census from participating facilities to providers to assist in monitoring CLNM member utilization.

Nursing Facility Level of Care (NFLOC)

MCOs will provide training to Health Home providers on the criteria indicating eligibility for a NFLOC designation. If a CNA indicates that a member may qualify for community-based long-term services and supports, the care coordinator must ask the member if they wish to be evaluated for a NFLOC. A MCO care coordinator will identify indicators that may signal a member's eligibility for NFLOC, and relay that information to the provider. If the member is interested in a NFLOC evaluation, the CLNM care coordinator shall arrange for the evaluation with the assigned MCO, and will accompany the MCO care coordinator for the member's assessment. If a FFS recipient is in need of a NFLOC assessment for long-term services and supports, the State requires that the member must enroll with a MCO.

Factors that might indicate a member may be eligible for a NFLOC designation include the following:

- The individual is unable to self-administer "life preserving" medications;
- The individual has a cognitive or physical impairment that limits abilities to complete activities of daily living independently, such as getting dressed, bathing, grooming, eating, and acquiring or preparing food. Mobility and incontinence issues may also be present.

The MCO will be responsible for completing a NFLOC assessment, including the Centennial Care Community Benefit Service Questionnaire, for those CLNM members who qualify for Community Benefit Services. If NFLOC is met, the MCO will be responsible for completing

the allocation tool which is used to determine the number of hours of personal care services a member receives. The MCO will also develop the community benefit care plan. MCOs will provide the NFLOC assessment and care plans to the CLNM provider to coordinate and monitor utilization of Community Benefit Services. When a NFLOC is established, the care coordinators from the MCO and CLNM provider agency will jointly conduct an in-home assessment. If the member is eligible for community benefits, the MCO will retain the self-directed care budget, but the CLNM care coordinator will conduct the care management and care coordination.

The MCO will conduct a NFLOC reassessment at least annually. A NFLOC reassessment shall also be conducted within five business days of learning of a change in a member's functional or medical status. The CLNM care coordinator is responsible for tracking these dates and ensuring communication regarding the member's needs.

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

- Community Benefits as deemed appropriate based on the CNA;
- The option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit. Members who select the Agency-Based Community Benefit will have a choice of using the consumer-delegated model or consumer-directed model for personal care services.

The CLNM care coordinator shall be familiar with these benefits and ensure the member's choices are reflected in the member's Service plan. While the MCO is responsible for the NFLOC assessment, the CLNM care coordinator should be aware that the MCO must complete the CNA and NFLOC determinations 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-determination expiration.

Health Information Technology

The BHSDStar web-based data collection tool is used to create HIT linkages for provider agencies and ancillary care providers. The modules in support of care management are comprised of registration and activation and include the level of care in which the member is placed, a CLNM comprehensive needs assessment that requires first appointment screenings and imminent clinical risk assessment, with more comprehensive history and information gathering over the course of four appointments. A service plan is developed with the member inclusive of short- and long-term goals, service requirements and expected outcomes. All were developed for touch screen laptops or tablets for in-home or community use.

BHSDStar also collects member information including care coordination (with call tracking and referrals), assessments, Service plans, and quality tracking. These resources will be available to CLNM providers to support the Member and the Health Home Care Coordinator in identifying the unmet needs, gaps in care, clinical protocols required, case management, medical and behavioral health service, and social determinants of health.

In addition to the Star system, HSD will be using Medicaid Management Information System (MMIS) data elements for the purpose of CLNM enrollment. To support use of BHSDStar and other web-based data tools, the provider agency must have computers and an internet connection.

BHSDStar Modules

Manuals and user guides for staff registration and CareLink client registration, assessments, billing, and data upload may be accessed at: <http://www.bhsdstar.org/manuals-guides>

If you need additional information on BHSDStar, please contact Star support at: <https://support.bhsdstar.org/support/login>

Registration and activation modules

These modules are used to enter basic client contact information and levels of care coordination. The Member “Profile” module includes MCO affiliation and Medicaid ID number; this information should be confirmed (and frequently checked) in the New Mexico Medicaid Portal:

<https://nmmedicaid.portal.conduent.com/static/index.htm#ProviderEnrollment>

Client Services Module

Provider staff members will use this module to track activities contained within the six required core services. The module will contain a checklist of all activities within each of the six services, and a field for staff to record time spent conducting each activity. A table on page 40 of this Manual lists CLNM procedural codes for billing. A “reminder” tracking application for provider staff will help organize staff activities based on time allocations they have established when planning care activities.

CLNM Comprehensive Needs Assessment

This standardized CNA has been automated in BHSDStar, and has varying levels of security (permissions) reflective of which staff members have access to information. Access is based on the status of the relationship (existing MOA) and the member’s consent.

CLNM Service Plan

This is the standardized plan of service developed by HSD to be utilized by all CLNM providers and automated in BHSDStar. It has varying levels of security (permissions)

reflective of which staff members have access to the information. Access is based on the status of the relationship (existing MOA) and the member's consent.

Quality

The provider agency is responsible for collecting and using data that supports a continuous quality improvement program. Data must be sufficient to fully inform the following:

- Ongoing quality measurements;
- An evaluation of coordination of integrated care and chronic disease management on individual-level clinical outcomes;
- Experience of care outcomes;
- Quality of care outcomes at the population level.

Please see the "Quality and Outcomes" section on page 42 for more information. Appendix C of this manual (page 50) contains evaluation criteria for the CLNM program.

EDIE PreManage

Emergency Department Information Exchange software automatically sends real time notifications to CLNM providers when patients present at the ED. The content of the notification includes a patient's social information and clinical ED history, and care guidelines. New Mexico MCOs sponsor the EDIE program to help monitor and improve the quality of essential ED visits and potentially reduce unnecessary readmissions.

PRISM Risk Management

PRISM, a risk management application based on 15 months of rolling claims data affords CLNM providers with options to target care management services based on predictive risk scores and utilization data. Using this tool, care coordinators can review the relationship between PRISM predictive risk scores and alternative methods of targeting based on prior ED or inpatient 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. To register for PRISM access, Health Homes will request access from the CLNM Steering Committee through the Program Manager.

Meaningful Use

A core service of the CLNM program is the use of HIT to link services for members. To facilitate the use of HIT, CLNM providers are expected to adopt meaningful use practices outlined by the Office of the National Coordinator (ONC). ONC defines "meaningful use" as the use of EHR technology to:

- Improve quality, safety and 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:

- Improve clinical outcomes;
- Improve population health outcomes;
- Increase transparency and efficiency;
- Empower individuals;
- Improve research data on health systems.

Health Home Reimbursement

PMPM

CLNM providers are reimbursed through a per-member per-month (PMPM) payment specific to each CLNM provider. CLNM-dedicated services include the six core service categories that are not duplicative of Centennial Care services. A provider will bill for the approved list of CLNM core services using the CMS 1500. Additional Medicaid-covered services provided to members are billed and reimbursed separately from the approved list of CLNM core services. It is important that providers check a Member's Medicaid eligibility frequently to ensure CLNM services will be covered by Medicaid, and that the correct MCO is listed in the Member's records.

The PMPM rate will be updated as needed based upon results of analyses, including claims experience. HSD reserves the right to update PMPM rates as deemed necessary. The PMPM reimbursement is paid for each CLNM member, regardless of whether the member is enrolled with an MCO or in FFS Medicaid. The provider is responsible for verifying a member's affirmative agreement to participate and opt-in for CLNM services. In order to be reimbursed, providers must retain a signed opt-in statement in a member's file.

Billing Instructions

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

- IHS and 638 tribal facilities will be billing other services utilizing the OMB rate, and shall bill CLNM codes on a CMS 1500 claim form utilizing the HCPCS codes listed below.

Codes for common CLNM-approved services are listed below. Each month, G9001 and/or G9003 codes and one or more of the six CLNM core service codes listed below 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) Identify high risk individuals to ensure individuals and their families actively participating in the CNA and service planning. Monitor the implementation of the Service plan and: 1) evolution into member's health care and self-management; 2) use of services; 3) prioritization of transitional care activities. Assign appropriate CLNM team to lead member's care.	15 minutes
T1016	U1	Care Coordination (CC) Assigned team leaders coordinate activities of team and local providers to implement the Service plan. Reinforce treatment strategies to increase the individual's motivation to actively self-manage chronic health conditions.	15 minutes
T1016	U2	Comprehensive Transitional Care Maximize a member's ability to live safely in the community and minimize the use of out-of-home placements and ED. Assure continuation of the treatment plan across all levels of care such as early discharge planning and proactive prevention of avoidable readmissions. Require 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 Assist members to attain the highest level of health and functionality within the family and broader community. Ensure individual engagements support recovery and resiliency, and involve peer, family and other support groups, Tribal programs, and formal self-care programs as needed.	15 minutes
T1016	U4	Referral to Community and Social Support Services Identify available community-based resources and actively manage appropriate referrals. Engage other community and social supports, and follow up post-engagement. Referral may include service providers for: 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 Coordinate individual, group and environmental strategies aimed at disseminating information to support healthy living and reducing 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
G9003		Coordinated care fee – high risk for high fidelity wraparound services	Capitation PMPM

Compliance and Oversight

Quality and Outcomes

Quality and health outcome measures of CLNM members are crucial. In addition to being a federal requirement of the Health Home program, measurements also provide essential information to the State and eligible providers on program impact to support the underlying goals of the program.

HSD will monitor a set of core health measurements to evaluate health outcomes of CLNM members. The chart of Evaluation Criteria (Appendix C on page 50) lists required health performance measures, designating outcomes as clinical and social determinants of health, experience of care, quality of care, utilization of services, or cost of care. Please note the table is organized by the following five overriding goals of the CLNM program:

1. Promote acute and long-term health;
2. Prevent risk behaviors;
3. Enhance member engagement and self-efficacy;
4. Improve quality of life for individuals with SMI/SED;
5. Reduce avoidable utilization of emergency departments, inpatient, and residential services.

Much of this information will be captured through providers' use of the BHSDStar service module; other information will be collected through MCO HEDIS data, HSD claims data, and Member surveys. Quality reports will be monitored by the Steering Committee at regular intervals to determine program efficacy and as the basis of practice improvement plans if large gaps in health outcomes are identified.

Monitoring and Oversight

The Steering Committee, comprised of leaders from MAD, BHSD, CYFD, UNM Psychiatric Center, and MCOs, is charged with selection of participating agencies, oversight of program implementation, and monitoring of activities.

Monitoring and oversight are intended to monitor agency activities and data to determine conformance to expectations. Expectations are outlined throughout this Policy Manual and in agency-specific plans. Monitoring and oversight looks at membership, comprehensive case management, care coordination, health promotion and disease management, comprehensive transitional care, individual and family support services, referral to community and social support services, wraparound, integration of behavioral health and physical health, staffing, and other aspects of program implementation. Monitoring this information enables the Steering Committee to identify challenges and barriers, and to work with providers to develop practice improvement strategies when needed.

Data and information sources include:

1. System data derived from BHSDStar HSD claims data and Member surveys. Star data include quality and outcome evaluation metrics as well as well as measures that track service delivery and referrals (e.g., numbers of members receiving each service, frequency, and amounts).
2. Qualitative case review information derived from BHSDStar and provider-specific EHR that will allow for comparisons of the Comprehensive Needs Assessment (CNA), the service plan, service delivery, and referrals for consistency.
3. Interviews with and/or reports from providers that yield descriptions and explanations of findings from system data and case reviews.

Findings from oversight and monitoring will help inform future CLNM strategies with HSD leadership. Tools and measures used for monitoring and oversight shall be shared with providers to facilitate and foster proactive, continuous quality improvement efforts.

CLNM Member files (paper or electronic) must at minimum include the following:

- Participation agreement;
- Initial CNA and all reassessments;
- Initial CLNM Service plan and subsequent updates;
- Service tracking of member;
- Referral tracking of member;
- All releases of information signed by the member;

Long-term Evaluation of Return on Investments

This evaluation component is conducted by UNM's Consortium for Behavioral Health Research and Training (CBHTR). The research includes extensive analyses of claims and other data in order to determine whether monthly costs per CLNM Member have shifted from baseline measures (2014-15) to annual measures post implementation. These analyses are done by type of care provided (acute v. intervention), diagnosis (SMI, SED, and SMI and SUD), and by numbers of comorbid conditions.

Health Home Appendices

Appendix A – Acronyms

ACA	Patient Protection and Affordable Care Act
AOD	Alcohol or Other Drugs
BHA	Behavioral Health Agency
BHSD	Behavioral Health Services Division
CANS	Child and Adolescent Needs and Strengths assessment
CBSQ	Community Benefit Service Questionnaire
CCSS	Comprehensive Community Support Services
CLNM	CareLink NewMexico
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNA	Comprehensive Needs Assessment
COE	Category of Eligibility
CRA	Comprehensive Risk Assessment
CSA	Core Service Agency
EDIE	Emergency Department Information Exchange
EHR	Electronic Health Records
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
HRA	Health Risk Assessment
HSD	New Mexico Human Services Department
ICF/MR/DD	An individual with an intellectual or developmental disability 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
NFLOC	Nursing Facility Level of Care
NMAC	New Mexico Administrative Code
NMSA	New Mexico Statutes Annotated
PFOC	Primary Freedom of Choice
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

Appendix B – Criteria for SMI and SED

Criteria for Severe Emotional Disturbance Determination

Age

Less than 18 years of age, or between ages of 18 and 21, who received services prior to eighteenth birthday, was diagnosed with a SED, and demonstrates a continued need for services.

Diagnoses must meet category A or B below

- 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 (DSM). Please note: diagnoses that are included are only those providing a primary reason for receiving public system behavioral health services.
- Neurodevelopmental Disorders (299.00, 307.22, 307.23, 307.3, 307.9, 314.00, 314.01, 315.4, 315.35, 315.39, 315.8, 315.9, 319)
 - Schizophrenia Spectrum and other Psychotic Disorders (293.81, 293.82, 295.40, 295.70, 295.90, 297.1, 298.8, 293.89, 298.8, 301.22)
 - Bipolar and Related Disorders (293.83, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.89)
 - Depressive Disorders (296.99, 293.83, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 300.4, 31, 625.4)
 - Anxiety Disorders (293.84, 300.00, 300.01, 300.02, 300.09, 300.22, 300.23, 300.29, 309.21, 300.23)
 - Obsessive-Compulsive Related Disorders (294.8, 300.3, 300.7, 312.39, 698.4)
 - Trauma-and Stressor Related Disorders (308.3, 309.0, 309.24, 309.28, 309.3, 309.4, 309.81, 309.89, 309.9, 313.89)
 - Dissociative Disorders (300.12, 300.13, 300.14, 300.15, 300.6)
 - Somatic Symptom and Related Disorders (300.11, 300.19, 300.7, 300.82, 300.89)
 - Feeding and Eating Disorders (307.1, 307.50, 307.51, 307.52, 307.53, 307.59)
 - Elimination Disorders (307.6, 307.7, 787.60, 788.30, 788.39)
 - Disruptive, Impulse Control and Conduct Disorders (312.32, 312.33, 312.34, 312.81, 312.89, 312.9, 313.81)
 - Substance-Related and Addictive Disorders (292.9, 303.90, 304.00, 304.20, 304.30, 304.40, 304.50, 304.60, 304.90)
- 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. 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;
- Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events listed 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.

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, inability 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 or work:** Impairment in school/work function is manifested by an inability to pursue educational goals in a normal timeframe (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).

Symptoms

Individuals manifest symptoms in one of the following categories:

- **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 which substantially interfere with or limit 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 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 as 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.

Duration

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

Criteria for Serious Mental Illness Determination

Age

The individual must be an adult 18 years of age or older.

Diagnoses

The individual must have one of the diagnoses specified in the list below 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.

- Schizophrenia (295.90)
- Other Psychotic Disorders
 - Delusional Disorder (297.1);
 - Schizoaffective Disorder (295.70)
 - Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (298.8)
 - Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (298.9)
- Major Depression and Bipolar Disorder
 - Major Depressive Disorder (296.xx)
 - Bi-Polar Disorders (296.xx except Unspecified Bi-Polar and Related Disorder 296.80)
- Other Mood Disorders
 - Cyclothymic Disorder (301.13)
 - Persistent Depressive Disorder (300.4)
- Anxiety Disorders
 - Panic Disorder (300.01)
 - Generalized Anxiety Disorder (300.02)
- Obsessive Compulsive & Related Disorders
 - Obsessive Compulsive & Related Disorders (300.3)
- Trauma and Stressor-Related Disorders:
 - Posttraumatic Stress Disorder (309.81)
- Eating Disorders
 - Anorexia Nervosa (307.1)
 - Bulimia Nervosa (307.51)
- Somatic Symptom and Related Disorders
 - Conversion Disorder (300.11)
 - Somatic Symptom Disorder (300.82)
 - Factitious Disorder Imposed on Self (300.19)
- Dissociative Disorders
 - Dissociative Amnesia (300.12)
 - Dissociative Identity Disorder (300.14)

- Personality Disorders (for which there is an evidence-based clinical intervention)
 - Borderline Personality Disorder (301.83)

Functional Impairment

The disturbance is excessive and causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.

Duration

Duration of the disorder is expected to be six months or longer.

In order to receive a diagnosis of SMI, a person must meet one of the following criteria in Section A or Section B in addition to one of the diagnoses listed above.

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

Appendix C - 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: Prevent Risk Behaviors

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

Intermediate Actions	Adult/child/ both	Domain	Reporting Frequency	Measure	Value	Data source
Screening for recommended immunizations	B	QOC	Annual	% of members with immunizations in a reporting year	+/-	Star Service Tracking
Screening for alcohol use	B Ages 8 & >	QOC	Annual	% of members screened	+/-	Star Service Tracking
Screening for tobacco use	B Ages 8 & >	QOC	Annual	% of members screened	+/-	Star Service Tracking
Other substance use screening	B Ages 8 & >	QOC	Annual	% of members screened for substance use	+/-	Star Service Tracking
Suicide risk assessment	B	QOC	Semi-annual	% of members screened for suicide risk	+/-	Star Service Tracking
Major depressive disorder (MDD) suicide screening	B	QOC	Semi-annual	% of members with Depression Survey score of 15 or above screened for suicide risk	+/-	Star Service Tracking
Screening for clinical depression and follow up plan [CDF] CMS criteria	B Ages 12 & >	QOC	Semi-annual	% of members age 12 and older screened for clinical depression using an age-appropriate standardized depression screening tool, and if positive, had a follow-up plan documented on the date of the positive screen	+/-	Star service Tracking

Adult Body Mass Index Assessment (BMI) – adults [ABA] CMS criteria	A	QOC	Annual	% of members 18-74 years (those with at least one outpatient visit during the measurement year) who had their BMI documented during the measurement year or the year prior to the measurement year	BMI value	Star Service Tracking
Weight Assessment Children – (BMI)	C	QOC	Semi-annual	% of members ages 3-17 who had visit and had 9 BMI documented during the measurement year or the year prior to measurement year (NOTE: actual BMI will be graphed over time)	BMI value	Star Service Tracking
Diabetes screening for adults that are overweight or obese	A	QOC	Annual	% of adults ages 40-70 who are overweight or obese that had a glucose test or HbA1c	HbA1c or glucose value	Star Service Tracking
Diabetes screening for people who are on atypical anti-psychotics (HbA1C)	B [18+ = Adults?	QOC	Semi-annual	% of members ages 18 & > having a glucose test or an Hba1c during the measurement year	HbA1c or glucose value	Star Service Tracking
Physical examination within 1 month of admission to HH or transfer of records current within the last 12 months	B	QOC	Annual	% of members w physical exam w/in 1 month of HH opt-in	Date of exam	Star Service Tracking
Serum lipid profile for adults with SMI who are on atypical anti-psychotics	A	QOC	Annual	% of members ages 18-74 who had serum lipid profile done	Actual value	Star Service Tracking
Screening for cervical cancer	A	QOC HEDIS	Annual	% of women ages 21-64 meeting the criteria	+/-	MCO
Screening for breast cancer	A	QOC HEDIS	Annual	% of women ages 50-74 who had a mammogram to screen for breast cancer in measurement year or 2 years prior	+/-	MCO

Screening for colon cancer	A Ages 50-75	QOC HEDIS	Annual	% of members ages 50-75 who had appropriate screening for colorectal cancer in measurement year & 1 year prior	+/-	MCO
Screening for chronic infectious diseases: HIV	B Ages 11 & >	QOC	Annual	% of members age 11 & > screened	+/-	Star Service Tracking
Screening for chronic infectious diseases: Hepatitis B	B Ages 11 & >	QOC American Assoc of Pediatrics	Annual	% of members ages 11 & > screened	+/-	Star Service Tracking
Screening for chronic infectious diseases: Hepatitis C	B Ages 11 & >	QOC American Assoc of Pediatrics	Annual	% of members ages 11 & > screened	+/-	Star Service Tracking
Metabolic monitoring for children & adolescents on antipsychotics	C	QOC HEDIS	Annual	% of members ages 1–17 (in 3 age stratifications: 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	MCO
Child abuse screening	B	QOC	Annual	% of members screened for past or present child abuse within the measurement year	+/-	Star Service Tracking
Intimate Partner Violence screening	B	QOC	Annual	% of members all ages screened for domestic violence within the measurement year	+/-	Star Service Tracking

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

Intermediate Actions	Adult/child/both	Domain	Reporting Frequency	Measure	Value	Data source
Control of diabetes for individuals with a diagnosis of type 1 or type 2 diabetes mellitus	B		Semi-Annual	% of members with a diagnosis of type 1 or type 2 diabetes mellitus with a hemoglobin A1c (HbA1c) > 9.0% % of members with a diagnosis of type 1 or type 2 diabetes mellitus with a hemoglobin A1c (HbA1c) < 8.0	HbA1c value	Star Service Tracking
Follow-up plan for positive suicide risk screening	B	QOC	Semi-annual	% of members with a plan documented in care plan	y/n	Star Service Tracking
Follow-up plan for positive depression screen (see above, part of CMS criteria)	B Ages 12 & >	QOC	Semi-annual	% of members ages 12 & > w a plan documented on date of positive depression screen	y/n	Star Service Tracking
Treatment plan for BMI >30	B	QOC	Semi-annual	% of members with BMI > 30 who have a treatment plan to address obesity		Star Service Tracking
Treatment plan for BMI < 17.5	B	QOC	Semi-annual	% of members with BMI < 17.5 w a treatment plan to address weight & nutrition		Star Service Tracking
Controlling high blood pressure (Source: NCQA) CMS criteria	A	OC HEDIS	Annual	% of patients ages 18-85 with serious mental illness who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year	Actual value	Star Service Tracking

Initiation and engagement of alcohol and other drug dependence treatment CMS criteria	B Ages 13 & >	QOC HEDIS	Annual	% of members ages 13 & > with a new episode of alcohol or other drug (AOD) dependence who 1) initiated treatment through an IP AOD admission, OP visit, IOP 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 treatment	y/n	MCO
Tobacco cessation follow-up	B Ages 8 & >	OC	Semi-annual	% of members ages 8 & > reporting a reduction or cessation of smoking	y/n	Star Service Tracking
Follow-up after hospitalization for mental illness 7 days (see below, part of 2-part CMS criteria)	B Ages 6 & >	QOC HEDIS	Annual	% of discharges for members ages 6 & > 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	MCO
Follow-up after hospitalization for mental illness 30 days CMS criteria	B	QOC HEDIS	Annual	% of discharges for members 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 30 days of discharge	y/n	MCO
Care coordinator involved in discharge planning for IP admissions, residential, NF, or correctional facility	B	QOC	Annual	% of discharges with active participation of HH staff	y/n	Star Service Tracking

Antidepressant medication management (AMM)	A	OC HEDIS	Annual	% of members ages 18 & > who were treated with antidepressants, had a dx of major depressive disorder (MDD) and who remained on anti-depressant medication for at least 84 days (12 weeks)	y/n	MCO
Quarterly medication reconciliation with adolescents, adults and PCP	B	QOC	Semi-annual	% of members for whom medications were reconciled by a prescribing practitioner, clinical pharmacist or registered nurse	y/n	Star Service Tracking
Multidisciplinary care management meetings	B	QOC	Semi-annual	% of members that had a multi-disciplinary care team meeting	date	Star Service Tracking
Completed visits for referral	B	QOC	Semi-annual	Composite % of all visits for members for whom referrals have been made and the referral appt. was kept	y/n	Star Service Tracking
Coordinate with school (with parental permission) related to setting of care transitions	C	QOC	Semi-annual	% of care transitions for youth where coordination with school is indicated	y/n	Star Service Tracking

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

Intermediate Actions	Adult/child/both	Domain	Reporting Frequency	Measure	Value	Data source
Peer Support	B	QOC EOC	Annual	% of members reporting positive experience w peer support services	y/n	Star Service Tracking & member survey
Family Support	B	QOC EOC	Annual	% of family members reporting positive experience w/family support services		Member survey
Care planning with member/family	B	EOC	Annual	% of members and/or family reporting inclusion in goal development and care planning	y/n	Member survey

Education	B	QOC	Annual	% of members 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	Member survey
Education Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A	OC HEDIS	Annual	% of individuals ages 18 & > with schizophrenia or schizoaffective disorder who had at least 2 rx 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).		MCO
Antidepressant medication management	A	QOC HEDIS	Annual	% of members ages 18 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	MCO
Knowledge of condition(s)	B	EOC	Annual	% of members and/or family who report having adequate or higher level of knowledge of condition(s)	y/n	Member survey

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

Intermediate Actions	Adult/child/both	Domain	Reporting Frequency	Measure	Data source
Achievement in goals & activities identified by member	B	OC EOC	Annual	% of members reporting positive progress in identified goals & activities	Member survey
Skills development	B	QOC EOC	Annual	% of members reporting learned coping skills that work	Member survey

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

Intermediate Actions	Adult/child/both	Domain	Reporting Frequency	Measure	Data Source
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite [PQ192]: CMS criteria (AHRQ)	A	OC \$ SU	Annual	Rate of inpatient hospital admissions for HH Members 18 years or more for ambulatory care sensitive chronic conditions per 100,000 enrollee months (includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure)	MCO
Plan All Cause Readmission Rate [PCR] CMS criteria	A	\$ SU	Annual	% of acute inpatient stays during the measurement year for HH Members age 18 and older that were followed by an unplanned acute readmission for any diagnosis within 30 days.	MCO

Follow-up after hospitalization for mental illness HEDIS CMS criteria	B Ages 6 & >	QOC	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 practitioner within 7 days and 30 days of discharge.	MCO
Follow-up after residential treatment	C	QOC	Annual	% of discharges from residential treatment to a lower level of care followed up with a behavioral health visit within 30 days.	MCO
Ambulatory Care – Emergency Department Visits [AMB] CMS criteria	B	\$ SU	Annual	Rate of emergency department visits during the measurement year per 1,000 enrollee months.	HSD Claims Data
Inpatient Utilization [IU] CMS criteria	B	\$ SU	Annual	Rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) during the measurement year per 1,000 enrollee months.	HSD Claims Data
Utilization of ED CMS criteria	B	\$ SU	Annual	% of Members with 2 or more ED visits within 6 months for a behavioral health condition including substance abuse	MCO
Nursing Facility Utilization [NFU] CMS criteria	A	\$ SU	Annual	Two rates: <ul style="list-style-type: none"> • Rate of admissions to a nursing facility from the community that resulted in a short-term (less than 101 days) during the measurement year per 1,000 enrollee months. • Rate of admissions to a nursing facility from the community that resulted in a long-term stay (equal to or greater than 101 days) during the measurement year per 1,000 enrollee months. 	HSD Claims Data

Appendix D - CLNM Member Participation Agreement

Name: Client Name	Medicaid ID # 12345	Page 1 of 2
Type: Client Participation Agreement		Date:

CLNM AGENCY NAME

CARELINK NM (HEALTH HOME) PARTICIPATION

I understand that I have been Identified as being eligible to participate in the CareLink New Mexico (CLNM) Health Home program. The health home program is designed to help coordinate the care I receive between my Managed Care Organization (MCO), primary care provider, behavioral health provider, and any other identified health professional(s) identified through my Comprehensive Needs Assessment (CNA) and Care Plan (CP).

By participating in CLNM, I grant **CLNM AGENCY NAME** permission to release/disclose any and all health records including alcohol and substance abuse records covered under 42 CFR, Part 2, necessary for the purposes of registration, determination of eligibility, for coordination of care, and billing /payment purposes. By agreeing to participate, I give consent for my MCO to make available to **CLNM AGENCY NAME** past treatment and care coordination records. I agree to release **CLNM AGENCY NAME** and any related entities, employees and Directors from any and all liability related to or arising from any such release or disclosure. I understand that the information used for the above purposes will be kept strictly confidential in accordance with all federal and state privacy and confidentiality laws.

I understand that I may revoke this consent at any time; however, if I revoke my signed consent, I may no longer be eligible for services under the CLNM Health Home.

It has been explained to me that I may choose to participate in this program or to decline participation and that by declining, it will in no manner effect the current mental health or primary care services I am receiving. At this time, I:

- Choose to participate
- Decline to participate

By choosing or declining to participate in the CareLink NM Health Home program, I understand that **CLNM AGENCY NAME** will notify my MCO of my decision. Identified MCO:

- Blue Cross Blue Shield
- Molina Health Care
- Presbyterian Health Plan
- UnitedHealthcare Community Plan

CLIENT or legal representative SIGNATURE: _____
(Relationship to Client) (Date)

STAFF SIGNATURE: _____
(Staff Name) (Date)

I hereby authorize **MCO NAME** to disclose all health records and care coordination records. I further authorize disclosure of health information that includes information relating to:

- _____ initials here treatment for alcohol and/or substance abuse records
- _____ initials here behavioral health services/psychiatric care records
- _____ initials here HIV or AIDS infection or other sexually transmitted disease records

These records are for the time period of _____ .I understand that I have a right to revoke/cancel this authorization at any time. I understand that if I revoke this authorization I must do so in writing and give my written revocation to **CLNM AGENCY NAME**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance when the law provides my insurer with the right to contest a claim under my policy. Unless I have revoked this authorization, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire in one (1) year from the date on which it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal and state privacy laws or regulations.

I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization and do not need to sign this authorization in order to obtain health care treatment, payment, enrollment, or eligibility for benefits. I understand that I have a right to a copy of this signed authorization.

SIGNATURE: _____ DATE _____
(Relationship to Client)

Appendix E – House of Representatives Bill HR443

Text from the bill that supports, affirms, and advances trauma informed care throughout the United States:

Whereas traumatic experiences affect millions of people in the United States and can affect a person’s mental, emotional, physical, spiritual, economic, and social well-being;

Whereas adverse childhood experiences (ACEs) can be traumatizing and, if not recognized, can affect health across the lifespan and, in some cases, result in a shortened life span;

Whereas ACEs are recognized as a proxy for toxic stress, which can affect brain development and can cause a lifetime of physical, mental, and social challenges;

Whereas ACEs and trauma are determinants of public health problems in the United States such as obesity, addiction, and serious mental illness;

Whereas trauma informed care is an approach that can bring greater understanding and more effective ways to support and serve children, adults, families, and communities affected by trauma;

Whereas trauma informed care is not a therapy or an intervention, but a principle-based, culture-change process aimed at recognizing strengths and resiliency as well as helping people who have experienced trauma to overcome those issues in order to lead healthy and positive lives;

Whereas adopting trauma informed approaches in workplaces, communities, and government programs can aid in preventing mental, emotional, physical, and/or social issues for people impacted by toxic stress and/or trauma;

Whereas trauma informed care has been promoted and established in communities across the United States, including the following different uses of trauma informed care being utilized by various types of entities:

(1) The State of Wisconsin established Fostering Futures, a statewide initiative partnering the State with Tribes, State agencies, county governments, and nonprofit organizations to make Wisconsin the first trauma informed State. The goal of Fostering Futures is to reduce toxic stress and improve lifelong health and well-being for all Wisconsinites.

(2) The Menominee Tribe in Wisconsin improved educational and public health outcomes by increasing understanding of historical trauma and childhood adversity and by developing culturally relevant, trauma informed practices.

(3) In Chicago, Illinois, schools of medicine provide critical trauma informed care, including the University of Illinois at Chicago Comprehensive Assessment and Response Training System, which improves the quality of psychiatric services provided to youth in foster care, and the University of Chicago Recovery & Empowerment After Community Trauma Initiative, which helps residents who are coping with community violence.

(4) In Philadelphia, Pennsylvania, service providers, academics, and local artists use art to engage their community to educate and involve citizens in trauma informed care activities.

(5) In San Francisco, California, the city's public health department aligned its workforce to create a trauma-informed system.

(6) In Kansas City, Missouri, schools worked to become trauma informed by encouraging teachers and children to create their own self-care plans to manage stress. They have implemented broad communitywide, trauma informed culture change.

(7) In Tarpon Springs, Florida, the city crafted a community effort to gather city officials, professionals, and residents to coordinate multiple trauma informed activities, including a community education day.

(8) In Worcester, Massachusetts, community members worked with the Massachusetts State Department of Mental Health to create a venue with peer-to-peer support to better engage individuals dealing with trauma or extreme emotional distress.

(9) In Walla Walla, Washington, the city and community members launched the Children's Resilience Initiative to mobilize neighborhoods and Washington State agencies to tackle ACEs.

(10) The State of Oregon passed the first law to promote trauma informed approaches to decrease rates of school absenteeism and understanding and promoting best practices to leverage community resources to support youth.

(11) The State of Massachusetts passed a law to promote whole-school efforts to implement trauma informed care approaches to support the social, emotional, and academic wellbeing of all students, including both preventive and intensive services and supports depending on students' needs.

(12) The State of Washington implemented the ACEs Public-Private Initiative, a collaboration among private, public, and community organizations to research and inform policies to prevent childhood trauma and reduce its negative emotional, social, and health effects;

Whereas the Substance Abuse and Mental Health Services Administration provides substantial resources to better engage individuals and communities across the United States to implement trauma informed care; and

Whereas numerous Federal agencies have integrated trauma informed approaches into their programs and grants and could benefit from closer collaboration: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes the importance, effectiveness, and need for trauma informed care among existing programs and agencies at the Federal level; and

(2) encourages the use and practice of trauma informed care within the Federal Government, its agencies, and the United States Congress.

Appendix F – Medicaid Categories of Eligibility - Limited Funding

MEDICAID CATEGORIES OF ELIGIBILITY - LIMITED FUNDING			
Category	Description	Benefit Type	Benefit Details
007	Children’s Medical Services	Limited	State funded through Public Health Division of Dept. of Health
029	Family Planning Only Medicaid	Limited	Family planning for women
041	Qualified Medicare Beneficiary - age 65 and over	Limited	Services limited to payment of Medicare premiums, coinsurance and deductibles for Medicare-covered services
042	Specified Low-income Medicare Beneficiaries, Qualified Individuals	Limited	Coverage is limited to payment of Medicare Part B premium; individuals do not receive a Medicaid card
044	Qualified Medicare Beneficiary - under age 65	Limited	Services limited to payment of Medicare premiums, coinsurance, and deductibles for Medicare-covered services
045	Specified Low-income Medicare Beneficiaries, Qualified Individuals	Limited	Coverage is limited to payment of Medicare Part B premium; individuals do not receive a Medicaid card
046	CYFD Foster Care, placed out-of-state	Limited	All services require prior authorization; individual does not receive a Medicaid card; CYFD category
047	CYFD Adoption Subsidy (IV-E), placed out-of-state	Limited	All services require prior authorization; individual does not receive a Medicaid card; CYFD category
050	Qualified Disabled Working Individuals	Limited	Coverage limited to payment of Medicare part A premium
081	Institutional Care - Aged	Full Benefits	For individuals requiring institutional care
083	Institutional Care Blind – full Medicaid coverage	Full Benefits	For individuals requiring institutional care
084	Institutional Care Disabled – full Medicaid coverage	Full Benefits	For individuals requiring institutional care
085	EMC for Undocumented Aliens	Limited	Coverage for emergency services for certain undocumented non-citizens who meet all eligibility criteria for a Medicaid category <i>except</i> for their alien status.