Infomational Session Frequently Asked Questions (FAQs)

Q: How will individuals be identified as being eligible for enrollment in CareLink NM?
A: The target populations of the CareLink NM (CLNM) program (eligible recipients) are those enrolled in Medicaid who have one or more serious mental illness (SMI) or severe emotional disturbance (SED) as defined by the State of New Mexico. In order to be eligible for enrollment in CLNM on January 1, 2016, an eligible recipient must be enrolled in Medicaid managed care or Medicaid fee-for-service (FFS), have one or more SMI or SED, and reside in a county approved by the CMS through a State Plan Amendment (SPA). Managed Care Organizations (MCOs) are in the process of identifying members who are eligible for enrollment. In FFS Medicaid, the State is currently developing a system to identify who is eligible. Outreach to identified eligible recipients must be HIPAA compliant. Further direction will be available in the Provider Manual once it is finalized.

Q: What documentation is needed for eligible recipients who are automatically enrolled in CareLink NM to opt-out of the program?
A: The State is still in the process of developing the opt-out system. Eligible recipients currently receiving services from a provider/agency that is awarded a Health Home designation will be required to opt-out of the program. The CLNM agency will be responsible for orienting eligible recipients to the program and explaining the opt-out process. The New Mexico Human Services Department (HSD) will continue to work with provider agencies on language for the opt-out form and the process.

Q: Is there an expected minimal threshold of CareLink NM enrollees?
A: HSD conducted a preliminary estimate of potential CLNM eligible recipients using current claims and utilization data. There are approximately 300 to 500 managed care members who have been identified as eligible for enrollment in the CLNM program in each of the initial counties. This estimate was used to calculate the CLNM reimbursement rate and only apply to the two counties identified for Phase 1 of the program. As the program evolves, new thresholds may be established based on utilization trends and census information.

Q: Regarding pre-readiness requirements in the application, what is expected of providers on January 1, 2016?
A: HSD will provide technical assistance on a case by case basis for all applicants who have questions about the application process or requirements. Each applicant will have an opportunity to work with HSD to address any questions or concerns regarding the application or readiness review. HSD will provide guidance with completing the application and can address each section of the application as required. Applicants are encouraged to reach out for technical assistance while putting together the application.

Q: If an individual is "self-referred", is it the same process as the initial transition of CareLink NM members (i.e. members are identified from those receiving services, MCOs conduct the HRAs and CNAs set up the care plans)?
A: If eligible recipients are self-referring as MCO members then they will be required to go through the MCO onboarding process, including completing the health risk assessment (HRA) prior to transitioning into CLNM. This is a standard process for each eligible recipient joining CLNM from the MCOs. Self-referred eligible recipients, who are currently receiving services through an FFS arrangement, will need
to contact the CLNM provider to join the CLNM program. Each self-referred eligible recipient joining a
CLNM provider will be required to complete the comprehensive need assessment (CNA) as part of the
onboarding process with the CLNM provider. The State does not expect very many self-referred FFS
eligible recipients during the early phases of the CLNM program.

**Q: When will the steering committee conduct the post-readiness review? Will this be within the first 6
months or 9 months?**

**A:** The steering committee will review applications and provide feedback to applicants leading up to the
onsite readiness review. Following the onsite readiness review, each CLNM provider agency will be
issued recommendations and may receive requests for individualized action plans and other post-readiness
review activities to be completed over specific periods of time. Critical components of the
program, such as transitional care, assessments, care plans and services will be prioritized. Please note
this will be a unique process for each respective applicant based on the findings of the readiness review.
After a CLNM designation has been awarded, the State will maintain an open dialogue with each
provider agency to ensure an open and transparent process.

**Q: In terms of staffing, what are the current ratios?**

**A:** The State developed the PMPM using the following ratios:

- Level 2 Care Coordination 1:100
- Level 1 Care Coordination 1:50
- Supervisor to Care Coordinator 1:10

Please note that these ratios are considered the **maximum** allowable ratios. Each CLNM provider should
have a process for analyzing individual caseloads factoring in at a minimum: Member need, travel time,
assessed risk, care coordinator work balance etc. CLNM providers should be prepared during readiness
to describe the approach to managing and ensuring appropriate caseloads.