Care Coordination

4.1. General Information

The MCO, through implementation of its policies and procedures, will develop a comprehensive program for continuous monitoring of the effectiveness of its care coordination processes. The policies and procedures will include the staff responsible for the monitoring, how the monitoring will be done, as well as the frequency of the oversight. Care Coordination strategies will be analyzed for effectiveness and appropriate changes made. Any issues or concerns will be addressed immediately.

4.2. Care Coordination Functions

The following primary care coordination functions are requirements for care coordination that must be performed by staff employed by the MCO.

- Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and who are not currently identified for Care Coordination Level 2 or 3 services;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
- Administer the Community Benefit Service Questionnaire (CBSQ) as applicable (see Section 4.5 CBSQ);
- Semi-annual or quarterly in-person visits with the member;
- Quarterly or monthly telephone contact with the member;
- Comprehensive Care Plan (CCP) development and updates; and
- Targeted Health Education, including disease management, based on the member's individual diagnosis (as determined by the CNA).

MCOs may delegate care coordination functions in the following instances:

- MCOs that own and operate patient-centered medical homes (PCMHs) as part of their provider network may delegate to such PCMHs, provided the PCMH Care Coordinator is employed by the MCO;

- MCOs may delegate all primary care coordination functions to a designated Section 2703 Health Home, provided the Health Home is determined ready by the Health Home Steering Committee to perform such functions;

- MCOs may fully delegate care coordination to providers/health systems in a value-based purchasing (VBP) arrangement that outlines a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes; and/or

- MCOs may delegate the HRA, CNA, care coordination touch points with high need members, coordination of referrals, linking Members to community services, and locating and engaging with Unreachable and Difficult to Engage Members as part of the Shared Function Model with entities or individuals for a mutually-agreed upon reimbursement rate.

The MCOs may not delegate the NF level of care (LOC) assessment and may not delegate care coordination for members who are in the SDCB model.

The MCO, through its care coordination monitoring of MCO staff and care coordination delegates, will ensure, at a minimum:

- The care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured (frequency and methodology stated in the policies and procedures such as inter-rater reliability) to determine effectiveness and appropriateness of processes.

- Competencies will be evaluated in the following areas, but not limited to:

    - LOC assessments and reassessments occur on schedule in compliance with the Agreement and are submitted to the lead or supervising Care Coordinator;

    - CNAs and reassessments, as applicable, occur on schedule in compliance with the contract;

    - Care plans are developed and updated on schedule in compliance with the Agreement;

- Care plans reflect needs identified in the CNA and reassessment process;
- Care plan goals are member-centric, and agreed-upon by the member;
- Care plans are appropriate and adequate to address the member's needs including the need for all Community Benefit (CB) services;
- Services are delivered as described in the care plan and authorized by the MCO;
- Services are appropriate to address the member's needs:
- Services are delivered;
- Service utilization is appropriate;
- Service gaps are identified and addressed;
- Minimum Care Coordinator contacts are conducted;
- Care Coordinator-to-member ratios are appropriate;
- Service limits are monitored (as described in the policies and procedures) and appropriate action is taken if a member is nearing or exceeds a service limit; and
- CBSQ is administered as appropriate.

- The MCO, or its delegate, will use an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the 1115(a) Waiver, Federal and State statutes, regulations, the Agreement and the MCO's policies and procedures. The functionality will include but not be limited to the ability to:
  - Capture and track enrollment dates, date of development of the care plan, date of authorization of the care plan, date of initial service delivery for each service in the care plan, date of each LOC and needs reassessment, date of each update to the care plan, and dates regarding transition from an institutional facility to the community;
  - Capture care coordination level assignments and track compliance with minimum care coordination contacts as specified in the Agreement;

- Notify the Care Coordinator of eligibility end date, date for annual LOC reassessment, date of comprehensive needs reassessment, and date to update the care plan;
- Capture and track eligibility/enrollment information, LOC assessments and reassessments, and needs assessments and reassessments;
- Capture and monitor the care plan;
- Track requested and approved service authorizations, including Covered Services and VAS, as applicable;
- Document all referrals received by the Care Coordinator on behalf of the member for Covered Services and VAS, as applicable, needed in order to ensure the member's health, safety and welfare, and to delay or prevent the need for more expensive institutional placement. Include notes regarding how such a referral was handled by the Care Coordinator, including any additional follow up;
- Establish a schedule of services for each member identifying the time that each service is needed and the amount, frequency, duration and scope of each service;
- Track service delivery against authorized services and providers;
- Track actions taken by the Care Coordinator to immediately address service gaps;
- Document case notes relevant to the provision of care coordination; and
- Allow HSD or its designee to have remote access to case files.

4.3. Health Risk Assessment

The MCO or its delegate shall conduct HSD standardized HRAs on all members who are newly enrolled in Centennial Care for the purpose of: introducing the MCO to the member, obtaining basic health and demographic information about the member, and confirming the need for a CNA to determine if the member should be assigned to care coordination level 2 or level 3. The MCO may assign a member for care coordination without completion of a CNA, provided they obtain HSD approval in advance of the level assignment.

The standardized HRA (Section 4.15.1.) will be completed for each new Centennial Care member within 30 calendar days of the member's enrollment in the MCO. Additionally, an HRA will be completed upon a change in the member's health condition if the member is not in care coordination level 2 or level 3. The HRA may be conducted by telephone, in person, or as otherwise approved by HSD; HRA information must be obtained from the member or the AR and must be documented in the member's file. The MCO shall ensure its staff, subcontractors, or vendor(s) conducting the HRA are adequately trained to effectively conduct the HSD standardized HRA.

The MCO or its delegate will make reasonable efforts to contact members to conduct an HRA and provide information about care coordination. Such efforts shall include, but not be limited to, engaging community supports such as Community Health Workers (CHWs), Community Health Representatives (CHRs), Core Service Agencies (CSAs), 1915 (c) HCBS Waiver Case Managers and Consultants, New Mexico Brain Injury Resource Center, and Centers for Independent Living. For CYFD protective services (PS) and/or juvenile justice services (JJS) involved children/youth, the MCO or its delegate will collaborate with the assigned CYFD permanency placement worker (PPW), juvenile probation officer (JPO), and community behavioral health clinician (CBHC) for behavioral health services. The MCO or its delegate shall document at least three attempts to contact a member which includes at least one attempt to contact the member at the most recently reported phone number. The three attempts shall be followed by a letter sent to the member's most recently reported address that provides information about care coordination and how to obtain an HRA. Documentation of the three attempts shall be included in the member's file. Such attempts shall occur on not less than three different calendar days, at different hours of the day, including day and evening hours and after business hours.

After these attempts have been made and documented, and if the member has not been engaged, the member is categorized as "Unreachable" and is not assigned to care coordination level 2 or level 3. The MCO will conduct quarterly claims mining for these members and will renew attempts to reach the member if claims indicate a possible need for care coordination.

If the MCO has made three documented attempts to contact and has reached the member at least once, but the member fails to engage with the completion of the HRA or CNA, the member is categorized as "Difficult to Engage" (DTE) and is not assigned a care coordination level 2 or level 3. If the member is categorized as a care coordination level 2 or level 3 based on the most recent CNA but fails to engage in

two consecutive contract required touch points (telephonic or in person), the member is then categorized as DTE, with appropriate documentation in the member's file. The MCO will perform quarterly claims mining for these Members and will renew attempts to reach Members if claims mining indicates a possible need for care coordination. ~~The MCO will continue attempts to reach the member quarterly or until the member has signed, or has documentation of refusing to sign, the care coordination declination form.~~

The HSD standardized HRA includes the following information:

- Member demographics
    - Member name, address, telephone number, date of birth;
    - Member Medicaid number;
    - Names and relationship of person(s) completing form (other than member);
    - Emergency contact and telephone number;
    - HRA date; and
    - Assessment Method and Type.
- Member Health Information
    - Language preference, translation needs, and special preferences (cultural, religious, physical);
    - Main health concern;
    - Current or past PH and BH conditions or diagnoses, including brain injury;
    - Pending PH or BH procedures;
    - Most recent physical examination and/or recent medical appointment;
    - Emergency room visits, including reason, number of visits and dates of visit(s);
    - Number of hospital stays in past 6 months, and any readmissions;
    - Indication of a 1915(c) waiver LOC assessment ~~or client individual assessment (CIA);~~

- Number of medications;
- Living situation;
- Assistance with two or more activities of daily living (ADL) and type of need;
- Interest in and need for LTC services;
- Advance directives preference and interest in receiving information; and
- Interest in receiving care coordination.

The MCO or its delegate shall provide the following information to every member during his or her HRA:

- The purpose of care coordination;
- The care coordination levels (CCLs);
- Notification of the member's right to request a higher CCL;
- Requirement for an in-person CNA for the purpose of providing services associated with CCL2 or CCL3; and
- Specific next steps for the member.

Within seven calendar days of completion of the HRA, all members shall be informed of the need for a CNA. MCOs may request to add additional questions to the HRA to meet the requirements of regulatory and accrediting bodies by submitting the additional questions and the reason(s) for inclusion for State approval. Requests must be sent for approval to HSD/MAD through the MCO's Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

The HRA and the CNA may be performed concurrently.

4.4. Comprehensive Needs Assessment

A CNA is conducted for Medicaid members eligible for managed care who are identified through the HRA as having significant health conditions and risk indicators signifying the potential need for CCL2 or CCL3. The MCO shall schedule a CNA within 14 calendar days of completion of the HRA and complete

the CNA within 30 calendar days of completion of the HRA unless the member is in a model approved for delegated care coordination functions with other State-approved guidelines.

Members who are identified as not needing a CNA shall be monitored by the MCO care coordination unit quarterly through predictive modeling software and available utilization and claims data to determine if the member had a change in health status and is in need of an HRA or CNA.

For members who reside in a~~n~~ NF, rather than conduct a CNA, the MCO shall ensure the Minimum Data Set (MDS) is completed and collect supplemental information related to BH needs and the member's interest in receiving CB services.

For members who have indicators that may warrant ~~an~~ a NF LOC, the MCO Care Coordinator shall conduct an in person, in home CNA at the member's primary residence. The MCO shall use the New Mexico Medicaid NF LOC Criteria and Instructions to determine NF LOC for members.

The CNA is the sole responsibility of the MCO Care Coordinator unless delegated to another entity via a Shared or Full Delegation Model.

CNAs must be performed through the utilization of an assessment tool that has been approved by HSD for assessing the member's medical/PH, BH, LTC, and social needs. The assessment tool may include the identification of targeted needs related to improving health, functional outcomes, or quality of life outcomes (e.g., related to targeted health education, pharmacy management, or increasing and/or maintaining functional abilities, including provision of covered services). Any changes to the assessment tool must be approved by HSD 30 calendar days prior to use by the MCO or its delegate.

The CNA must be conducted in the member's primary place of residence or facility for members reintegrating back into the community. The MCO or its delegate will involve collateral respondents when scheduling the CNA, including family members, caregivers, CHRs, CHWs, and/or other significant social support individuals, with the consent of the member. For CYFD PS and/or JJS involved children/youth, the MCO or its delegate will collaborate with the assigned CYFD permanency placement worker (PPW), juvenile probation officer (JPO), and community behavioral health clinician (CBHC) for behavioral health services. The MCO or its delegate must evaluate the need for translation, including signing or communication boards when scheduling the CNA.

CNAs must be conducted face-to-face with the member and collateral parties in the home, unless an exception has been granted by HSD. Home setting is defined as the primary residence for the member in the community where there is an identifiable address, and the member is residing for an established period of time for shelter, safety, physical assistance, recovery, legal requirements, or treatment services.

The CNA may be conducted without requesting an exception from the State under the following conditions:

- If the member is homeless, or in a transition home and the assessment can be conducted in a private setting at a location, mutually agreeable to the member, such as a church meal site program, community non-profit organization center, community MH agency, food bank site, etc.;
- If the member is currently part of the jail-involved population preparing for release; or
- If the Member is in a Health Home or being served by a provider approved for a Full Care Coordination Delegation Model.

Other requests for exceptions to the CNA face-to-face or in the member's home setting requirements must be made directly to HSD by the MCO using the following process:

- Complete the Centennial Care CNA Exception Request form (MAD 601);
- Alternate locations must be submitted to HSD for review and should be assessed for privacy to ensure the member's Protected Health Information (PHI) is not jeopardized;
- Send the completed MAD 601 by secure email to: HSD-QB-CCU-CNA@state.nm.us;
- HSD will review the request and respond to the specific MCO requestor within two business days;
- If an exception is approved, it shall only be valid for six months, or until the next CNA is needed, whichever comes first; and
- Requests **will not** be reviewed or approved if submitted:
    - Via unsecure email;
    - To an email address other than HSD-QB-CCU-CNA@state.nm.us; and

- Via any format other than the MAD 601 Form.

All efforts must be made to negotiate with and educate the member about the importance of participating in the completion of a CNA. The MCO or its delegate must provide documentation of further negotiations with the member and/or legal representatives when refusal by the member is articulated.

CNAs are considered to be best practice and valid when conducted in the home setting. The home setting must be evaluated for health, welfare, and safety of the member. The CNA, when conducted with the member in his/her home, includes determination of: any structural problems for member's mobility access; need for safety enhancements, such as smoke detectors, fire extinguishers, ramps, guard rails, and bathroom equipment; fall prevention concerns such as throw rugs; doorway access for wheelchairs; plumbing and electricity issues; nutritional concerns such as no food resources or food/beverage items identified as being beyond expiration dates; and other structural damages such as mold, broken windows, entry doors without locks, broken flooring. Additional areas of considerations include assessing for rodent/pest infestation, fire hazards due to electrical wiring issues and clutter/hoarding, as well as outdoor hazards due to overgrown weeds and undergrowth of yards/trees. The practice of conducting in home CNAs further allows for observation of the existence of other parties living in the home and possibly presenting support or risk to the member.

When a member, currently categorized as a CCL2 or a CCL3, refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the needs assessment with the member, emphasizing this assessment makes the determination of useful resources to meet the member's needs, such as the CB for personal care assistance, special home environment modifications and adaptive equipment. The MCO will ensure the member signs the HSD-approved care coordination declination form and maintain the signed form in the member's file. If the member refuses to sign the care coordination declination form, the MCO shall document such refusal in the member's record. The MCO will perform quarterly claims mining for these members and will renew attempts to reach the member if claims mining indicates a possible need for care coordination. The member who has refused care coordination will not be assigned to care coordination level 2 or level 3. In documented refusal circumstances, the MCO will submit a proposal to the member outlining a basic care plan with minimum services outlined and

suspend any requests for increased services/personal care hours until a CNA and NF LOC is conducted and completed.

At a minimum, the CNA shall:

- Assess PH and BH needs, including but not limited to: current diagnoses; history of significant PH and BH events, including hospitalizations and emergency room visits; medications; allergies; providers involved in member's care; DME; brief substance abuse screening questionnaire, as approved by HSD/BHSD and history; family medical and BH (MH and substance use/abuse) history; cognitive capacities, (including evaluation of alertness, orientation, history of head/brain injury); health-related lifestyle (smoking, food intake/nutrition, sleep patterns, exercise, continence); and functional abilities, including ADLs (mobility, grooming, bathing, eating, dressing, and medications) ~~(i.e., self-administration and safety)~~ and instrumental activities of daily living (IADLs)~~/ADLs~~ (i.e., money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, and grocery shopping).

- Assess LTC needs including but not limited to: environmental safety including items such as smoke detectors; pests/infestation; trip and fall dangers; and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the CB, the MCO shall assess for all CB services.

- Include a risk assessment, using a tool and protocol approved by HSD, as applicable. A risk agreement that shall be signed by the member or his/her representative that shall include: identified risks to the member; the consequences of such risks; strategies to mitigate the identified risks; and the member's decision regarding his/her acceptance of risk.

- Assess disease management needs, including: identification of disease state; need for targeted intervention and education; and development of appropriate intervention strategies.

- Determine a social profile including, but not limited to: living arrangements; natural and social support systems which are available to assist the member; demographics; transportation; employment; financial resources and challenges (other insurance, food, utilities, housing expenses); Medicare services; other community services being accessed, such as senior companion services, meals-on-wheels, etc.; living environment (related to health and safety); Individualized Education Plan; and Individualized Service Plans for Developmental Disabilities, Medically Fragile (MF), or Mi

Via Waiver Program recipients, (if applicable). A copy of the HCBS Waiver Prior Authorization or budget is not required to be obtained by the Care Coordinator.

- Identify possible suicidal and/or homicidal thinking, planning/intent and lethality risk, history of aggressive and/or violent behaviors, history of running away and wandering for both adults and children.
- Identify cultural information, including language and translation needs and utilization of ceremonial or natural healing techniques.
- Ask the member for a self-assessment regarding their viewpoint of their condition(s) and service needs.
- In the event the member is a minor under the age of 18, identify the parent or legal guardian participating in and/or responding for the minor during assessment.
- For members on the DD, Mi Via, or MF Waivers (categories of eligibility [COEs] 095 and 096) and as applicable to the member's living arrangement, identify the parent, family member or legal guardian participating in and/or responding for the member during the assessment.
- In the event the member is receiving the Alternative Benefit Plan (ABP) and meets the definition and criteria of Medically Frail or is otherwise ABP Exempt, notify the member that he/she may be exempt, explain the difference in benefits and facilitate his/her transition to the ABP Exempt benefit package at the member's choice.

4.5. Community Benefit Service Questionnaire

As part of the CNA process, MCO Care Coordinators must administer the CBSQ. The CBSQ/CBMA will be administered as part of the CNA, at the beginning of the CNA. The CBSQ assists the Care Coordinator in discussing all available CB services with the member, and the Community Benefit Member Agreement (CBMA) elicits the member's participation in identifying risks. The CBMA is not used to document the member's refusal to complete a CBSQ.

The completed CBSQ and the CBMA are considered part of the member's CNA. The MCOs must ensure all Care Coordinators are trained in administering these documents. The MCOs must have a process in

place to monitor that CBSQs and CBMAs are completed correctly and in accordance with Section 4.5 of the Managed Care Policy Manual.

The CBSQ/CBMA will be administered as part of the CNA, at the beginning of the CNA, for the following members:

- Allocated members receiving their first CNA, including members who are in the process of community reintegration from a~~n~~ NF and members who lost their full Medicaid Category of Eligibility (COE) and are being allocated for continuity of care.
- Annually for members with a current NF LOC (see note about CCL3 members below).
- Full Medicaid members without a~~n~~ NF LOC who request CB services.
- Full Medicaid members without a~~n~~ NF LOC who have not requested CB service but appear to meet NF LOC criteria prior to or during the CNA. MCOs must determine this through claims data or other information obtained prior to the member's CNA.

The CBSQ/CBMA will not be administered for the following members:

- Members who have not previously met a~~n~~ NF LOC and who are not requesting CB at the time of the CNA.
- Members who may meet a~~n~~ NF LOC for a short period of time due to a clinical episode (i.e., pregnancy).
- Members not being assessed for a~~n~~ NF LOC.
- Members on the DD, Mi Via, or MF Waivers (categories of eligibility [COEs] 095 and 096).
- Members in a~~n~~ NF (unless in the process of being allocated through community reintegration or member has a COE (i.e., Supplemental Security Income [SSI]) that deems them eligible to reintegrate without a waiver allocation).
- Members who decline assessment for NF LOC or refuse CB services. The MCO Care Coordinator must document the refusal in the member's record.
- Members who decline care coordination. The declination form must be on file with the MCO.

CCL3 members:

- For all members with CCL3 and ~~an~~ a NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the Care Coordinator.
- For members with CCL3 but without a~~n~~ NF LOC, follow the criteria above.

In any circumstances not covered by the criteria, the Care Coordinator should use his/her judgment and consult with his/her supervisor as necessary to determine appropriate use of the CBSQ. Care Coordinators should use the CBSQ as a tool to guide the discussion with the member and/or the member's representative to inform them of the availability of CB services.

HSD will audit CBSQ and CBMA completion to ensure that these requirements are met.

4.6. CNA Reassessments

The CNA shall be conducted at least annually for level 2 care coordination and semi-annually for level 3 care coordination, to determine if the care plan is appropriate for the member and if a higher or lower LOC coordination may be needed.

Additional CNAs may also be conducted, as the Care Coordinator deems necessary, as requested by the member, provider, family member or legal representative, or as a result of a change in health status and/or social support situation.

Specific indicators warranting a need for conducting a new CNA may include but are not limited to: significant changes in member's medical and/or BH condition (decline or improvements in health status); changes in setting of care (SOC), such as hospitalization, rehabilitation and/or short-term NF admission (long-term NF stay(s) require administration of the MDS): residential treatment facility admission; changes in the member's family or natural/social support system (such as, sudden illness and/or convalescence or death of a family caregiver); living arrangement disruption (loss of residence, eviction, fire/flooding, move to another family home); involvement of Adult Protective Services (APS), Child Protective Services, Juvenile Justice Services, Behavioral Health Services and/or other New Mexico Children, Youth & Family Department (CYFD) interventions; and changes in the amount of caregiver services requested and requested amount exceeds the range of hours corresponding with member's

existing assessment score. These events may at times not require a new CNA be completed. If a new CNA is not conducted, the member's record should clearly establish why the triggering event did not result in the MCO conducting a new CNA. The decision can be made via telephone contact or face to face visit with the member.

4.7. Comprehensive Care Plan Requirements

This policy is in conjunction with all elements described in the CCP Requirements outlined in the Agreement, which defines the processes for development, implementation and management of a care plan for all members in levels 2 and 3 of care coordination. The MCO- or HSD-approved designee is responsible for ensuring a CCP is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the CCP.

- CCP Scope and Process. The MCO- or HSD-approved designee must establish a process to ensure coordination of care for members that includes:
    - Coordination of the member's PH, BH, and long-term health care needs through the development of the CCP;
    - Collaboration with the member, member's friends and family (at member's request), member's PCP, specialists, BH providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan, including documentation of all attempts to engage providers and other individuals identified in the development of the care plan;
    - With the member's consent to share information, the care plan should be shared and utilized by those involved in providing care to the member (e.g., BH providers should be aware and take into consideration the member's PH care issues when working with the member); and
    - Verification of all decisions made regarding the member's needs and services, and ensures all information is documented in a written, CCP.
- CCP Development and Management:
    - The CCP is in a language the member ~~and or/family~~ and/or family member can understand. The member shall lead the person-centered planning process to ensure the CCP is member-centric and agreed upon by the member;
    - The member may designate his/her representative to have a participatory role, as needed, and as defined by the member, unless the representative has decision making authority, under law; and

- The MCO or HSD approved designee shall develop and authorize the CCP within 14 business days of completion of the CNA unless the member is in a health home and/or using the Treat First model of care.
- The Care Coordinator shall:
  - Ensure the member or member's legal representative understands, reviews, signs and dates the CCP.
  - Provide a copy of the completed CCP to the member, member's legal representative as applicable or other providers authorized to deliver care to the member in a format that is easily readable (e.g., 12 font).
  - With the member's and/or parent, legal guardian and/or CYFD worker's (if in CYFD Custody) consent, confirm family, providers, or any other relevant parties are included in the treatment and planning of the member's CCP.
  - Ensure timelines for the development and implementation and/or update the CCP are met.
  - Facilitate treatment and coordinate with providers to assist the member and his or her family and CYFD lead worker (if in CYFD custody) with navigating the system including scheduling appointments, arranging transportation, or advocating for the member as needed.
  - Verify services have been initiated and/or continue to be provided as identified in the CCP and ensure services continue to meet the member's needs.
  - With member's consent, maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the member's care.
  - Identify, address, and evaluate service gaps to determine their cause and minimize any gaps going forward and ensuring back-up plans are implemented and effectively working; including strategies for solving conflicts or disagreements, and provide clear conflict-of-interest guidelines for all planning participants.

- Identify and list specific risk factors and changes to member's risk, address those changes and update the member's risk agreement and CCP as necessary to include measures to minimize the identified risks.
- Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.
- Educate members with identified disease management needs by providing specific disease management interventions and strategies.
- Educate the member about his or her ability to have an Advance Directive and ensure the member's decision is well documented in the member's file.
- Educate member about non-Medicaid services available as appropriate (e.g., Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant MH).
- Reflect cultural considerations of the member and conduct the CCP process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

o Required Elements of a CCP include the following:

- Pertinent member demographics and enrollment data.
- Ensure implementation of interventions and the dates by which the interventions must occur and identify specific agencies or organizations with which treatment must be coordinated, including non-Medicaid providers.
- Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.
- Member's current status, including present levels of function in physical, BH cognitive, social, and educational domains.
- Member or family, foster family or extended kinship barriers to receiving treatment, such as a member or family member's inability to travel to an appointment.

- Identify the member or family's, foster family's, and/or extended kinship/guardian's strengths, resources, priorities, and concerns related to achieving mutual recommendations made in caring for the member.
- Services recommended achieve the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member's desired outcomes.
- Identify services provided by natural supports that are scheduled to be enhancers and back-up (including emergency purposes) to services that are authorized by the MCO.
- An interdisciplinary team, with member's consent, including but not limited to: the Care Coordinator; social worker; registered nurse (RN); medical director; PCP; and others must be identified to develop, implement and update the CCP as needed.
- Reflect the setting in which the individual resides is chosen by the member, and is integrated in and supports full access of members receiving HCBS, to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
- Reflect the member's strengths and preferences.
- Identify goals and desired outcomes that reflect the least restrictive, community-based services and supports (paid and unpaid) that will assist the member to achieve identified goals, and include who will provide the services and supports.
- Identify goals and preferences related to relationships, community participation, employment, income and savings, health care and wellness, education and others.
- Include services and, the purpose or control of which the member elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.

o CCP Revisions

- The CCP will be revised when the member experiences one of the following circumstances:

- Risk of significant harm: within one business day of the MCO receiving notification, the care coordination team will convene, in person or by teleconference; and if necessary the care plan will be modified accordingly within 72 hours;
- Major medical change;
- The loss of a primary caregiver or other significant person;
- A serious accident, illness, injury or hospitalization that disrupts the implementation of the CCP;
- Serious or sudden change in behavior;
- Change in living situation, including out-of-home placements and subsequent discharges;
- Proposed change in services or providers (e.g. CB);
- It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect, or exploitation;
- Any team member requests a meeting to propose changes to the CCP;
- Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or
- As requested by HSD.

▪ Within five business days of completing a reassessment of a member's needs, the Care Coordinator shall update the member's CCP as appropriate, and the MCO or HSD approved designee shall authorize and initiate services in the updated CCP.

o Ongoing Care Coordination

▪ This policy along with all elements described in Ongoing Care Coordination outlined in the Agreement, defines how the MCO or HSD approved designee shall perform real time and ongoing care coordination to ensure all members receive the appropriate care.

- Ongoing care coordination functions shall include all elements defined in the Agreement including the following:
    - Identify gaps and address the needs of the member, including develop and/or update the care plan as needed.
    - Ensure when a member's LOC coordination increases or decreases that continuity of care is always maintained.
    - Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.
    - Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member's goals and foster independence.
    - Coordinate and provide access to specialists, as needed; relevant long-term specialty providers, relevant emergency resources, relevant rehabilitation therapy services, relevant non-Medicaid services, etc.
    - Education regarding service delivery through Medicare and/or Medicaid.
    - Measure and evaluate outcomes designated in the CCP and monitor progress to ensure covered services are being received and assist in resolution of identified problems.
    - Achieve coordination of physical, BH, and LTC services.
    - Maintain consistent communication and contact with member's PCP, specialists, and other individuals involved in the member's care. The MCO shall maintain consistent communication and contact with the assigned CYFD permanency placement worker (PPW) for protective services involved children and youth, juvenile probation officer (JPO) for juvenile justice involved youth, and community behavioral health clinician (CBHC) for CYFD involved children and youth.
    - Maintain and monitor the member's CB and provide assistance with complex services.
    - Consider member and provider input to identify opportunities for improvement.

- Collaborate and/or cooperate with representatives of the Independent Consumer Support System.

4.8. Staffing Requirements and Delegations

The MCO may utilize a care coordination team approach to perform care coordination activities, with the MCO's care coordination team consisting of the member's primary Care Coordinator and other individuals with relevant expertise and experience appropriate to address the needs of members. While the MCO may subcontract the HRA activities, the MCO shall ensure its staff, subcontractor(s), or vendor(s) conducting the HRA are adequately trained to effectively conduct the HSD standardized HRA. CNAs must be performed by primary Care Coordinators employed by the MCO or its delegate. The MCO may delegate some care coordination functions to local resources, such as: PCMHs, FQHCs, CHWs, CHRs, school-based health centers [SBHCs], Correctional Facilities, CSAs, Paramedicine programs, county entities, Centers for Independent Living, and Tribal entities. The MCO will implement policies and procedures that will define and specify the qualifications, experience, and training of each member of the MCO care coordination team and its delegated Care Coordinators to ensure specific functions are performed by a qualified Care Coordinator.

Maximum caseload per Care Coordinator, are established by HSD and shall not be exceeded by the MCO. As the MCO transitions more care coordination functions to the provider level, it will collaborate with HSD to adjust care coordination caseload requirements. Caseload to Care Coordinator ratios are as follows:

- CCL2:
  - Members not residing in a~~n~~ NF 1:75; and
  - Members residing in a~~n~~ NF 1:125.
- CCL3:
  - Members not residing in a~~n~~ NF 1:50; and
  - Members residing in a~~n~~ NF 1:125.

- Care coordination for members who participate in the self-directed CB:
    - CCL2 is 1:75; and
    - CCL3 is 1:50.

MCOs or its delegate shall submit, upon request by HSD, a Care Coordination Staffing Plan, which at a minimum shall specify:

- The number of Care Coordinators, care coordination supervisors, other care coordination team members the MCO plans to employ;
- The ratio of Care Coordinators to members;
- The MCO's plans to maintain ratios as outlined by care coordination level and the explanation of the methodology used for determining such ratios;
- How the MCO will ensure such ratios are sufficient to fulfill the Agreement requirements;
- The roles and responsibilities for each member of the care coordination team;
- A strategy that encourages the use of Native American Care Coordinators and limits duplication of services between Indian Health Services, Tribal Health Providers, and Urban Indian Providers (I/T/U) and non-I/T/U providers;
- How ratios are adjusted to accommodate travel requirements for those Care Coordinators serving members in rural/frontier areas of the State and/or for those members that require extraordinary efforts from the assigned Care Coordinator; and
- How the MCO will use Care Coordinators to meet the needs of New Mexico's unique population.

The MCO or its delegate shall ensure members have a telephone number for direct contact with their Care Coordinator and/or a member of their care coordination team, (without being routed through several contact points), during normal business hours (8:00 a.m. – 5:00 p.m. Mountain Standard Time). When the member's Care Coordinator or a member of the member's care coordination team is not available, the call shall be answered/facilitated by another qualified staff person in the MCO's or its delegate's care coordination unit. Calls requiring immediate attention shall be "warm" transferred directly to another Care Coordinator, not letting the call go to voice mail. After normal business hours,

calls requiring immediate attention by Care Coordinator shall be handled by the member services line, as stipulated by Section 4.15.1 of the Agreement.

When Native American members request a Native American Care Coordinator, the MCO must employ or contract with a Native American Care Coordinator or contract with a CHR to serve as the Care Coordinator.

The MCO or its delegate must accommodate the member's requests to change to a different Care Coordinator if desired and if there is an alternative Care Coordinator available. Such availability may take into consideration the MCO's or its delegate's need to efficiently deliver care coordination in accordance with the requirements in the Agreement. In ensuring quality and continuity of care the MCO or its delegate shall make efforts to minimize the number of changes in a member's Care Coordinator. The MCO or its delegate may need to initiate change in the following circumstances:

- Assigned Care Coordinator is no longer employed by the MCO or its delegate;
- There is a conflict of interest preventing neutral support for the member;
- Care Coordinator is on temporary leave from employment; or
- Caseload of the assigned Care Coordinator must be adjusted due to its size or intensity.

The MCO or its delegate shall develop policies and procedures regarding notice to members of Care Coordinator changes initiated by either the MCO or its delegate, or the member, including notice of planned Care Coordinator changes initiated by the MCO or its delegate.

The MCO or its delegate shall ensure continuity of care when Care Coordinator changes are made. The MCO or its delegate shall demonstrate use of best practices by encouraging newly assigned Care Coordinators to attend a face-to-face transition visit with the member and the out-going Care Coordinator, when possible, and include documentation of such transition in the member's file.

Initial training shall be provided by the MCO or its delegate to newly hired Care Coordinators and ongoing training provided at least annually to all Care Coordinators. Involvement of New Mexico Tribes as training instructors should be utilized where appropriate.

4.9. Engagement of Members

HSD recognizes there may be a select few managed care members who present challenges to the service delivery system due to the complexity of their needs. This policy is designed for members who demonstrate inappropriate behaviors and/or frequent contact of State and MCO staff, and/or have been unresponsive to traditional care coordination efforts and noncompliant with recommended BH services.

This group of "high health risk/high resource utilization" (HHR/HRU) is different than other populations and individuals in the care system because denying or delaying care to them has significant immediate negative consequences to their health and safety. The risk to the individual can be documented in assessments, contact notes, and care plans. Responding to the challenges presented by this category of members requires monitoring of attempted delivery of care, documenting interactions, and thresholds of behavior or conditions that escalate events to a higher level of response and identifying appropriate teams to design and implement responses. Consistent, well-crafted responses to concerns are essential when providing care or addressing resistance to care. This will minimize excessive use of State, MCO, and provider resources, as well as minimizing risk to the individual's health and safety.

The following protocol is to be utilized across MCOs, agency providers, and State employees and programs for each recipient identified as part of the HHR/HRU population. The expected result is a more efficient use of resources to achieve an optimal outcome for the individual. This is intended to free time and energy to manage all complex individuals in the care system and to achieve optimal levels of health and safety for all individuals.

Intervention Procedures/Policies: Care delivery literature recommends the use of behavioral contractual agreements with members so all parties agree on appropriate responses in a non-compliant care situation. The State may partner with MCOs to make this intervention consistent for all MCOs and all individuals identified as HHR/HRU.

At the threshold of risk agreed upon by the MCO, a meeting is arranged with the individual and appropriate recipients of the care team. For CYFD involved clients, include the CYFD community behavioral health clinician (CBHC). This team must include the Care Coordinator, a management level staff of the MCO and a high level clinical staff member of the MCO. The member may request one or two people to be in attendance. The intention of the meeting with the participant is to:

- Establish/discuss optimal outcome for health and safety;
- Identify the issues interfering with optimal health and safety outcomes;
- Clarify roles for each member of the team;
- Clarify rules of engagement (who can call whom and when, etc.) and program regulations;
- Assign tasks to each team member with timeline;
- Sign agreement that documents the discussion and assignment of tasks and holds each member accountable;
- Schedule 2nd meeting within two weeks. Second meeting is a final meeting. Review tasks. Discuss/establish consequences of any failure to deliver on tasks. Sign contract/care plan. (Includes updates weekly and addressing ongoing/emergent issues at a bi-monthly meeting.)
- Schedule updates between participants, MCO staff on a regular basis; and
- Ensure maintenance of documentation is with MCO, participant, and natural supports.

When HHR/HRU recipients are identified, the MCOs will designate one point of contact and communicate that point of contact to HSD/MAD and other involved individuals. If the identified recipient calls HSD/MAD or other agencies, the individual will be referred back to the MCO point of contact.

If the process outlined above does not provide resolution, the MCOs will utilize their complex case team and complex case rounds protocol.

4.10. MCO Care Coordination with 1915 (c) HCBS Waivers: ~~DDs, MF, and MI VIA~~ Developmental Disabilities (DD), Mi Via, and Medically Fragile (MF) Waivers

The MCOs provide acute and ancillary medical and BH services to the 1915 (c) HCBS recipients/MCO members. The MCO is responsible for ensuring a CCP is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO CCP. The MCOs are required to perform all care coordination functions described in this Manual section including but not limited to: capturing the member's medical, BH, and ancillary needs; explaining to the member, family, and/or guardian, the

Medicaid benefits that are available from the MCO, and how the MCO care coordinator can assist with coordinating services with the case manager or consultant; developing a CCP; and completing all required touch points identified by the member's current care coordination level. Exceptions to care coordination functions are specifically described below for members receiving 1915(c) HCBS waiver services.

4.11. Overview of Medicaid 1915(c) HCBS Waiver Programs

- **Developmental Disabilities Waiver (DDW) Program**

  The DDW provides an array of HCBS to help individuals with ~~DDs~~ developmental and/or intellectual disabilities to remain in their homes and communities as opposed to institutional care, become more independent, and reach their personal goals. The DDW serves individuals who meet an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) LOC. DDW individuals have a Medicaid Category of Eligibility (COE) 096.

  The DDW provides the following HCBS: behavior support consultation; case management; community integrated employment services; customized community supports; customized IHS; crisis support; environmental modification; independent living transition service; intensive medical living supports; living supports; non-medical transportation; nutritional counseling; personal support technology; preliminary risk screening and consultation related to inappropriate sexual behavior; adult nursing; respite; socialization and sexuality education; supplemental dental care; and skilled therapies. DDW services are supplementary to early periodic screening, diagnostic, and treatment (EPSDT) benefits for recipients under the age of 21.

  DDW services and budgets are outlined in the recipient's Individual Service Plan (ISP). The ISP is developed through a person-centered planning process which allows recipients to select services that will help them achieve personally defined outcomes in the most integrated community setting. The ISP is created by the DDW recipient with the assistance of their DDW case manager and the DDW Interdisciplinary team (IDT). The DDW case manager provides information, support, guidance, and assistance to recipients during the Medicaid eligibility process and afterwards during the ISP development. The IDT serves to help the recipient identify supports, services and goods that meet their need for DDW services and are specific to the recipient’s qualifying condition.

- **Mi Via Self-Directed Waiver Program**

  Mi Via is the State of New Mexico’s self-directed waiver program serving individuals who meet an ICF-IID LOC. Medicaid members served through the Mi Via waiver are referred to as “participants”. Mi Via participants are identified with either COE 095 Medically Fragile or COE 096 Developmental Disability and a Setting of Care (SOC) of “MIV”. The goal of Mi Via is to provide home and

community-based alternatives that facilitate greater participant choice and control over the types of services and supports they receive. It is important to distinguish that Mi Via is a self-directed waiver program that is operated separately from the Centennial Care Self-Directed Community Benefit (SDCB) Program.

Mi Via provides the following services: consultant/support guide services; behavior support consultation; community direct support; customized community supports; in-home living supports; emergency response network; Employment Supports services; environmental modification services; Home Health Aide; homemaker/direct support services; nutritional counseling; personal plan facilitation; private duty nursing for adults; respite; skilled therapies for adults; specialized therapies; related goods; and non-medical transportation. Mi Via services are supplementary to EPSDT benefits for participants under the age of 21 years old.

Mi Via waiver services and budget are outlined in the participant's Service and Support Plan (SSP). The SSPs are developed through a person-centered planning process which allows participants to select services that will help them achieve personally defined outcomes in the most integrated community setting. The SSP is created by the Mi Via participant with the assistance of their consultant. Consultants provide information, support, guidance, and assistance to participants during the Medicaid eligibility process and afterwards during SSP development. Consultants serve to help the participant identify supports, services, and goods that meet their need for Mi Via waiver services and are specific to the participant's qualifying condition. The level of support a consultant provides is unique to the individual participant and their ability to self-direct in the Mi Via program.

- **Medically Fragile Waiver (MFW) Program**

  The MFW serves individuals who have been diagnosed with an MF condition defined as a life threatening, chronic condition which results in a prolonged dependency on skilled nursing care at home. MFW individuals have a Medicaid COE 095. MFW recipients meet an ICF/IID LOC, as well as established MF parameters.

  The MFW provides the following HCBS: RN case management; private duty nursing (RN, licensed practical nurse [LPN]); home health aide; behavior support consultation; respite care; nutritional counseling; skilled therapies (physical, occupational, and speech) for adults; environmental

modifications; and specialized medical equipment. MFW services are supplementary to EPSDT benefits for recipients under the age of 21.

The UNM Health Sciences Center, Center for Development and Disability has a Medically Fragile Case Management Program (MFCMP) that currently provides RN/case management services to both MF waiver and non-waiver (EPSDT) MF persons statewide. Case managers from the UNM/MFCMP assess the recipient for MF parameters, compile the MFW LOC forms, and submit the MFW LOC packet to the Medicaid Third Party Assessor (TPA) for an ICF/IID LOC determination. Case Managers also create the MFW recipient's ISP that includes services and budget amounts determined by the LOC.

- ~~Mi Via Self-Directed Waiver Program~~

~~Mi Via is the State of New Mexico's self-directed waiver program serving individuals who meet an ICF-IID LOC. Medicaid recipients served through the Mi Via waiver are referred to as "participants". Mi Via participants have a Medicaid COE of either COE 095 MF or COE 096 Developmental Disability and a SOC of "MIV". The goal of Mi Via is to provide home- and community-based alternatives that facilitate greater participant choice and control over the types of services and supports they receive. It is important to distinguish that Mi Via is a self-directed waiver program that is operated separately from the Centennial Care Self-Directed Community Benefit (SDCB) Program.~~

~~Mi Via provides the following services: consultant/support guide services; behavior support consultation; community direct support; customized community supports; in-home living supports; emergency response network; Employment Supports services; environmental modification services; Home Health Aide; homemaker/direct support services; nutritional counseling; personal plan facilitation; private duty nursing for adults; respite; skilled therapies for adults; specialized therapies; related goods; and non-medical transportation. Mi Via services are supplementary to EPSDT benefits for participants under the age of 21 years old.~~

~~Mi Via waiver services and budget are outlined in the participant's Service and Support Plan (SSP). The SSPs are developed through a person-centered planning process which allows participants to select services that will help them achieve personally defined outcomes in the most integrated community setting. The SSP is created by the Mi Via participant with the assistance of their consultant. Consultants provide information, support, guidance, and assistance to participants~~

~~during the Medicaid eligibility process and afterwards during SSP development. Consultants serve to help the participant identify supports, services, and goods that meet their need for Mi Via waiver services and are specific to the participant's qualifying condition. The level of support a consultant provides is unique to the individual participant and their ability to self-direct in the Mi Via program.~~

4.12. MCO Care Coordination Activities and the 1915 (c) HCBS Waivers Service Plan (ISP or SSP)

- Members who transition from Community Benefits to a 1915 (c) HCBS Waiver
    - Coordination between the MCO and 1915 (c) Waiver program must be coordinated to avoid gaps in home and community-based services (i.e. Community Benefits and 1915 (c) Waiver) during the transition.
    - The MCO Care Coordinator shall work proactively with the member and member's 1915 (c) case manager/consultant to coordinate the transition dates for the member to move seamlessly from Community Benefits to the 1915 (c) waiver service plan.
- Members in the DD Waiver program
    - The MCO Care Coordinator shall request a copy of the approved DDW LOC packet, consisting of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) abstract (MAD 378 form) and related waiver assessments ~~CIA~~ from the Medicaid TPA for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs.
    - A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC packet ~~abstract and CIA~~.
    - The MCO Care Coordinator ~~has no influence in regards to the DDW services and budget. The Care Coordinator~~ cannot make ~~recommendations or~~ changes to the member's DDW ISP and Budget.
    - The MCO will not complete a~~n~~ NF LOC on members enrolled in the DD 1915 (c) waiver, unless the member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the member's DDW case manager in the event of a NF long-term permanent placement.
    - The MCO will utilize the DDW LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the ~~recipient/~~member.

- The MCO Care Coordinator shall have knowledge that while the MCO is responsible for annual CNA visits, the DD waiver case manager assists the member with the DD waiver LOC assessment process and ISP and Budget development. The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for members who are receiving HCBS through the DD waiver.

- MCO members in the Mi Via Self-Directed Waiver Program
  - The MCO Care Coordinator shall request a copy of the approved Mi Via LOC packet, consisting of the abstract (MAD 378 form) and related assessments from the TPA for the purpose of obtaining a complete, comprehensive picture of the participant and their needs.
  - A CIU/MAD 054 form is faxed to the Medicaid TPA to request the LOC abstract and CIA.
  - The MCO Care Coordinator cannot make changes to the member's Mi Via SSP and Budget.
  - The MCO will not complete a NF LOC on members enrolled in the Mi Via 1915 (c) Waiver, unless the member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the member's Mi Via consultant in the event of a NF long-term permanent placement.
  - The MCO Care Coordinator will utilize the LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the member.
  - The MCO Care Coordinator shall have knowledge that while the MCO is responsible for the annual CNA visits, the consultant assists the participant with the annual Mi Via waiver LOC assessment process (which requires the TPA to conduct an in-home assessment of long-term HCBS needs). The MCO and consultant are encouraged to coordinate the CNA visits and LOC in-home assessment at the same time in order to reduce the burden to the participant/member and the participant's family.
  - The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for members who are receiving HCBS through the Mi Via waiver.

- MCO Members in the MFW Program

- The MCO Care Coordinator shall request a copy of the approved MFW LOC packet and ISP packet from the ~~UNM/MFCMP~~ MFW case management agency prior to the completion of the CNA. The MCO will utilize the LOC and ISP information to complete as much of the CNA as possible prior to the visit.
- The MCO shall ensure the MFW ISP serves as the CCP for the MF member.
- The MCO shall work with the MFW case management agency ~~UNM/MFCMP~~ to coordinate MFW LOC assessments and/or CNA visits at the same time in order to reduce the burden on these families.
- The MCO will not complete a~~n~~ NF LOC on members enrolled in the MF 1915(c) Waiver, unless the member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the member's MFW case manager in the event of a NF long-term permanent placement.
- Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The ~~UNM/MFCMP~~ MFW case management agency will conduct monthly visits and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CNA as needed.
- Conduct the required annual in person visit and CNA for MF members.
- Utilize the MFW ISP as the CCP for the MFW recipient.

~~• MCO members in the Mi Via Self-Directed Waiver Program. The MCO Care Coordinator shall:~~

- ~~Request a copy of the approved Mi Via LOC abstract (MAD 378 form) and CIA from the TPA for the purpose of obtaining a complete, comprehensive picture of the participant and their needs.~~
  - ~~A CIU/MAD 054 form is faxed to the Medicaid TPA to request the LOC abstract and CIA.~~
  - ~~The Care Coordinator has no influence in regards to the Mi Via goals, services, and budget. The Care Coordinator cannot make recommendations or changes to the Mi Via SSP and Budget.~~
- ~~The MCO will not complete an NF LOC on members enrolled in the Mi Via 1915(c) Waiver.~~

- ~~Utilize the LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the participant/member.~~
- ~~Have knowledge that while the MCO is responsible for the annual CNA visits, the consultant assists the participant with the annual Mi Via waiver LOC assessment process (which requires the TPA to conduct an in-home assessment of long-term HCBS needs). The MCO and consultant are encouraged to coordinate the CNA visits and LOC in-home assessment at the same time in order to reduce the burden to the participant/member and the participant's family.~~
- ~~Utilize only the PH and BH portion of the MCOs' CCP for members who are receiving HCBS through the Mi Via waiver.~~

4.13. MCO Care Coordination Activities for MF EPSDT (Non-Waiver) Members Case Managed by the MFW Case Management Agency ~~UNM/MFCMP~~

The MCOs are contracted with ~~UNM/MFCMP~~ the MFW case management agency to continue to provide RN/case management services for those individuals (non-waiver) who meet the MF criteria. The same MF parameters are utilized for non-waiver members.

For MF EPSDT (non-waiver) clients, the MCO Care Coordinator shall:

- Request a copy of the approved MF ISP from the MFW case management agency ~~UNM/MFCMP~~ prior to the completion of the CNA. The MCO will utilize the information in the ISP to complete as much of the CNA as possible prior to the annual visit.
- ~~The MCO will~~ Not complete a~~n~~ NF LOC assessment on MF EPSDT members.
- Ensure the MF ISP serves as the CCP for the MF member.
- Work with the MFW case management agency ~~UNM/MFCMP~~ to coordinate the CNA in-person visits at the same time in order to reduce the burden on these MF members and families.
- Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The MFW case management agency ~~UNM/MFCMP~~ will conduct monthly visits or phone

conference calls with the MCO Care Coordinator and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CCP as needed.

- Conduct the required annual in-person visit and CNA for MF members.

4.14. Transitions from the HSD Non-Medicaid Brain Injury Services Fund to a Centennial Care MCO

The HSD Brain Injury Services Fund (BISF) offers short-term non-Medicaid services to individuals with a confirmed diagnosis of brain injury, either traumatic brain injury (TBI) or other acquired brain injury. The MCO shall implement policies and procedures for ensuring members with brain injury transition from the BISF into benefits and services that are covered under the MCO. The MCO may contact the HSD BISF service ~~care~~ coordination contractor to verify the status of a member's BISF eligibility. At a minimum, the following must be addressed:

- The MCO shall maintain ongoing communication, enlist the involvement of, and coordinate with BISF service coordinators to effect the full transition of the member's care from the BISF to the MCO. ~~To effect the full transition of MCO members:~~
  - The HRA shall include questions about specific health diagnoses, including brain injury.
  - For members who identify as having brain injury during the HRA, opportunity shall be given to reschedule the HRA when natural supports and advocates, including a BISF service coordinator can be presented. During any HRA, information shall be requested by the reviewer about the member's specific needs and what services were assessed as needed through the BISF or its currently contracted providers.
  - An HRA containing information about a self-reported brain injury shall trigger the scheduling of a CNA to include the person with the brain injury, any natural supports or advocates, and the BISF service coordinator or BISF life skills coach, as applicable.
  - All parties are to ensure a Release of Information has been signed by the member to affect the participation of the BISF service coordinator and/or other identified advocates in the member's transition.

- ~~In the event a BISF participant was assigned to an MCO and wishes to transfer to a different MCO, the receiving MCO shall have the responsibility of working with the BISF service coordinator.~~

- The MCO Care Coordinator is to acquire a copy of the BISF participant's ~~*Confirmation of ICD-10 code* and copies of any medical records entrusted to~~ BISF assessment and Independent Living Plan (ILP) from the BISF service coordinator to ensure their inclusion in the member's file. These efforts are intended to preserve the history of brain injury and ensure that care needs are related to the brain injury diagnosis~~. can be readily implemented.~~

- ~~The MCO Care Coordinator shall maintain the primary responsibility for completing any transition paperwork but may request the assistance of the BISF service coordinator, as is mutually agreeable.~~

- ~~The MCO Care Coordinator shall assume the responsibility of assisting the member in setting up the services identified on the member's CCP. The MCO Care Coordinator may consult with the BISF service coordinator regarding available service and community support providers.~~

- ~~Any additional recommendations made by the BISF service coordinator shall be noted in the member's file.~~

- ~~The MCO shall maintain continuity of care and implement the CCP services and supports that are needed to support the independent functioning of the member in their home and community.~~

- ~~The MCO shall have the primary responsibility in assisting members who identify that they wish to self-direct their care. The input of the BISF service coordinator may be considered in anticipation of a SDCB budget and SSP to meet the member's anticipated needs.~~

- The MCO shall receive brain injury training by the HSD including: general brain injury information; available state and community resources; and communication strategies. Other topics may include: how to conduct assessments that capture the needs of brain injury; and how to develop a CCP that considers the needs of members with brain injury. Training by the MCO shall be required for any new care coordination staff within three months of employment, with renewed training to occur on a two-year schedule.

4.15. Appendix

4.15.1. Health Risk Assessment

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Health Risk Assessment (HRA)

Member's Name (First, Middle, Last)		Member's Medicaid ID	Date
Has Member Given Permission for Another Person to Complete this form? ☐ Yes ☐ No	**Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member**		
Member's Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Other Phone**	
Emergency Contact Name/Phone		**Date of Birth**	
Assessment Method ☐ Telephonic ☐ In-person ☐ Other		**Demographics Verified?** ☐ Yes ☐ No	
Assessment Type ☐ Initial assessment ☐ Reassessment ☐ Change in health status			

	Question	Response
1.	Do you have a language need other than English? Do you need translation services? Please describe:	☐ Yes ☐ No ☐ Yes ☐ No _____
2.	Do you have any special preferences we should be aware of?	☐ Cultural preference ☐ Hearing Impairment ☐ Religion/Spiritual needs or preferences ☐ Visual Impairment ☐ Literacy ☐ None ☐ Other (describe):_____
3.	What is your main health concern right now?	_____
4.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐ Behavioral health diagnosis ☐ Comorbid conditions ☐ ICF/MR/DD ☐ High risk pregnancy ☐ Transplant patient ☐ Medically Fragile Waiver Program ☐ Medically frail ☐ Traumatic brain injury ☐ Other acute or terminal disease: _____
5.	(*Adult only question*) Compared to others your age, would you say your health is.....?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐ Yes ☐ No _____
7.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for visit(s):	☐ Yes ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more _____ _____

	Question	Response
8.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more ☐Yes ☐No
9.	How many medicines are you currently taking?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐6+
10.	What is your current living situation?	☐ Homeless ☐ Living alone ☐ Living in group home ☐ Living in shelter ☐ Living with other family ☐ Living with others unrelated ☐ Living with spouse ☐ Living in assisted living facility ☐ Lives in out of state facility ☐ Lives in out of home placement ☐ Dependent child in out of home placement ☐ Living in a nursing facility ☐ Other (describe): _____
11.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	☐ Yes ☐ No ☐ Dressing ☐ Bathing/grooming ☐ Eating ☐ Meal acquisition/preparation ☐ Transfer ☐ Mobility ☐ Toileting ☐ Bowel/bladder ☐ Daily medication ☐ Other: _____ ☐ Yes ☐ No
12.	Do you need or are you interested in Long-Term Care services?	☐ Yes ☐ No
13.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advance directive in place? Could I send you more information?	☐ Living will ☐ Advance directive (for medical care) ☐ Advance directive (for psychiatric care) ☐ No living will or advance directive in place ☐ Declined discussion ☐ Requested further information
14.	Are you interested in receiving Care Coordination Services?	☐ Yes ☐ No

The MCO shall provide the following information to every Member during his or her HRA:

1. Information about the services available through Care Coordination
2. Information about the Care Coordination Levels (CCLS)
3. Notification of the Member's right to request a higher Care Coordination Level
4. Requirement for an in-person Comprehensive Needs Assessment for the purpose of providing services associated with Care Coordination level 2 or level 3
5. Information about specific next steps for the Member