CareLink NM Health Homes

2022 Policy and Billing Manual

Fall 2022

CARELINK NM
YOUR CARE. OUR COMMUNITY.

Contents

Section 1

Overview and Purpose

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 HSD Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD) to assist in the administration of the CLNM program and provide direction to agencies that serve as CLNM providers.

The CLNM program is a set of services delivered through a designated provider agency authorized by Section 2703 of the Affordable Care Act (ACA). Prior to becoming a designated health home, a provider agency must complete a CareLink NM application, complete a readiness assessment, and enroll as a New Mexico Medicaid provider. CLNM services are provided to enhance integration and coordination of primary, acute, behavioral health, and long-term services and supports.

The CLNM provider assists eligible members by engaging members in a comprehensive needs assessment. The needs assessment is utilized to:

- Develop an integrated service plan.
- Increase access to health education and promotion activities.
- Monitor member treatment outcomes and utilization of resources.
- Coordinate appointments with primary care and specialty practitioners.
- Share information with physical and behavioral practitioners to reduce the duplication of services.
- Actively manage transitions between services and levels of care.
- Participate as deemed appropriate in the arrangements of hospital discharge.

The CLNM model builds on 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) enhance 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 Medicaid eligible members enrolled in fee-for-service (FFS) and managed care organization (MCO) already receiving behavioral health services, as well as new individuals who are eligible to participate in the program.

The goals of the CLNM providers are to:

1. Promote coordinated care for acute health conditions and improve long-term health;
2. Prevent risk behaviors;
3. Enhance member engagement and self-efficacy;

4. Improve quality of life for individuals with serious mental illness (SMI), severe emotional disturbance (SED), and substance use disorder (SUD); and
5. Reduce avoidable utilization of emergency department, inpatient, and residential services.

Section 2

Authority

New Mexico implemented Centennial Care in 2014 to modernize New Mexico's Medicaid program and developed the CLNM benefit for 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 eligible members enrolled in FFS and MCO members with chronic conditions, targeting a vulnerable population with behavioral health needs. CLNM provides services for Medicaid-eligible adults with SMI, Medicaid-eligible children and adolescents with a SED, and FFS recipients and MCO members with a SUD.

The policies in this Manual will be reviewed annually by Human Services Department. HSD reserves the right to modify or supersede any policies and procedures. The CLNM Policy and Billing Manual may be viewed or downloaded from MAD's home page website available here.

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

Section 3

Introduction to the CareLink Health Home Model

Definitions

CLNM Providers must deliver services in six core categories to members:

1. Comprehensive Care Management
2. Care Coordination
3. Prevention and Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support Services
6. Community and Social Support Service Referrals

High Fidelity Wraparound, while not a service, helps to make these core category services more effective. Detailed descriptions of the core service categories and High Fidelity Wraparound are provided below.

Comprehensive Care Management

Comprehensive Care Management requires a comprehensive needs assessment and the development of an individualized comprehensive service plan with active participation from the CLNM member, family, caregivers, and the CLNM provider team.

CLNM Care Coordination

These services are provided 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 their own health conditions. Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the service plan with a specific focus on enhancing CLNM members' and family members' ability to manage care and live safely in the community and enhancing the use of proactive health promotion and self-management.

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, sexually transmitted disease (STD) prevention and early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, and obesity reduction and prevention. Health promotion activities encourage 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.

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 emergency department services, residential treatment centers, and inpatient hospitalization, to transition 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 emergency department use and prevent gaps in services that could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care.

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 traditional and foster care family involvement and support, improve access to education and employment supports, and support recovery and resiliency.

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.

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.

Section 4

Provider Requirements

Enrollment as a Medicaid Provider and Contracting with MCO

Services offered to CLNM members are furnished by a variety of providers and provider groups. A CLNM provider must:

1. Be enrolled as a New Mexico Medicaid provider;
2. Meet all applicable CLNM standards; and
3. Secure Medicaid contracts with all New Mexico Managed Care Organizations.

Section 5

Health Information Technology to Link Services

The provider agency is responsible for using HIT to link available, appropriate services. The comprehensive needs assessment (CNA), service plan, critical planning and transition documents, and MCO or FFS utilization information may be shared via secure data exchange, email, or hard copy.

BHSDStar is used to collect and monitor 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 Data Tracking and 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 evaluation of coordination of care and chronic disease management clinical outcomes at the individual-level, and experience and quality of care outcomes at the population level. Specific health home quality indicators are mandated by CMS, and additional state-defined criteria are outlined in the Performance and Oversight section on page 30 of this Manual.

Providers will use the web-based tool, BHSDStar for data collection and reporting. BHSDStar tracks multiple member measures, including registration status, care coordination level, MCO, Medicaid eligibility, assessments, screenings, the CLNM service plan, referrals, and opt-in/opt-out status. Providers are required to update the care coordination level in BHSDStar once the CNA is completed and monitor the Medicaid portal to verify Medicaid eligibility and MCO selection. All rendered CLNM services are to be entered into service tracking modules.

To support use of BHSDStar, 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 Health Information Technology section of this manual on page 45.

Children, Youth and Families Department (CYFD) Wraparound staff work with CLNM providers and participating teams to use Wraparound-specific evaluation tools to measure program fidelity and ensure quality assurance. Please refer to the Performance and Oversight section of this manual on page 30 for specific tools and measures.

Eligible Providers

To be designated a CLNM provider, applicants 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; licensed psychologist; licensed independent social worker; clinical nurse specialist in psychiatric nursing; licensed, certified nurse practitioner in psychiatry; clinical nurse specializing in psychiatric nursing; licensed professional clinical mental health counselor; licensed marriage and family therapist; or licensed, independent school psychologist.
- Have 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; and
- Successfully complete a readiness review process.

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. **Director:** One director with a minimum of three years' experience working with a health home population. The director is to be specifically assigned to CLNM service oversight and administrative responsibilities. The director is responsible for overall service oversight, financial performance and quality management.
2. **Health Promotion Coordinator:** One health promotion coordinator with a bachelor's 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, and pulmonary and hypertensive care. Programs are developed based on the prevalent conditions and comorbidities of the regional population. The health promotion

coordinator role also includes the development and management of relationships with outside providers, such as the Department of Health and MCOs, to incorporate additional referral opportunities not available for the CLNM provider. This position also identifies gaps in disease management programming based on the specific CLNM population.

3. **Care Coordinator**: Multiple care coordinators who are licensed by Regulation and Licensing Department (RLD) as behavioral health practitioners, hold a human services bachelor's degree or master's degree with two years of behavioral health experience, are a registered nurse in New Mexico, or have other qualifications that are approved through the Health Home Steering Committee. A care coordinator develops and oversees a member's comprehensive care management and coordinates all physical, behavioral, and support services. Care coordinators 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; and
   - *Care Coordination Level 9* High Fidelity Wraparound: 1:8 - 1:10.

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

4. **Community Liaison:** A bilingual community liaison proficient in language(s) and experienced with local community resources. The community liaison works with member care coordinators to appropriately connect and engage members with needed community services, resources, and providers, including Indian Health Services (IHS) and Tribal programs.

5. **Certified Peer Support Workers (CPSW):** The CPSW are Certified Peer Support Workers, certified by the New Mexico Credentialing Board for Behavioral Health Professionals. CPSW have lived experience, having successfully navigated their own behavioral health experiences to assist peers in their own recovery processes. CPSW provide several individual and family support services and may be employed on a contract basis or full-time for other positions. More information and support to connect providers with peer support workers is available from the New Mexico Credentialing Board for Behavioral Health Professionals website and BHSD's Office of Peer Recovery and Engagement website.

6. **Certified Family Peer Support Workers (CFPSW)**: CFPSW 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. CFPSW provide support services to individuals and families and may be employed on a contract basis or full-time for other positions. More information and support to connect providers with family support specialists is available at the CYFD Behavioral Health Services website.

7. **Clinical Supervisor:** The Clinical Supervisor serves as a clinical review or resource for the care coordination staff, community liaison staff, health promotion coordinator, and peer and family support staff. Clinical Supervisors are independently licensed behavioral health practitioners as described in 8.321.2 of New Mexico Administrative Code (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 board requirements for supervision.

8. **Physical Health Consultant:** The physical health consultant is required to be a licensed physician (MD or DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC. The physical health consultant is available to the care team to address member physical health or substance use conditions. Physical health consultants must comply with their licensing board's requirements for supervision. The physical health consultant or the psychiatrist consultant must have the ability to consult with an addiction specialist or the UNM Project ECHO. Project ECHO connects community providers with specialists at centers of excellence in real-time collaborative sessions.

9. **Psychiatric Consultant**: The psychiatric consultant is required to be a licensed physician (MD or DO) and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC. The consulting psychiatrist is available to the care team to address member mental health or substance use conditions. The psychiatric consultant must comply with their licensing board requirements for supervision. The physical health consultant or the psychiatrist consultant must have the ability to consult with an addiction specialist or the UNM Project ECHO. Project ECHO connects community providers with specialists at centers of excellence in real-time collaborative sessions.

10. **Wraparound Supervisor-Coach:** The Wraparound supervisor-coach must be a Certified Wraparound Facilitator and completed or enrolled in the Coach in Training (CIT) track to receive a coaching endorsement. Wraparound Supervisor-Coaches develop and manage Wraparound facilitators. They are responsible for coordinating the implementation of the High Fidelity Wraparound model at their agency.

11. **Wraparound Facilitator**: The Wraparound facilitator must complete the "Foundations of Wraparound Practice" training and be certified by the New Mexico Credentialing Board for Behavioral Health Professionals. Wraparound facilitators provide intensive, supportive interventions for identified families using Wraparound values, principles, and practices. Interventions include facilitating team meetings, coordinating care with other agencies, developing and utilizing informal/formal supports, and identifying and making use of family strengths.

For additional information on Wraparound staff qualifications and responsibilities access the High Fidelity Wraparound Program website.

Note: A CLNM provider may employ additional required staff. Examples include: administrative assistants, nurses, physician 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.

Eligible Members

The target population of the CLNM program is Medicaid members who receive services through FFS or managed care and who are diagnosed with SMI, SED, or SUD.[1] To be eligible for CLNM, an individual must be enrolled in Centennial Care or Medicaid FFS and have one or more SMI, SED, or SUD.

A Medicaid eligible member:

- Is 21 years of age and older who meets the HSD criteria for serious mental illness (SMI).
- Is under 21 years of age who meets the HSD criteria for serious emotional disturbance (SED).
- Is any age and meets the HSD criteria for substance use disorder (SUD).

Once enrolled in CLNM, participants are referred to as CLNM members, but should not be confused with a Medicaid eligible member enrolled in FFS or MCO, which refers to an individual's type of Medicaid participation.

High Fidelity Wraparound

If approved by HSD or the CLNM Steering Committee, CLNM providers may also implement High Fidelity Wraparound. In addition to serving the members described above, separate member projections and per member per month (PMPM) rates are developed for the population of vulnerable children and youth ages 4-21 who meet the following conditions:

- Diagnosis of SED for youth younger than 18 or SMI for youth ages 18-21;
- Current or historical multi-system involvement (i.e., involvement with two or more systems including Juvenile Justice, child welfare, special education, or behavioral health); and
- Within a two-year period prior to evaluation experienced out-of-home placement, incarceration, or acute hospitalization; OR, currently in out-of-home placement, at risk of out-of-home placement, or precariously housed.

Identifying Members

Medicaid Diagnosis Eligibility

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

1. Medicaid enrollee in a "full" eligibility category,[2] including Medicaid eligible members enrolled in FFS and Managed Care, who are 18 years of age or older and meet the criteria for SMI; or

[1] SED as defined by the State of New Mexico (criteria are listed in Appendix B, beginning on page 51) and SUD as defined by the Diagnostic and Statistical Manual of Mental Disorders DSM-5 (DSM-5) described beginning on page 66 of this manual.

[2] Excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries

2. Medicaid enrollee in a "full" program eligibility category,[3] including Medicaid eligible members enrolled in FFS and Managed Care, who are under age 18 (or 21 years of age if services were received prior to age 18) and meet criteria for SED; or

3. Medicaid enrollee in a "full" program eligibility category,[4] including FFS recipients and MCO members, who are any age and meet the criteria for SUD, including but not limited to alcohol, opioids, benzodiazepines, cocaine, and methamphetamines.

High Fidelity Wraparound

CLNM providers will identify potential High Fidelity Wraparound members through relationships and referrals through community stakeholders such as local CYFD Juvenile Justice and Protective Services offices, schools, Treatment Foster Care providers, and residential treatment centers. High Fidelity Wraparound does not require preauthorization. Rather, in addition to meeting the High Fidelity Wraparound eligibility criteria described, a committee comprised of staff members from CYFD Wraparound, MCOs, and the CLNM Providers (and others who may inform youth Wraparound) must approve candidate eligibility for High Fidelity Wraparound.

Note: A member's Medicaid eligibility can be checked in the New Mexico Medicaid Portal available here.

"Full" Medicaid coverage for CLNM purposes includes most categories of eligibility (COE). For a list of those categories not covered, please refer to Appendix E, page 80 of this manual. The criteria for SMI, SED, and SUD diagnoses can be found in Appendix B, beginning on page 51 of this Manual. Individuals eligible for enrollment in CLNM will be broadly identified by HSD, MCOs, CLNM providers, community members, and emergency department. Additional enrollment considerations include:

- A Medicaid recipient can participate in CLNM if in FFS or managed care;
- A member cannot be enrolled with more than one CLNM provider simultaneously; and
- MCO staff may not enroll a Medicaid recipient into CLNM; only CLNM providers may complete this task.

The CLNM Member Participation Agreement can be found in Appendix D, beginning on page 78 of this Manual.

[3] Excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries

[4] Excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries

Section 6

Covered and Non-Covered Services

CLNM providers must demonstrate the ability to deliver core services and meet data and quality reporting requirements described in this Manual. CLNM Providers may meet member service needs by providing integrated physical and behavioral health services through a co-location of services model or through a memoranda of agreement (MOA).

MOAs are required with:

- At minimum one primary care practice that serves members less than 21 years of age; and
- At minimum 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.

CareLink NM services rendered during a Medicaid eligible member's stay in an acute care or freestanding psychiatric hospital and a residential treatment facility (not to include foster care and treatment foster care placements), except when part of the Medicaid eligible member's transition plan, are not covered services. Services that duplicate other MAD services, including care coordination activities that the MCO has not delegated to the provider agency, are not covered services.

CLNM core service categories:

1. Comprehensive Care Management;
2. CLNM Care Coordination;
3. Prevention and Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and
6. Community and Social Support Service Referrals.

In addition, High Fidelity Wraparound, wraps around these six core services categories to make them more effective.

Descriptions of the core service categories and High Fidelity Wraparound are below.

Comprehensive Care Management

The definition of Comprehensive Care Management is available in the Definitions section of this document.

Comprehensive care management services must include:

- Assessment of preliminary risk conditions and health needs;
- Comprehensive service plan development outlining member goals, preferences, optimum clinical outcomes, and 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 that bridges treatment and wellness support across behavioral health, primary care, and social health supports;
- Monitoring member health status and service use through claims-based data sets to determine adherence with treatment guidelines; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery, and costs.

CLNM Comprehensive Needs Assessment[5]

Comprehensive care management activities must include a needs assessment.

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

The CNA:

- Provides all the required data elements specified in the HSD authorized CNA;
- Assesses preliminary risk conditions and health needs;
  - Uses data from the risk management system (PRISM) 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 begin assessment within the mandated 14-calendar day timeframe;
  - May be conducted face-to-face in member home. If the member is homeless, the meeting may be held at a mutually agreed upon location;
  - Does not need to be completed during the first visit if the Treat First model is employed. The member would be assigned a "pending" status or assigned care coordinator Level 8 until a

[5] 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).

diagnosis of SMI, SED, or SUD 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;

- Must be completed within 90 days of member opt-in. Once the CNA is completed, the member care coordination level should be updated to “6”, “7”, or “9.” If a provider is unable to complete the CNA within the 90-day timeframe, they should opt-out the member in BHSDStar and notify the appropriate MCO. The exception to the 90-day timeframe is a member who has had two face-to-face encounters (in addition to Maintaining Engagement) with the provider within the 90-day period, and those services are documented in BHSDStar Service Tracking; and
- Include the following health screens:
  - Clinical screen for depression;
  - C-SSRS for suicide risk;
  - Audit-10 for risk of alcohol abuse; and
  - Questions related to past or current substance use, and PC-PTSD for indications of post-traumatic stress disorder.

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 within a MCO and CNA Frequency

A 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 behavioral health services with a pertinent diagnosis, but whom a provider has not been able to contact, may also be referred.

Guidelines within the CLNM for frequency of needs assessments based upon care coordination levels and outlined 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 system 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. Once the CNA has been completed, the CCL in BHSDStar should be updated to reflect the designated level (“6,” “7,” or “9”).
- Level 6 care coordination requires a needs assessment at least annually. Level 6 caseload recommendation is 1:51-1:100.
- Level 7 care coordination requires a needs assessment at least semi-annually. Level 7 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.

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. CLNM care coordinators should also consider changes in a member's housing, social supports, or other nonmedical services that would impact a member's care or wellbeing.

Care Coordination Level 6 Requirements

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

- A comorbid health condition.
- High emergency department 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) living 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 to members with one of the following:

- Determination of medical complexity or fragility.
- Excessive emergency department 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 Diagnostic and Statistical Manual of Mental Disorders (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 (for High Fidelity Wraparound members)

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

- Diagnosis of SED;
- Current or historic multi-system involvement in at least two of the following: child welfare, Juvenile Justice, special education services, 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.

CLNM Service Plan

The service plan template in BHSDStar[6] maps the 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 intended to be updated frequently to reflect member needs, communicate services a member will receive, and serve as a shared plan for the member, their family or representatives, caregivers, service providers, and other relevant stakeholders. The plan is intended to be supplemented by treatment plans developed by practitioners. The service plan:

- Requires active participation from members, family, caregivers, and CLNM team members;
- Requires consultation with interdisciplinary team experts, primary care providers, specialists, behavioral health providers, and other participants in member care;
- Identifies additional recommended health screenings;
- Addresses long-term and physical, behavioral, and social health needs;
- Is organized around member goals, preferences, and optimal clinical outcomes, including self-management and 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 designated 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 (NF LOC) determination. There is no required template; the plan is uploaded as a file into the State's web-based data collection tool, BHSDStar;
- Includes a crisis/emergency plan listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency. These are individualized plans entered into BHSDStar;
- Is shared with members and their providers; and

[6] Please refer to the "Heath Information Technology" section of this manual on page 10 for information on BHSDStar.

- Is updated with status and plan changes.

CLNM Team Roles

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., member 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

The definition of CLNM Care Coordination is available in the Definitions section of this document.

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 and providing access to substance abuse services.
- Coordinating primary, specialty, and transitional health care from emergency department, hospitals, and psychiatric residential treatment facilities.
- Making referrals, assisting in scheduling appointments, and conducting follow-up monitoring.
- Arranging for transportation to medically-necessary services.
- 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.
- Coordinating with the MCO care coordinator when a member has a NF LOC determination.
- Conducting a face-to-face in-home visit within two weeks of a NF LOC determination.

- Interrupting patterns of frequent hospital emergency use and reducing hospital admissions.

Prevention, Health Promotion, and Disease Management

The definition of Prevention, Health Promotion, and Disease Management is available in the Definitions section of this document.

Health promotion activities include, but are not limited to:

- Use of member-level, clinical data to address member-specific health promotion and self-care needs and goals. Assessment data is available in BHSDStar.
- Development of disease management and self-management plans with members.
- Delivery of health education specific to member 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, reduction and treatment, 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 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.
- 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

The definition of Comprehensive Transitional Care is available in the Definitions section of this document.

All CLNM providers are expected to register with the Collective Medical Emergency Department Information Exchange (EDIE). Through the EDIE system, CLNM providers receive notification when members are admitted to the emergency department or a hospital. CLNM providers may select the notification method (e.g., email, text) to provide necessary transitional care services.

Unplanned discharges for CLNM members trigger a team meeting convened by care coordinators, who are the designated points of contact. Wraparound Facilitators are the points of contact for discharges from congregate care settings and out-of-home placements for CLNM members enrolled

in High Fidelity Wraparound. The 7.20.11.23(H)(3) NMAC addresses unplanned discharges for minors: “If the child’s parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is affected. If the child’s family refuses to take physical custody of the child, the agency refers the case to the department.

It is expected that providers of transitional services will consider member transition from childhood to adulthood, member shift from pediatric to adult medical providers, or issues such as independent living arrangements when developing a service plan. 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 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, 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 emergency departments, domestic violence and other shelters, and residential treatment centers. Services should also support decreased hospital admissions and readmissions, homelessness, and involvement with State agencies such as Juvenile Justice, Protective Services, and Corrections.
- Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports.
- Sharing critical planning and transition documents with all providers involved with an individual’s care via web-based tools, secure email or hard copy.
- Facilitating critical transitions from child to adult services, or to long-term services and supports.

Individual and Family Support Services

The definition of Individual and Family Support Services is available in the Definitions section of this document.

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 the 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, which are especially critical in treating members with SUD.

- Assisting members in obtaining and adhering to medication schedules and other prescribed treatments.
- Assisting members in accessing self-help activities and services.
- Identifying resources for individuals to support them in attaining their highest level of health and functionality within their families and in their community.
- Assessing impacts of a member's behaviors on families and assisting in obtaining respite services as needed.

Referral to Community and Social Support Services

The definition of Referral to Community and Social Support Services is available in the Definitions section of this document.

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, supports for 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 health care 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 assisting members to establish and maintain eligibility for services. Common linkages could include continuation of health care 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.
- Confirming members' and providers' encounters and following up post-referral.

High Fidelity Wraparound

The definition of High Fidelity Wraparound is available in the Definitions section of this document.

High Fidelity 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;

- **Vision**: Helps a youth and family define their goals and inspires them to persevere during difficult times;
- **Needs-driven**: Helps understand why a behavior is occurring; and
- **Team-based**: Includes family members and natural supports as well as physical, behavioral health, and social services professionals working collaboratively to creatively address challenges.

Best Practices

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

- Provide quality-driven, cost-effective, culturally-appropriate, and person- and family- centered services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and SUD.
- 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 health care system.
- Coordinate and provide the practice and use of trauma responsive care to more effectively support youth and adults impacted by toxic stress and trauma.
- Participate in members' discharge planning 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 health care 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 demonstrate the ability to collect and report on data to evaluate member outcomes.

Section 7

Billing and Claims Requirements

General

MAD covered services provided to a Medicaid eligible member, including behavioral and physical health services, are billed and reimbursed independent of the PMPM payment to the provider agency. The PMPM reimbursement is paid for CLNM services regardless of whether the Medicaid eligible member is a MCO member or enrolled in FFS. The CLNM provider agency is responsible for verifying that the Medicaid eligible member has affirmatively agreed to participate in CLNM services, documentation of which should be in a signed statement in the Medicaid eligible member's file, in order to receive reimbursement.

PMPM codes will be used to document various CLNM services provided to a Medicaid eligible member, and trigger the PMPM reimbursement. To receive reimbursement, the provider agency must fully execute at least one CLNM service in a given month, meaning direct contact and interaction with a Medicaid eligible member to deliver comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, or referral to community and support services. A non-exhaustive list of actions by a CLNM provider that fail to meet full execution of a CLNM service includes attempting to call or visit an eligible member. For referral to community and support services that may not include direct contact with a Medicaid eligible member, the CLNM provider must, at a minimum, include a service referral and a follow-up with the service provider after the Medicaid eligible member engagement, in order to receive reimbursement.

- FFS reimbursement: For a Medicaid eligible member who is utilizing FFS benefits, the provider agency will submit a PMPM health home code through the fiscal agent's claims system when a CLNM service is provided to a Medicaid eligible member, which will then result in a PMPM payment. The requirement for the provider agency to submit a claim for payment allows HSD to ensure that the Medicaid eligible member receives the CLNM service before payment is made. If a CLNM service is not provided to a Medicaid eligible member in a given month, the provider agency will not receive a PMPM payment. The claims submission also provides data to HSD on CLNM services rendered and the date of service for monitoring and evaluation purposes including outcome and quality studies.
- Managed care reimbursement: For a Medicaid eligible member who is a member of a MCO, the provider agency and the MCO shall negotiate reimbursement at any amount no less than the established PMPM rate for a health home.

PMPM

CLNM providers are reimbursed through a 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 CLMN core services. It is important that providers check

member Medicaid eligibility frequently to ensure CLNM services will be covered by Medicaid, and that the correct MCO is listed in member records.

The PMPM rate will be updated as needed based upon results of analyses, including member enrollment and 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 member affirmative agreements to participate and opt-in for CLNM services. To be reimbursed, providers must retain a signed opt-in statement in member files.

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 National Provider Identifier (NPI) may be used in the rendering provider field as well as in the billing provider field;
- Federally Qualified Health Centers (FQHCs) that bill other services utilizing a UB claim form and a revenue code shall bill the CLNM codes on a CMS 1500 claim form using Health Care Common Procedure Coding System (HCPCS) codes listed below. FQHC will need to obtain a separate NPI and facility ID for CLNM services; and
- IHS and 638 tribal facilities will be billing other services utilizing the Office of Management and Budget 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 to receive a PMPM payment for that month.

More information on the reimbursement methodology is available here.

More information on fee schedules is available here.

CareLink NM HCPCS Codes

Code	Modifier	CLNM Code Description	Units
S0280		**Comprehensive Care Management (CCM)** Identify high-risk individuals to ensure individuals and their families actively participate 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 care coordinators 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 emergency departments. 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
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

Code	Modifier	CLNM Code Description	Units
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

Section 8
Operations

This section includes information on CLNM provider operations and oversight from the State. The section includes a number of topics, which are organized into two categories: Performance and Oversight as well as Member Services and Support. Separate headings are included for each topic.

Performance and Oversight

Quality and Outcomes

Quality and health outcome measures of CLNM members are crucial. In addition to being a federal requirement of the CLNM program, measurements also provide essential information to the State and eligible CLNM providers on the program impact. Program impact measures 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 67) lists required health performance measures, designating outcomes as clinical and social determinants of health, experience of care, quality of care, utilization of services, and cost of care. Criteria is organized by the five goals of the CLNM program:

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

Most information is captured through provider use of the BHSDStar service module. Other information is collected through MCO Healthcare Effectiveness Data and Information Set (HEDIS) data, HSD claims data, and member surveys. Quality reports are monitored by the Steering Committee at regular intervals to determine program efficacy and are used as the basis for practice improvement plans, if large gaps in health outcomes are identified. HSD monitors CLNM enrollment, staffing, and caseload ratios monthly. This data is provided to HSD leadership and Steering Committee members. MCOs may monitor enrollment and capacity through data and BHSDStar tracking.

CYFD works with CLNM providers employing the Wraparound model to use additional tools to ensure program fidelity, quality assurance, and quality improvement protocols are in place:

1. Wraparound Fidelity Index
2. Wraparound Document Assessment and Review Tool
3. Wraparound Team Evaluation Tool

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. An annual site visit is conducted with each CLNM provider by a team comprised of representatives from HSD and one representative from each MCO. The visit will include the following:

- Monitoring and oversight protocols to review 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;
- High Fidelity Wraparound;
- Integration of behavioral health and physical health;
- Staffing;
- Caseload ratios; and
- Other aspects of program implementation.

This information enables the Program Manager and Steering Committee to identify challenges and barriers. When needed, this information informs work with providers to develop practice improvement strategies.

Data and information sources include:

1. System data derived from BHSDStar, HSD claims data, and member surveys. BHSDStar data includes quality and outcome evaluation metrics 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 Electronic Health Records (EHR) that allows comparison of the CNA, the service plan, service delivery, and referrals for consistency; and
3. Interviews with and/or reports from providers that yield descriptions and explanations of findings from system data and case reviews. This includes HSD oversight of staffing levels and compliance with caseload ratio recommendations (listed on page 11).

Findings from oversight and monitoring will help inform future CLNM strategies with HSD leadership. Any deficiencies noted in oversight and monitoring will be presented to the CLNM Steering Committee for review and further action. Additional education and technical support may be provided to CLNM providers to address noted issues. 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; and
- All releases of information signed by the member.

Long-term Evaluation

The long-term evaluation component is conducted by the University of New Mexico Consortium for Behavioral Health Research and Training (CBHTR). The research includes extensive analyses of claims data to determine whether monthly costs per CLNM member have shifted from baseline measures (before enrollment in CLNM) to annual measures post-CLNM enrollment. Analyses are based on a number of factors, including the type of care provided (acute vs. intervention), diagnoses (SMI, SED, and SUD), and by number of comorbid conditions.

Member Services and Support

Member Enrollment/Disenrollment Instructions

High Fidelity Wraparound serves youth and adolescents with the most complex behavioral health needs, so it is important for CareLink providers to establish relationships with an array of service 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. MCOs may also provide referrals for members enrolled in either in- or out-of-state residential treatment centers.

The Health Home Community Liaison (and other staff) work with a variety of community providers to inform them of High Fidelity Wraparound and to develop a robust referral network for all members. CLNM and CYFD High Fidelity Wraparound staff hold “Wraparound 101” education and information sessions for providers, community members, and other community stakeholders to inform them of the High Fidelity Wraparound program and help build referral sources.

To participate in Wraparound, members must meet the eligibility criteria outlined on page 16 of this manual. Anyone making a referral to a High Fidelity Wraparound provider must complete a High Fidelity 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:

- Individual who made the referral;
- Representative from the CLNM provider facilitating care coordination;
- Staff from CYFD Behavioral Health Services;
- Relevant MCO;
- Appropriate family members or caregivers; and
- Other stakeholders familiar with the member's situation (e.g., agencies or systems with which the member has been involved).

Referral review meetings should be held within two business days of the provider's receipt of the High Fidelity Wraparound Referral Form.

MCO Referral Process

New members may be identified by an MCO or agency and referred to a CLNM provider. MCOs may refer new members to CLNM providers after a health risk assessment or a comprehensive needs assessment has been conducted, if chronic behavioral health issues have been identified or suspected. In counties with more than one CLNM provider, MCOs will implement the procedure below to refer members not enrolled with a CLNM provider to the most appropriate provider. MCOs will provide information on all CLNM providers to help members make an informed choice. A referral should be based on the following criteria:

- Geography;
- Cultural or linguistic preferences;
- Provider specialties (e.g., multi-systemic therapy or intensive outpatient program (IOP) if indicated); and
- Capacity (to avoid putting a member on a wait list).

MCOs will provide all referral information to the appropriate CLNM provider, who may then reach out to the member.

Section 9

Member Enrollment

Eligible individuals, their parents, or their guardians must agree to opt-in to CLNM no later than 90 calendar days from a referral by signing an opt-in form. Medicaid members may also contact participating providers or their assigned MCO to discuss their possible eligibility for CLNM services. Once opted in, CLNM staff should enter all member information in the BHSDStar Comprehensive Needs Assessment and service plan.

Enrollment of Centennial Care Members

Phase 1:

For members enrolled in Centennial Care who are eligible for CLNM services and are already engaged with a CLNM provider for other services, the provider identifies members who may meet CLNM enrollment criteria to determine interest in and eligibility for enrollment in CLNM.

Phase 2:

For counties in which there is only one CLNM provider

MCOs and CLNM providers work to engage and enroll MCO members who may be eligible for CLNM services who have not engaged directly with a CLNM provider. For those members, HSD will provide MCOs with a list of members who have a behavioral health diagnosis within the SMI, SED, and SUD criteria who are not enrolled with a CLNM provider. MCOs will send a letter (HSD template) to members who live in an eligible county. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the CLNM provider. The CLNM provider will describe the program and determine member interest in participating. The list of potential members will also be sent to each CLNM provider in the appropriate county. CLNM providers will contact MCO members to determine eligibility and interest. The CLNM will opt-in those members who express interest and meet eligibility criteria. Opt-in determinations are transmitted through OmniCaid to MCOs on a nightly basis, and MCOs transfer care coordination to the CLNM provider for those members who opt-in to the CLNM program. Those who do not meet the SMI, SED, or SUD criteria after evaluation will be advised by CLNM provider care coordinators and continue to receive care coordination services through their MCO.

For individuals newly enrolled in Centennial Care who have had a health risk assessment and potentially meet qualifications for participation in CLNM, the MCO will inform the member they are a candidate for the CLNM program and refer the individual to the provider for evaluation. MCOs will also provide member contact information to the CLNM provider.

For counties in which there is more than one CLNM provider

The MCO will send a letter to members living in an eligible county who have a behavioral health diagnosis within the SMI, SED, or SUD criteria. The letter will inform them of the CLNM program, their potential eligibility, and that a provider of their choice will contact them to introduce the program and ascertain their interest in participating. The letter will contain a brief description and location of each

CLNM provider in their county and request they contact HSD to select a provider. HSD staff will refer individuals to the appropriate provider and advise the provider of the member's interest. CLNM providers will follow up with members to determine interest and eligibility. From that point forward, the enrollment process described above should be followed.

Medicaid eligible Members enrolled in FFS

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

For counties in which there is one CLNM provider, HSD will send a letter to the Medicaid eligible member enrolled in FFS who live in an eligible county and have a behavioral health diagnosis within the SMI, SED, or SUD spectrum to inform them of the CLNM program and their potential eligibility. The letter advises individuals that they will be contacted by the area CLNM provider to introduce the program and determine their interest in participating. The provider will contact the Medicaid eligible member enrolled in FFS to arrange an appointment for an evaluation to determine eligibility and interest. Providers opt in referred individuals identified through this process who wish to participate.

Individual activation status is documented in the BHSDStar activation module and transmitted to BHSDStar/OmniCaid on a nightly basis. CLNM Staff should complete all member information documentation in BHSDStar.

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.

CLNM providers are required to research and investigate critical incidents. New Mexico State statutes and regulations define the expectations and legal requirements for properly reporting Medicaid member-involved incidents in a timely and accurate manner. The CLNM 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 here.

- For questions about reporting or to obtain passwords and access to the reporting portal email the HSD Critical Incident team at: HSD-QB-CIR@state.nm.us.
- The HSD Critical Incident Reporting Portal website is available here.

For counties in which there is more than one CLNM provider

HSD will send a letter to the Medicaid eligible member enrolled in FFS who live in an eligible county and have a behavioral health diagnosis within the SMI, SED, and SUD criteria to inform them of the CLNM program, their potential eligibility, and a description of each CLNM provider in the county. The letter advises the member they can be referred to any provider 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 the provider will schedule an appointment. HSD provides registration lists to the appropriate providers. From that point forward, the process described on page 24 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.

Members who do not sign release of information forms

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 not enrolling the 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 for the provider to receive reimbursement for delivery of CLNM services. The activation information can be entered in BHSDStar at any time and is automatically transmitted to the OmniCaid system and subsequently to MCOs 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 CLNM provider 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 MCOs 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, secure e-mail, or any other secure method the two parties have agreed upon. The DMZ contains folders for each MCO within each of the CLNM providers' folders. If documentation 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:

- HRA if no CNA;
- Most recent CNA;
- Comprehensive care plan;
- NF LOC service plan;
- Member contact special considerations (e.g., notes/alerts for vicious animals);
- Established power of attorney;

- Emergency plan (e.g., plan for member in the event of a weather emergency, loss of electricity, etc.);
- A cover sheet to indicate no documents are available; and
- Back-up plan (the plan to provide services if a caregiver is ill or designated support system is unavailable).

Transitioning a member who relocates

If a member relocates from a county served by a CLNM provider into a new county served by a different CLNM provider, care coordinators will assist members in identifying appropriate services in their new location, whether with a new CLNM provider or with their MCO. CLNM care coordinators will assist in the transition by transferring member records to the new service provider. CLNM providers should note the following:

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

If the original CLNM provider rendered any of the six core services during the month the member relocates, 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 CLNM provider and opted in to the second.

Disenrollment of Centennial Care Members

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 CLNM program. Documentation that Medicaid members have elected to opt out of CLNM must be retained on file. To disenroll a member, the CLNM provider 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 relevant 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.

If a member is no longer engaged with the CLNM program, providers will opt-out the member and notify the MCO to resume care coordination services. Some reasons for opting out CLNM members follow:

- The member no longer meets the SMI, SUD, or SED criteria, e.g., has stabilized with no functional impairments;
- The member has moved away from the area;
- The CNA has not been completed within 90 days of enrollment; or
- The member has lost Medicaid eligibility.

CLNM providers should check the Medicaid portal each time a member has an appointment to verify Medicaid eligibility and MCO. Members may lose Medicaid eligibility or fail to renew their Medicaid and may not notify their provider or MCO of the change in eligibility status. Once a provider establishes member ineligibility, the provider will:

1. Help the individual renew Medicaid eligibility if appropriate; or
2. Disenroll the individual in BHSDStar with an effective end date of the end of that month.

The CLNM provider should notify the MCO any time they disenroll a member and transmit all documents related to the member's health and services through the DMZ.

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 – 5:00 PM). "Outside of regular business hours" operations means compliance with 8.321.2 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 eligible member, make referrals as necessary, and provide follow-up to the Medicaid eligible member." CLNM members should be provided with information about how to reach their care coordinator or other qualified members of the CLNM team in the event of an emergency 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 Protected Health Information (PHI), as defined by the HITECH Act, without unreasonable delay and in no event later than 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 CLNM provider delivery of services including, but not limited to, information relating to CLNM members, potential recipients of HSD services, 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 request, erased or destroyed. The provider agency shall provide HSD with certificates evidencing such destruction.

The CLNM provider contract 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 CLNM provider shall give prompt notice to HSD of such order.

Disclosure of HSD's Confidential Information

The CLNM provider will immediately report to HSD and MCOs as appropriate any and all unauthorized disclosures or uses of confidential information of which it, its consultants, or its agents are aware or has knowledge. The CLNM 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 CLNM provider, its consultants, or its 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 CLNM provider all damages and liabilities caused by or arising from the CLNM 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 provider.

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

Member Records

The CLNM 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 CLNM 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), 42 U.S.C. § 290-dd-2 and regulations (42 C.F.R. Part 2), 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 CLNM provider produces reports or other forms of information that the CLNM provider believes consist of proprietary or otherwise confidential information, the CLNM 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; and
- 7.26.6.1.4 1.12.20 NMAC et seq.

Referrals and Communication Protocols

The CLNM 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 may request 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 may request relevant health data on the member and provide necessary follow-up care. If after-care is scheduled, the CLNM provider confirms that the appointment occurred and check on outstanding care or treatment issues that arose during the appointment. As part of the CLNM provider 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 CLNM 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 the following:

- Assistance with continuation of health care benefits eligibility;
- Disability benefits;

- Housing;
- Legal services;
- Educational support;
- 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 members with natural supports, and ensure that these connections are solid and effective. For referrals such as DME, a care coordinator will work with member physical health providers and MCOs 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.

Member Grievances and Appeals

CLNM care coordinators are 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 member MCOs 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.

MCO Role

The MCO shall comply with Section 2703 of the ACA 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 providers.

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 CLNM Steering Committee, which includes all MCOs, shall ensure that CLNM providers deliver the delegated care coordination functions for members enrolled with a CLNM provider, including the following:

- Perform a CNA for CLNM members who meet the criteria. For members with a CLNM provider that uses the Treat First Model, an in-home visit will be required within six months;
- Assign Care Coordination levels for each CLNM member;
- Adhere to Care Coordination activities for Level 6 or Level 7 as set forth in the CLNM Policy Manual;
- Develop and implement CCP for members in Care Coordination Levels 6 and 7 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, and refer them to an appropriate CLNM provider;
- 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 emergency department and behavioral health crisis services utilization;
- Monitor the CLNM's care planning and discharge planning processes;
- Maintain individual case files for each member;
- Provide training required to perform the care coordination activities; and
- Ensure member transition to a MCO if opting out of the CLNM Health Home in accordance with HSD's protocols.

The MCO will provide available member documentation to the CLNM provider, including but not limited to:

- HRA if no CNA.
- Most recent CNA.
- Comprehensive care plan.
- Member contact special considerations (e.g., notes/alerts for vicious animals).
- NF LOC service plans.
- Established power of attorney.
- Emergency plan (e.g., plan for member in the event of a weather emergency, loss of electricity, etc.).
- Backup plan (e.g., the plan to provide services if a caregiver is ill or the designated support system unavailable).
- Cover sheet if no documentation exists.

Documents may be uploaded to the DMZ for secure transfer. All CLNM providers have folders for each MCO in their DMZ folder. 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 NF LOC assessment, including the Centennial Care Community Benefit Service Questionnaire (CBSQ) with the CLNM care coordinator, and providing results to CLNM providers

to be incorporated into Service plan (please refer to the NF LOC section below for more information);

- Establishing 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;
- Assisting CLNM providers in developing memorandum of understanding with providers and identifying a referral network for CLNM Members; collecting and reporting on CLNM Member outcome measures identified by the CLNM Steering Committee; and
- Sponsoring the EDIE program so CLNM providers may receive real-time notifications of a member's admission to an emergency department or a hospital.

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: 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.

Referral Protocols

CLNM providers are responsible for taking a lead role in transitional care activities for members, including interrupting patterns of avoidable emergency department use, inpatient stays, and unplanned readmissions. CLNM Provider agencies will work with additional health care 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 emergency department, and unplanned readmissions. When a member uses emergency services, participating hospitals are required by Section 2703 of the ACA to refer the member to a provider agency. Referral protocols should be established in MOA with hospitals in the geographic vicinity. CLNM providers will subscribe to EDIE to receive timely notifications of member admissions to an emergency department or as a hospital inpatient (see p. 47 for additional information).

Nursing Facility Level of Care

MCOs will provide training to CLNM providers on the criteria indicating eligibility for a NF LOC 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 NF LOC. A MCO care coordinator will identify indicators that may signal member eligibility for NF LOC and relay that information to the CLNM provider. If the member is interested in a NF LOC evaluation, the CLNM care coordinator shall arrange for the evaluation with the assigned MCO and will accompany the MCO care coordinator for the member assessment. If a Medicaid eligible member enrolled in FFS needs a NF LOC assessment for long-term services and supports, the State requires that the individual must enroll with a MCO.

Factors that might indicate a member may be eligible for a NF LOC 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 ADL 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 NF LOC assessment, including the Centennial Care Community Benefit Service Questionnaire, for those CLNM members who qualify for Community Benefit Services. If NF LOC criteria are 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 NF LOC assessment and care plans to the CLNM provider to coordinate and monitor utilization of Community Benefit Services. When a NF LOC 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 NF LOC reassessment at least annually, unless the member has an approved Continuous NF LOC eligibility status. A NF LOC 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 NF LOC 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 member choices are reflected in the member service plan. While the MCO is responsible for the NF LOC assessment, the CLNM care coordinator should be aware that the MCO must complete the CNA and NF LOC 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 NF LOC-determination expiration. For more information on NF LOC criteria, and instructions from the State, please refer to the state website.

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 that support care management activities are comprised of registration and activation and include the following:

- Member level of care;
- CLNM CNA that requires behavioral and physical health screenings;
- Imminent clinical risk assessment; and
- Comprehensive health history and information gathering over the course of four appointments.

The care coordinator and member develop a service plan inclusive of short- and long-term goals, service requirements, and expected outcomes. BHSDStar modules were developed for use with laptops or tablets.

BHSDStar is also used to collect member information including care coordination (with service tracking and referrals), assessments, service plans, and quality tracking. These resources will be available to CLNM providers to support the member and the CLNM care coordinator in identifying unmet needs, gaps in care, required clinical protocols, case management, medical and behavioral health services, and social determinants of health.

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

CLNM BHSDStar Modules

- Manuals and user guides for staff registration and CareLink member registration, assessments, billing, and data upload are available here.
- Training for the CLNM portion of the BHSDStar system is available here.
- If you need additional information on the BHSDStar system, contact BHSDStar Support at support@fallingcolors.com.

Registration and activation modules

These modules are used to enter basic member contact information and levels of care coordination to enroll a member in the CLNM program. 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 available here.

It is important that accurate Medicaid numbers be entered into the member registration modules. Use of a placeholder (e.g., any number beginning “YIF”) will prevent the file from uploading to the system, the member registration will not be completed, and providers may not be paid for services.

Member Services Module

Provider staff will use this module to track activities contained within the six core services of the CLNM program, as defined by CMS. The module contains 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 28 of this Manual lists CLNM procedural codes for billing.

CLNM Comprehensive Needs Assessment

The CNA has been automated in BHSDStar and has varying levels of security (permissions) reflective of which provider staff members, State, or MCO staff have access to information.

CLNM Service Plan

This plan of service is developed by CLNM care coordinators with the member to identify services the member is or will be receiving. The service plan should be updated regularly, based upon goals and target dates identified by members.

ASAM Screening for placement of SUD services

This screening is conducted when the CNA or diagnostic evaluation indicates a substance use disorder may exist. It assists the care coordinator in determining the level of substance use service needed.

Quality

The CLNM 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 coordinated, integrated care and chronic disease management on individual-level clinical outcomes;
- Experience of care outcomes; and
- Quality of care outcomes at the population level.

See the Quality and Outcomes section on page 30 for more information. Appendix C of this manual (page 67) contains evaluation criteria for the CLNM program.

EDIE PreManage

EDIE software automatically sends real time notifications to CLNM providers when members present at the emergency department or are admitted as patients. The content of the notification includes member social information and clinical emergency history and care guidelines. New Mexico MCOs sponsor the EDIE program to help monitor and improve the quality of essential transitional care and emergency department visits and potentially reduce unnecessary readmissions. CLNM providers must register with Collective Medical, the company that manages the EDIE system, to receive alerts when their members are admitted to the emergency or as inpatients. Providers designate staff they wish to receive member notifications and may select the method(s) of notification. CLNM providers must upload a member roster to EDIE on a regular basis to receive notifications for enrolled CLNM members. There is no charge to CLNM providers for this service.

For additional information or to register with EDIE, access www.collectivemedical.com.

PRISM Risk Management

PRISM, a predictive risk management tool 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 emergency department 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, CLNM providers will request access from the CLNM Steering Committee through the Program Manager.

Project ECHO

New Mexico Project ECHO's Behavioral Health and Addiction program is a robust online learning network developed and sponsored by University of New Mexico to connect community providers with specialists at centers of excellence in real-time collaborative sessions. The ECHO program partners with the State's MCOs and delivers trainings covering a wide range of behavioral health issues, including medication-assisted treatment. Providers may present specific cases to the team's addiction specialists for consultation. The ECHO website is available here.

For information about Medication assisted treatment (MAT) please access the NM Opioid Hub: ewatts@salud.unm.edu.

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.

CLNM Provider agencies adopt meaningful use of HIT to:

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

Appendix A

Acronyms

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 New Mexico
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 development 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
NF LOC	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
ROI	Release of Information
ROI	Return on Investment
SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorder
UR	Utilization Review

Appendix B

Criteria for SMI, SED, and SUD

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 18th 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 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. 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; and
   - 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 that 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 that 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, or 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 that 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, when exposed to a known single event or series of discrete events, experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:
  - A disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns;
  - Under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial;
  - Under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse;
  - Over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed; and
  - 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

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 DSM. 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 department visits or at least one psychiatric hospitalization within the last year;
  - Individuals with SUD that complicates SMI and results in worsened intoxicated/withdrawal complications, bio-medical conditions, or emotional/behavior/cognitive conditions; or
  - Person is experiencing trauma symptoms related to sexual assault, domestic violence, or other traumatic event.

B. Co-occurring Disorders:

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

Criteria for Substance Use Disorder Determination

According to the DSM-5, a diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. The State of New Mexico uses the American Society of Addiction Medicine (ASAM) criteria to determine levels of care and match intensity of treatment services to individual risks and needs, strengths, skills, and resources. ASAM criteria provide a comprehensive set of guidelines for multi-dimensional assessment, treatment and service planning, placement, continued stay, and transfer/discharge of individuals who have substance use and co-occurring conditions. Guidelines provide a means to match risk, severity, and service needs with type and intensity of services.

A brief description of ASAM levels of care follows. For a detailed description of services typically offered in each level of care, the care setting, and how to identify which patients would benefit best from services based on an ASAM dimensional needs assessment, please refer to *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (Version 3.13, June 2022).*

- ASAM Level 0.5 – Early Intervention for adolescents and adults, this level of care constitutes a service for individuals who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable SUD.
- ASAM Level 1 – Outpatient Services for adolescents and adults, this level of care typically consists of less than nine hours of service per week for adults, or less than six hours per week for adolescents that focus on recovery or motivational enhancement therapies and strategies. Level 1 encompasses organized services that may be delivered in a wide variety of settings.
- ASAM Level 2.1 – Intensive Outpatient Services for adolescents and adults, this level of care typically consists of nine or more hours of service per week or six or more hours for adults and adolescents, respectively, to treat multidimensional instability. Level 2 encompasses services that can meet the complex needs of people with addiction and co-occurring conditions. This level is comprised of organized outpatient services that deliver treatment services during the day, before or after work or school, in the evening, and/or on weekends.
- ASAM Level 2.5 – Partial Hospitalization Services for adolescents and adults, this level of care typically provides 20 or more hours of service per week for multidimensional instability that does not require 24-hour care. Level 2 encompasses services that can meet the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services, usually during the day as day treatment, or partial hospitalization services.
- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services, this adolescent and adult level of care typically provides a 24-hour living support and structure with available trained personnel and requires a minimum of five hours of clinical service per week in recovery skills development. This level is often a step-down from a higher level of care and prepares the Medicaid member for transition to the community and outpatient services.
- ASAM Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services, this adult-only level of care typically offers 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments who are unable to use full active milieu or therapeutic community.
- ASAM Level 3.5 – Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults. This level of care provides 24-hour care with trained counselors to stabilize individuals in multidimensional imminent danger and prepare for outpatient treatment.
- ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services for adolescent and Medically Monitored Intensive Inpatient Services for adults, this level of care provides 24-hour evaluation and monitoring services. Organized services are delivered by medical and nursing

professionals under the direction of a physician or clinical nurse practitioner who is available by phone 24 hours per day. Patients in this level of care require medication and have a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter continuing addiction treatment. This is the appropriate setting for patients with subacute biomedical and emotional, behavioral, or cognitive problems that are so severe they require inpatient treatment.

- ASAM Level 4 – Medically Managed Intensive Inpatient Services for adolescents and adults, this level of care offers 24-hour nursing care and daily physician care for severe, unstable problems. Counseling is available 16 hours a day to engage patients in treatment.

Levels of Care – Withdrawal Management

- ASAM 3.2-WM – Clinically managed residential withdrawal management services as specified in *The ASAM Criteria,* requiring 24-hour support for moderate withdrawal; managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions; facility has an ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health, and other therapies administered on an individual or group basis to enhance the Medicaid member's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The Medicaid member remains in a Level 3.2 withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care, or the Medicaid members' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.

- ASAM 3.7-WM – Medically monitored inpatient withdrawal management services as specified in *The ASAM Criteria*. This level of care requires 24-hour nursing care and physician visits as needed for severe withdrawal; services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers, or other health and technical personnel under the direction of a licensed physician. Medicaid members are monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions. Providers must have the ability to arrange for appropriate laboratory and toxicology tests and provide a range of cognitive, behavioral, medical, mental health, and other therapies administered on an individual or group basis to enhance the Medicaid member's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The Medicaid member remains in a Level 3.7 withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care, or the Medicaid members' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.

The following tables include relevant diagnosis codes and a discretion for each SMI/SED category.

SMI[7]/SED Category	DSM 5 ICD-10	Description
Neurodevelopmental Disorders	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	F90.0	Attention-Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	F90.1	Attention-Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	F90.2	Attention-Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	F90.8	Attention-Deficit/Hyperactivity Disorder: Other Specified Attention-Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	F90.0	Attention-Deficit/Hyperactivity Disorder: Unidentified Attention-Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	F20.81	Schizophreniform Disorder

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

SMI[7]/SED Category	DSM 5 ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	F25.1	Depressive type
Schizophrenia Spectrum and other Psychotic Disorders	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	F06.34	Bipolar and Related Disorders due to another medical condition – With mixed features
Bipolar and Related Disorders	F31.9	Unspecified
Bipolar and Related Disorders	F31.11	Mild
Bipolar and Related Disorders	F31.12	Moderate

SMI[7]/SED Category	DSM 5 ICD-10	Description
Bipolar and Related Disorders	F31.13	Severe
Bipolar and Related Disorders	F31.2	With psychotic features
Bipolar and Related Disorders	F31.73	In partial remission
Bipolar and Related Disorders	F31.74	In full remission
Bipolar and Related Disorders	F31.9	Unspecified
Bipolar and Related Disorders	F31.31	Mild
Bipolar and Related Disorders	F31.32	Moderate
Bipolar and Related Disorders	F31.4	Severe
Bipolar and Related Disorders	F31.5	With psychotic features
Bipolar and Related Disorders	F31.75	In partial remission
Bipolar and Related Disorders	F31.76	In full remission
Bipolar and Related Disorders	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	F31.9	Unspecified Bipolar and related disorder

SMI/SED Category	DSM-5 ICD-10	Description
Depressive Disorders	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)– with depressive features
Depressive Disorders	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) – with major depressive-like episodes
Depressive Disorders	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	F32.9	Unspecified
Depressive Disorders	F32.0	Mild
Depressive Disorders	F32.1	Moderate
Depressive Disorders	F32.2	Severe
Depressive Disorders	F32.3	With psychotic features
Depressive Disorders	F32.4	In partial remission
Depressive Disorders	F32.5	In full remission
Depressive Disorders	F33.9	Unspecified
Depressive Disorders	F33.0	Mild
Depressive Disorders	F33.1	Moderate
Depressive Disorders	F33.2	Severe
Depressive Disorders	F33.3	With psychotic features
Depressive Disorders	F33.41	In partial remission
Depressive Disorders	F33.42	In full remission

SMI/SED Category	DSM-5 ICD-10	Description
Depressive Disorders	F34.1	Persistent Depressive Disorder
Depressive Disorders	F32.8	Other Specified Depressive Disorder
Depressive Disorders	F32.9	Unspecified Depressive Disorder
Depressive Disorders	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	F41.0	Panic Disorder
Anxiety Disorders	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	F40.00	Agoraphobia
Anxiety Disorders	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

SMI/SED Category	DSM- 5 ICD-10	Description
Obsessive-Compulsive Related Disorders	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	F43.22	With anxiety
Trauma-and Stressor Related Disorders	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	F43.10	Post-traumatic Stress Disorder
Trauma-and Stressor Related Disorders	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	F44.0	Dissociative Amnesia
Dissociative Disorders	F44.1	With dissociative fugue
Dissociative Disorders	F44.81	Dissociative Identity Disorder
Dissociative Disorders	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	F4 .9	Unspecified Dissociative Disorder

SMI/SED Category	DSM- 5 ICD-10	Description
Dissociative Disorders	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder) Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	F44.5	Conversation Disorder (Functional Neurological Symptom) Disorder Specify: with attacks of seizures; or with special sensory loss

SMI/SED Category	DSM-5 ICD-10	Description
Somatic Symptom and Related Disorders	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder – with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	F50.01	Anorexia Nervosa – Restricting type
Feeding and Eating Disorders	F50.02	Anorexia Nervosa – Binge-eating/Purging type

SMI/SED Category	DSM-5 ICD-10	Description
Feeding and Eating Disorders	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.8)
Feeding and Eating Disorders	F98.3	In children
Feeding and Eating Disorders	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	F34.1	Persistent Depressive Disorder – Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	F60.3	Borderline Personality Disorder

SUD Criteria	DSM-5 ICD-10	Description
Substance-Related and Addictive Disorders	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	F14.20	Stimulant-Related Disorder – Cocaine
Substance-Related and Addictive Disorders	F12.20	Cannabis- Related Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	F16.20	Hallucinogen-Related Disorder – Other Hallucinogen Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	F16.20	Hallucinogen-Related Disorder – Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders – Moderate, Severe

Appendix C

CLNM Evaluation Criteria

Domains to be evaluated:

1. Clinical and 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/SED, SUD

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Screening for recommended immunizations	Both	QOC	Annual	% of members with immunizations in a reporting year	+/-	BHSDStar Service Tracking
Screening for alcohol use	Both Ages 8 & >	QOC	Annual	% of members screened	+/-	BHSDStar Service Tracking
Screening for tobacco use	Both Ages 8 & >	QOC	Annual	% of members screened	+/-	BHSDStar Service Tracking
Screening for other substance use	Both Ages 8 & >	QOC	Annual	% of members screened	+/-	BHSDStar Service Tracking
Suicide risk assessment	Both	QOC	Semi-annual	% of members screened for suicide risk	+/-	BHSDStar Service Tracking
Major depressive disorder (MDD) suicide screening	Both	QOC	Semi-annual	% of members with Depression Survey score of 15 or above screened for suicide risk	+/-	BHSDStar Service Tracking

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Screening for clinical depression and follow up plan (CDF) CMS criteria	Both Ages 12 & >	QOC	Semi-annual	% of members age 12+ 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	+/-	BHSDStar Service Tracking
Adult Body Mass Index Assessment (BMI) – adults (ABA) CMS criteria	Adult	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	BHSDStar Service Tracking
Weight Assessment Children – (BMI)	Child	QOC	Semi-annual	% of members ages 3-17 who had visit and had BMI documented during the measurement year or the year prior to measurement year (Note: actual BMI will be graphed over time)	BMI value	BHSDStar Service Tracking
Diabetes screening for adults that are overweight or obese	Adult	QOC	Annual	% of adults ages 40-70 who are overweight or obese who had a glucose test or HbA1c	HbA1c or glucose value	BHSDStar Service Tracking
Diabetes screening for people who are on atypical antipsychotics (HbA1C)	Both Ages 18 & >	QOC	Semi-annual	% of members ages 18 & > having a glucose test or an Hba1c during the measurement year	HbA1c or glucose value	BHSDStar Service Tracking

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Physical examination within one month of admission to Health Home or transfer of records current within the last 12 months	Both	QOC	Annual	% of members w physical exam within one month of Health Home opt-in	Date of exam	BHSDStar Service Tracking
Serum lipid profile for adults with SMI who are on atypical anti-psychotics	Adults	QOC	Annual	% of members ages 18-74 who had serum lipid profile done	Actual value	BHSDStar Service Tracking
Screening for cervical cancer	Adults	QOC **HEDIS**	Annual	% of women ages 21-64 meeting the criteria	+/-	MCO
Screening for breast cancer	Adults	QOC **HEDIS**	Annual	% of women ages 50-74 who had a mammogram to screen for breast cancer in measurement year or two years prior	+/-	MCO
Screening for colon cancer	Adults Ages 50-75	QOC **HEDIS**	Annual	% of members ages 50-75 who had appropriate screening for colorectal cancer in measurement year and one year prior	+/-	MCO
Screening for chronic infectious diseases: HIV	Both Ages 11 & >	QOC	Annual	% of members age 11 & > screened	+/-	BHSDStar Service Tracking
Screening for chronic infectious diseases: Hepatitis B	Both Ages 11 & >	QOC American Assoc. of Pediatrics	Annual	% of members ages 11 & > screened	+/-	BHSDStar Service Tracking

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Screening for chronic infectious diseases: Hepatitis C	Both Ages 11 & >	QOC American Assoc. of Pediatrics	Annual	% of members ages 11 & > screened	+/-	BHSDStar Service Tracking
Metabolic monitoring for children and adolescents on antipsychotics	Child	QOC **HEDIS**	Annual	% of members ages 1–17 (in three age stratifications: 1-5 years; 6-11 years; 12-17 years and total) who had two or more anti-psychotic prescriptions and had metabolic testing	2 actual values	MCO
Child abuse screening	Both	QOC	Annual	% of members screened for past or present child abuse within the measurement year	+/-	
Intimate Partner Violence screening	Both	QOC	Annual	% of members all ages screened for domestic violence within the measurement year	+/-	BHSDStar Service Tracking

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

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	Both	QOC	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	BHSDStar Service Tracking
Follow-up plan for positive suicide risk screening	Both	QOC	Semi-annual	% of members with a plan documented in care plan	y/n	BHSDStar Service Tracking
Follow-up plan for positive depression screen (see above, part of CMS criteria)	Both Ages 12 & >	QOC	Semi-annual	% of members ages 12 & > with a plan documented on date of positive depression screen	y/n	BHSDStar Service Tracking
Treatment plan for BMI >30	Both	QOC	Semi-annual	% of members with BMI > 30 who have a treatment plan to address obesity		BHSDStar Service Tracking
Treatment plan for BMI <17.5	Both	QOC	Semi-annual	% of members with BMI < 17.5 with a treatment plan to address weight and nutrition		BHSDStar Service Tracking
Controlling high blood pressure (Source NCQA) CMS criteria	Adult	OC HEDIS	Annual	% of members ages 18-85 with SMI who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year *Note*: measure requires medical chart review	Actual value	BHSDStar Service Tracking

Intermediate Actions	Adult/ Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Initiation and engagement of alcohol and other drug dependence treatment CMS criteria	Both 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 inpatient (IP) AOD admission, outpatient (OP) visit, IOP encounter, or partial hospitalization within 14 days of diagnosis 2) initiation of treatment and had two 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	Both Ages 8 & >	OC	Semiannual	% of members ages 8 & > reporting a reduction or cessation of smoking	y/n	BHSDStar Service Tracking
Follow-up after hospitalization for mental illness 7 days (see below, part 2 of 2) CMS criteria)	Both 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 seven days of discharge	y/n	MCO
Follow-up after hospitalization for mental illness 30 days CMS criteria	Both	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

Intermediate Actions	Adult/ Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Care coordinator involved in discharge planning for IP admissions, residential, NF, or correctional facility	Both	QOC	Annual	% of discharges with active participation of Health Home staff	y/n	BHSDStar Service Tracking
Antidepressant medication management (AMM)	Adult	OC HEDIS	Annual	% of members ages 18 & > who were treated with antidepressants, had a dx of major depressive disorder (MDD) and who remained on antidepressant medication for at least 84 days (12 weeks)	y/n	MCO
Quarterly medication reconciliation with adolescents, adults, and PCP	Both	QOC	Semiannual	% of members for whom medications were reconciled by a prescribing practitioner, clinical pharmacist, or registered nurse	y/n	BHSDStar Service Tracking
Multidisciplinary care management meetings	Both	QOC	Semiannual	% of members who had a multidisciplinary care team meeting	date	BHSDStar Service Tracking
Completed visits for referral	Both	QOC	Semiannual	Composite % of all visits for members for whom referrals have been made and the referral appt. was kept	y/n	BHSDStar Service Tracking
Coordinate with school (with parental permission) related to setting of care transitions	Child	QOC	Semiannual	% of care transitions for youth where coordination with school is indicated	y/n	BHSDStar 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	Both	QOC EOC	Annual	% of members reporting positive experience with peer support services	y/n	BHSDStar Service Tracking and member survey
Family Support	Both	QOC EOC	Annual	% of family members reporting positive experience with family support services		Member survey
Care planning with member/family	Both	EOC	Annual	% of members and/or family reporting inclusion in goal development and care planning	y/n	Member survey
Education	Both	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	Adult	OC HEDIS	Annual	% of individuals ages 18 & > with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).		MCO

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Value	Data source
Antidepressant medication management	Adult	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)	Both	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 and Resiliency)

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Data source
Achievement in goals and activities identified by member	Both	OC EOC	Annual	% of members reporting positive progress in identified goals and activities	Member survey
Skills development	Both	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
Plan All Cause Readmission Rate [PCR] CMS criteria	Adult	$ SU	Annual	% of acute inpatient stays during the measurement year for Health Home Members age 18 and older that were followed by an unplanned acute	MCO

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Data Source
				readmission for any diagnosis within 30 days	
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite [PQ192] CMS criteria **(AHRQ)**	Adult	OC $ SU	Annual	Rate of inpatient hospital admissions for Health Home 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
Follow-up after hospitalization for mental illness HEDIS CMS criteria	Both 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	Child	QOC	Annual	% of discharges from residential treatment to a lower level of care followed up with a behavioral health visit within 30 days	MCO

Intermediate Actions	Adult/Child/ Both	Domain	Reporting Frequency	Measure	Data Source
Ambulatory Care – Emergency Department Visits [AMB] CMS criteria	Both	$ SU	Annual	Rate of emergency department visits during the measurement year per 1,000 enrollee months.	HSD Claims Data
Inpatient Utilization [IU] CMS criteria	Both	$ 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 Emergency Department CMS criteria	Both	$ SU	Annual	% of Members with two or more emergency department visits within six months for a behavioral health condition including substance abuse	MCO
Nursing Facility Utilization [NFU] CMS criteria	A	$ SU	Annual	Two rates: • Rate of admissions to a nursing facility from the community that resulted in a short-term stay (fewer 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

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

Category	Description	Benefit Type	Benefit Details
085	EMC for Undocumented Aliens	Limited	Coverage for emergency services for certain undocumented noncitizens who meet all eligibility criteria for a Medicaid category *except* for their alien status

Appendix E

Provider Application Process

NOTE: HSD is currently not accepting applications

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. 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; and,
- Additional relevant information as requested by the Steering Committee.

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

- The applicant must also agree to comply with all Medicaid program requirements.

Readiness Requirements

The Steering Committee conducts readiness reviews with selected applicants to evaluate their capacity to meet CLNM service requirements. The Readiness Review Protocol includes 12 components:

1. The Health Home population
2. Health Home Referral Relationships and Network Management
3. Health Home Services – Comprehensive Care Management
4. Health Home Services – Care Coordination
5. Health Home Services – Prevention, Health Promotion and Disease Management
6. Health Home Services – Comprehensive Transitional Care
7. Health Home Services – Individual and Family Support Services

8. Health Home Services – Referral to Community and Social Support Services
9. Staffing and Other Organizational Matters
10. Systems
11. Integration of Physical and Psychiatric Health Consultants
12. High Fidelity Wraparound capacity (applicable only to those who wish to provide Wraparound and are approved by HSD; Children, Youth and Families Department [CYFD]; and the CLNM Steering Committee)

Additional readiness guidelines and information is provided to applicants prior to site visits.