

## **4 CARE COORDINATION**

Revision Dates: August 15, 2014; February 23, 2015; March 3, 2015

Effective Date: January 1, 2014

### **OVERVIEW**

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. Any issues of concern will be addressed immediately. The strategies will be analyzed for effectiveness and appropriate changes made.

### **Care Coordination Functions**

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

1. Conducting CNAs semi-annually or annually;
2. Semi-annual or quarterly in-person visits with the member;
3. Quarterly or monthly telephone contact with the member; and
4. Comprehensive Care Plan (CCP) development and updates.

Other care coordination activities that will enhance the Care Coordination program may be sub-contracted to “extenders,” such as community health workers; furthermore, MCOs may delegate one or more of the four primary care coordination functions above in the following instances or:

1. MCOs that own and operate patient-centered medical homes (PCMHs) as part of their provider network may delegate to such PCMHs as early as January 1, 2014, provided the PCMH care coordinator is employed by the MCO.
2. MCOs may delegate all primary Care Coordination functions to a designated Section 2703 Health Home after April 1, 2016, provided the health home is determined ready by the Health Home Steering Committee to perform such functions.
3. MCOs may submit proposals to HSD for other potential delegation functions of care coordination.

The MCO, through its care coordination monitoring, will ensure, at a minimum:

1. 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 e.g. inter-rater reliability) to determine effectiveness and appropriateness of processes.
2. Staff competencies will be evaluated in these areas, but not limited to:
  - a. level of care assessments and reassessments occur on schedule in compliance with the contract and are submitted to the lead or supervising care coordinator;
  - b. comprehensive needs assessments and reassessments, as applicable, occur on schedule in compliance with the contract;

- c. care plans are developed and updated on schedule in compliance with the contract;
  - d. care plans reflect needs identified in the comprehensive needs assessment and reassessment process;
  - e. care plans are appropriate and adequate to address the Member's needs including the need for all Community Benefit services;
  - f. services are delivered as described in the care plan and authorized by the MCO;
  - g. services are appropriate to address the Member's needs (as defined in the MCO's policies and procedures);
  - h. services are delivered in a timely manner;
  - i. service utilization is appropriate;
  - j. service gaps are identified and addressed in a timely manner (as defined in the policies and procedures);
  - k. minimum care coordinator contacts are conducted;
  - l. care coordinator-to-Member ratios are appropriate; and
  - m. 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.
3. The MCO, or its HSD approved designee with, 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 contract and the MCO's policies and procedures. The functionality will include but not limited to the ability to:
- a. Capture and track key dates and timeframes, including, but not limited to, as applicable, enrollment, 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 level of care and needs reassessment, date of each update to the care plan, and dates regarding transition from an institutional facility to the community;
  - b. Capture care coordination level assignments and track compliance with minimum care coordination contacts as specified in this contract;
  - c. Notify the care coordinator about key dates, e.g., eligibility end date, date for annual level of care reassessment, date of comprehensive needs reassessment, and date to update the care plan;
  - d. Capture and track eligibility/enrollment information, level of care assessments and reassessments, and needs assessments and reassessments;
  - e. Capture and monitor the care plan;
  - f. Track requested and approved service authorizations, including Covered Services and Value Added Services, as applicable;
  - g. Document all referrals received by the care coordinator on behalf of the Member for Covered Services and Value Added Services, as applicable, needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the care coordinator, including any additional follow up;
  - h. 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;
  - i. Track service delivery against authorized services and providers;
  - j. Track actions taken by the care coordinator to immediately address service gaps;

- k. Document case notes relevant to the provision of care coordination; and
- l. Allow HSD or its designee to have remote access to case files.

### **HEALTH RISK ASSESSMENT (HRA)**

The purpose of an initial Health Risk Assessment (HRA) is to identify the Member's abilities, needs, preferences and supports and to determine the care coordination level. The MCO will conduct an HRA per HSD guidelines and processes, together with the MCO's policies and procedures, for the purpose of (i) introducing the MCO to the Member, (ii) obtaining basic health and demographic information about the Member, (iii) assisting the MCO in determining the level of care coordination needed by the Member, and (iv) determining the need for a detailed comprehensive needs assessment. During Steady State, the HRA shall be completed within (30) calendar days of the Member's enrollment with the MCO.

Members in care coordination Level 1 receive an annual HRA; after an initial HRA, those in Levels 2 and 3 will not have an annual HRA since they will have a comprehensive needs assessment. Those members residing in a nursing facility do not require an HRA; when the resident is ready to transition back into the community, the MDS and CNA will be used to determine the care coordination level.

The MCO will make reasonable efforts to contact Members to conduct an HRA. Reasonable efforts means documentation of at least three (3) separate attempts to contact the Member which includes at least one (1) attempt to contact the Member at the number most recently reported by the Member (if a phone number is available), and (1) attempt to contact the Member using the Member's last reported residential address. The (3) 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 (3) attempts must be included in the Member file. All attempts shall occur on three (3) different Calendar Days, at different hours of the day, including evening and after business hours.

### **COMPREHENSIVE NEEDS ASSESSMENT (CNA)**

A CNA is conducted for Medicaid members eligible for managed care who are identified through the HRA as needing a higher level of care coordination. The HRA identifies significant conditions and risk indicators signifying the potential for Level 2 or Level 3 Care Coordination. The CNA determines the member's physical health, behavioral health, and long-term care needs, utilizing information from the assessment process to establish a care plan that addresses the needs that have been assessed.

The comprehensive needs assessment is the sole responsibility of the MCO care —coordinator unless delegated to a HSD approved designee.

During Steady State, the MCO or HSD approved designee shall:

1. Accept the Member's nursing facility level of care determination, previously completed by HSD or its designee, until redetermination of the Member's Medicaid eligibility or scheduled level of care assessment, whichever date is earlier.
2. Continue providing services previously authorized by HSD or its designee in the Member's approved Home and Community-Based care plan or Behavioral Health

Treatment or service plan, without regard to whether such services are being provided by Contract or Non-Contract providers and shall not reduce these services until the MCO conducts a comprehensive needs assessment and develops a care plan in accordance with the Contract, Section 4.4.9.

3. Schedule a ~~CNA comprehensive needs assessment~~ within fourteen (14) Calendar Days of the Member receiving a care coordination level 2 or 3 assignment via the HRA; and Complete the comprehensive needs assessment within thirty (30) calendar days of the Health Risk Assessment (HRA), reminding members at least two weeks prior to the date scheduled for the assessment, through the most effective means of communication, about their scheduled date.
4. Should the MCO become aware of any significant change in a Member's medical condition, signifying increased needs, prior to the scheduled time for the comprehensive needs assessment, conducting the assessment must be expedited and an update of the Member's care plan executed, initiating any needed changes in services within ten (10) calendar days of becoming aware of the change in the Member's condition and needs.

~~Comprehensive needs assessments (CNAs)~~ must be performed by the MCO, or HSD approved designee, through the utilization of an assessment tool that has been previously approved by HSD, assessing the Member's medical/physical health, behavioral health, long term care 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 thirty (30) calendar days prior to use by the MCO or HSD approved designee. The comprehensive needs assessment must be conducted by a ~~staff~~ professional care coordinator, employed by the MCO or HSD approved designee. While additional partnership with community health workers, community health representatives, community behavioral health representatives and other advocates; is encouraged, the comprehensive needs assessment is the sole responsibility of the MCO care coordinator- or HSD approved designee.

The CNA must be conducted in the member's primary place of residence or in the nursing home for those residents reintegrating back into the community. In scheduling the comprehensive needs assessment, the MCO or its HSD approved designee is advised to involve collateral respondents for the assessment interview, including family members, caregivers, community health representative/worker, and/or other significant social support individuals, with the consent of the Member. Additional arrangements must also be discussed with the Member when scheduling the assessment to evaluate, in advance, any need for language translation, including signing or communications board use, for the comprehensive needs assessment interview process.

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 comprehensive needs assessment may be conducted without requesting an exception from the State under the following conditions:

1. 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 mental health agency, food bank site, etc.
2. If the member is currently part of the jail involved population preparing for release.

Other requests for exceptions to CNA requirements for assessments that cannot be completed face to face or in the member's home setting must be made directly to HSD by the MCO using the following process:

1. Complete the Centennial Care CNA Exception Request form (MAD 601).
2. Alternate locations submitted by the MCO to HSD for review, should be assessed for privacy to ensure that the Member's Protected Health Information (PHI) is not jeopardized.
3. Send the completed MAD 601 by secure E-mail to: **HSD-QB-CCU-CNA@state.nm.us**
4. HSD will review the request and respond to the specific MCO requestor within 2 business days.
5. If an exception is approved, it shall only be valid for the duration of 6 months, or until the next CNA is needed, whichever comes first.
6. 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**
  - Via any format other than the MAD 601 Form

Requests will be reviewed on an individual case by case basis. Alternate locations submitted by the MCO to HSD for review, should be assessed for privacy to ensure that the Member's Protected Health Information (PHI) is not jeopardized.

~~CNAs are performed 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, which can include personal single home dwelling, family member's residence where Member may be living, assisted living facility, temporary shelter, and so forth, where there is an identifiable address. If the Member is homeless, the comprehensive needs assessment may be conducted at a location, mutually agreeable to the Member, such as a church meal site program, community non-profit organization center, community mental health agency, food bank site, etc. Exceptions to requirement for assessments being completed in the home must be made directly to the MCO contract manager at HSD and will be reviewed on an individual case by case basis. Alternate locations submitted by the MCO to HSD for review, should be assessed for privacy to ensure that the Member's Protected Health Information (PHI) is not jeopardized.~~

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

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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, determines any structural problems for Member's mobility, access, need for safety enhancements, such as smoke detectors, fire extinguishers, ramps, guard rails, bathroom equipment, fall prevention concerns-throw rugs, doorway access for wheel chairs, 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 considerations assess 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 ~~CNA further observes~~ the existence of other parties living/dwelling in the home and possibly presenting support or risk to the Member.

~~When~~If a member establishes a new residence following completion of the CNA due to transition from a facility, temporary housing location or completion of a program or treatment, the Care Coordinator shall consider this a trigger event to determine if the Member may need to be re-assessed through a CNA in the new setting. If an in home assessment may be in the member's best interest, the Care Coordinator shall conduct a new assessment based on this triggering event. If the Care Coordinator determines a new CNA is not necessary based on this triggering event, the member record shall reflect the reason for determining that an additional CNA was not necessary~~no necessity for the member at this time.~~

When a Member refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the needs assessment with the Member, emphasizing that this assessment makes the determination of useful resources to meet the Member's needs, such as the community benefit for personal care assistance, special home environment modifications and adaptive equipment.—In documented refusal circumstances, the MCO will submit a proposal for a basic care plan with minimum services outlined and suspending any requests for increased services/personal care hours until an assessment is conducted and completed.

At a minimum, the CNA shall:

1. Assess physical and behavioral health needs, including but not limited to, current diagnoses; history of significant physical and behavioral health events, including hospitalizations and emergency room visits; medications; allergies; providers involved in Member's care; Durable Medical Equipment (DME); brief substance abuse screening questionnaire -cut-annoyed-guilty-eye (CAGE) and history; family medical and behavioral health, (mental health 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 Activities of Daily Living/Activities of Daily Living (ADLs) (mobility, grooming, bathing, eating, medications concerns (i.e. self-administration and safety) and Instrumental ADL~~setivities-of-Daily-Living~~/IADLs (i.e. money management, meal preparation, housekeeping/cleaning, emergency awareness and

- preparedness, grocery shopping).
2. Assess additional long-term care needs including, but not limited to, environmental safety including items such as smoke detectors, pests/infestation, emergency awareness and plans, trip and fall dangers, mobilization access issues such as doorway widening, ramps and other environmental improvement needs.
  3. Include a risk assessment, using a tool and protocol approved by HSD and develop, as applicable, a risk agreement that shall be signed by the Member or his/her representative and 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.
  4. Assess disease management needs, including identification of disease state, need for targeted intervention and education, and development of appropriate intervention strategies.
  5. 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); IADLs; Individualized Education Plan (IEP); and Individual Service Plan (ISP) for Developmental Disabilities or Medically Fragile Waiver Program recipients, (if applicable).
  6. 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.
  7. Identify cultural information, including language and translation needs and utilization of ceremonial or natural healing techniques.
  8. Ask the Member for a self-assessment regarding their viewpoint of their condition(s) and service needs.
  9. In the event the Member is a minor under the age of eighteen (18), identify the parent or legal guardian participating and/or responding for the minor during assessment.

### **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 level of care coordination may be needed. Additional comprehensive needs assessments may also be conducted, as the care coordinator deems necessary, due to requests from 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 to be performed [may](#) include, significant changes in Member's medical and/or behavioral health condition; changes in setting of care, such as hospitalization, rehabilitation and/or short-term nursing home admission (long-term nursing home 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 and/or other NM Children, Youth & Family (CYFD) interventions; 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.

### **STAFFING REQUIREMENTS AND DELEGATION**

The MCO may utilize a care coordination team approach to performing care coordination activities, with the MCO's care coordination team consisting of the Member's primary care coordinator and specific other individuals with relevant expertise and experience appropriate to address the needs of Members. While the MCO may subcontract the Health Risk Assessment (HRA) activities, the CNAs must be performed by professional ~~staff~~ care coordinators employed by the MCO other than when delegated as allowable. The MCO may use local resources, such as Indian Health Service, Tribes and Tribal Organizations and Urban Indian Organizations (I/T/Us); Patient-Centered Medical Homes (PCMH), ~~UNM Medically Fragile Case Management Program (MFCMP) and~~ Health Homes; Core Service Agencies (CSAs) for Behavioral Health; Tribal services; and other local service organizations, to collaborate in care coordination functions. The role of community health workers (community health advisors, community health representatives, lay health advocates, promotoras, outreach educators, peer health promoters and peer health educators), is to supplement and support the care coordination function required in managed care. The performance of the CNA is the primary responsibility of the MCO other than when delegated as allowable by the State.<sup>4</sup>

The MCO will implement policies and procedures that will define and specify the qualifications, experience and training of each member of the care coordination team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator.

Maximum caseload per care coordinator, by designated care coordination level as established by HSD, shall not be exceeded by the MCO. To the extent that I/T/Us, PCMHs, Health Homes, CSAs and Community Health Workers are utilized to perform care coordination functions, these local entities may be utilized in the caseload ratios. Caseload to care coordinator ratios are as follows:

- Level 1 care coordination: 1:1750;
- Level 2 care coordination: 1:75;
- Level 2 members residing in Nursing Facility: 1:125;
- Level 2 Self Directed Community Benefit 21 years of age and older: 1:100;
- Level 3 care coordination: 1:50;
- Level 3 members residing in Nursing Facility: 1:125;
- Level 3 Self Directed Community Benefit members 21 years of age and older: 1:75; and
- Care coordination for Members under 21 years of age who participate in the Self-Directed Community Benefit: 1:40

Costs associated with community health workers can include salaried employees, independent community health workers and/or contracted groups of community health workers, shall be considered as part of the care coordination expense (characterized as an administrative cost for the MCO).

Costs associated with Care Coordination functions, including community health workers will be categorized as care coordination expenditures. Care coordination expenditures are deemed medical expenditures for use in the medical loss ratio calculation. Encounter data is not required to be reported for community health workers and no codes will be developed.

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

1. The number of care coordinators, care coordination supervisors, other care coordination team members that the MCO plans to employ;
2. The ratio of care coordinators to Members;
3. The MCO's plans to maintain ratios as outlined by care coordination level and the explanation of the methodology used for determining such ratios;
4. How the MCO will ensure that such ratios are sufficient to fulfill the contract agreement requirements;
5. The roles and responsibilities for each member of the care coordination team;
6. A strategy that encourages the use of Native American care coordinators and limits duplication of services between I/T/U and non-I/T/U providers;
7. 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
8. How the MCO will use care coordinators to meet the needs of New Mexico's unique population.

The MCO or HSD approved designee, shall ensure that Members have a telephone number for direct contact with their care coordinator and/or a member of their care coordination team, (without being routed around through several contact points), during normal business hours (8 a.m. - 5 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 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 contract.

When Native American Members request assignment to a Native American care coordinator and the MCO or HSD approved designee, is unable to provide a Native American care coordinator to such Members when requested, the MCO or HSD approved designee must ensure that a Community Health Worker/Community Health Representative is present for all in-person meetings between the assigned care coordinator and the Member.

The MCO or HSD approved designee must accommodate 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 HSD approved designee's need to efficiently deliver care coordination in accordance with the requirements in the contract. In ensuring quality and continuity of care, however, the MCO or HSD approved designee shall make efforts to minimize the number of changes in a Member's care coordinator. Section 4.4.12.13

of the contract, outlines circumstances that the MCO or HSD approved designee may need to initiate change in a Member's assigned care coordinator:

1. Assigned care coordinator is no longer employed by the MCO or by the HSD approved designee;
2. There is a conflict of interest preventing neutral support for the Member;
3. Care Coordinator is on temporary leave from employment; or
4. Caseload of the assigned care coordinator must be adjusted due to its size or intensity.

The MCO or HSD approved designee shall develop policies and procedures regarding notice to Members of care coordinator changes initiated by either the MCO or HSD approved designee or Member, including notice of planned care coordinator changes initiated by the MCO or HSD approved designee.

The MCO or HSD approved designee shall ensure continuity of care when care coordinator changes are made. The MCO or HSD approved designee 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 HSD approved designee 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.

### **COMPREHENSIVE CARE PLAN REQUIREMENTS**

This policy is in conjunction with all elements described in Care Plan Requirements outlined in the managed care contract, which defines the processes for development, implementation and management of a care plan for all members in Levels 2 and 3 of care coordination. Members in Level 1 care coordination will not need to have a care plan. The MCO or HSD approved designee is responsible for ensuring a care plan is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the care plan.

1. Comprehensive Care Plan Scope and Process. The MCO or HSD approved designee must establish a process to ensure coordination of care for members that includes:
  - A. Coordination of the members health care needs through the development of the care plan;
  - B. Collaboration with the member, member's friends, family, members PCP, specialists, Behavioral Health 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;

- C. With the members 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 members physical health care issues when working with the member); and
  - D. Verification of all decisions made regarding the member's needs and services, and ensures all information is documented in a written, comprehensive care plan.
2. Comprehensive Care Plan Development and Management
- A. The Care Plan serves as a working and guiding tool of reference for integrating the member's treatment plan(s) into a language that the member and or/family member can understand. The member shall lead the person-centered planning process where possible; the member's representative should have a participatory role, as needed, and as defined by the member, unless State law confers decision-making authority to the legal representative. The MCO or HSD approved designee shall develop and authorize the CCP within fourteen (14) Business Day of completion of the comprehensive needs assessment.
  - B. The Care Coordinator shall:
    - a. Ensure the member or member's legal representative understands, reviews, signs and dates the care plan.
    - b. Provide a copy of the members completed care plan to the member, members 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).
    - c. Confirm that family, providers, or any other relevant parties are included in the treatment and planning of the members care plan.
    - d. Ensure timelines for the development and implementation and/or update the care plan are met-needed.
    - e. Facilitate treatment and coordinate with providers to assist the member and his or her family with navigating the system including scheduling appointments, arranging transportation, or advocating for the member as needed.
    - f. Verify that services have been initiated and/or continue to be provided as identified in the care plan and ensure services continue to meet the member's needs.
    - g. Maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the member's care.
    - h. 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.
    - i. Identify and list specific risk factors and changes to member's risk, address

those changes and update the member's risk agreement and Comprehensive Care Plan as necessary to include measures to minimize the identified risks.

- j. Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.
- k. Educate members with identified disease management needs by providing specific disease management interventions and strategies.
- l. 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.
- m. Educate member about non Medicaid services available as appropriate (e.g. Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant Mental Health).
- n. Reflect cultural considerations of the member and conduct the care plan process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

C. The Comprehensive Care Plan Required Elements include the following:

- a. Pertinent member demographics and enrollment data.
- b. 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.
- c. Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.
- d. Members' current status, including present levels of function in physical, cognitive, social, and educational domains.
- e. Member or family barriers to receiving treatment, such as a member or family member's ability to travel to an appointment.
- f. Identify the member or family's strengths, resources, priorities and concerns related to achieving mutual recommendations made in caring for the member receiving services.
- g. Services recommended achieving the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member's desired outcomes.
- h. Identified 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.
- i. An interdisciplinary team including but not limited to: the care coordinator, social worker, registered nurse, medical director, and PCP must be identified to develop, implement and update the care plan as needed.
- j. Reflect that 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.

- k. Reflect the member's strengths and preferences.
- l. Identify goals and desired outcomes, reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals, and include who will provide the services and supports.
- m. Identify goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
- n. Include those services, the purpose or control of which the member elects to self-direct.
- o. Prevent the provision of unnecessary or inappropriate services and supports.

#### D. Comprehensive Care Plan Revisions

- a. The care plan will be revised when the member experiences one of the following circumstances:
  - 1. Risk of significant harm. In this case the care coordination team will convene within one calendar day, in person or by teleconference; if necessary the care plan will be modified accordingly within 72 hours;
  - 2. Major medical change;
  - 3. The loss of a primary caregiver or other significant person;
  - 4. A serious accident, illness, injury or hospitalization that disrupts the implementation of the care plan;
  - 5. Serious or sudden change in behavior;
  - 6. Change in living situation;
  - 7. Proposed change in services or providers (e.g. Community Benefit);
  - 8. It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect or exploitation;
  - 9. Any team member requests a meeting to propose changes to the care plan;
  - 10. Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or
  - 11. ~~As r~~Requested by HSD.
- b. Within five (5) Business Days of completing a reassessment of a Member's needs, the care coordination team shall update the Member's CCP as appropriate, and the MCO or HSD approved designee shall authorize and initiate services in the updated CCP.

#### E. Ongoing Care Coordination Description

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

- b. Ongoing care coordination functions shall include all elements defined in the contract including the following:
1. Proactively identify gaps and address the needs of the member, including develop and/or update the care plan as needed.
  2. Ensure when a member's level of care coordination increases or decreases that continuity of care is always maintained.
  3. Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.
  4. Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member's goals and foster independence.
  5. 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.
  6. Education regarding service delivery through Medicare and/or Medicaid.
  7. Measure and evaluate outcomes designated in care plan and monitor progress to ensure covered services are being received and assist in resolution of identified problems.
  8. Proactively work to continue to achieve coordination of physical, behavioral health and long term care services.
  9. Maintain consistent communication and contact with member's PCP, specialists, and other individuals involved in the member's care.
  10. Maintain and monitor the member's Community Benefit and provide assistance with complex services.
  11. Consistently consider member and provider input to identify opportunities for improvement.
  12. Collaborate and/or cooperate with representatives of the Independent Consumer Support System (ICSS).

### **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 compliant with recommended behavioral health 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.

HSD in collaboration with the State Medicaid Physician has developed the following policy/procedure to ensure consistent responses to challenges presented by the HHR/HRU population. This protocol is to be utilized across MCOs, agency providers and State employees and programs for each recipient identified as part of this 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 that 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. This team must include the care coordinator, a management level staff of the MCO and a high level medical staff 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:

1. Establish/discuss optimal outcome for health and safety.
2. Identify the issues interfering with optimal health and safety outcomes.
3. Clarify roles for each member of the team.
4. Clarify rules of engagement (who can call who when, etc.) and program regulations.
5. Assign tasks to each team member with timeline.
6. Sign agreement that documents the discussion and assignment of tasks and holds each member accountable.
7. 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.)
8. Schedule updates between participants, MCO staff on a regular basis.
9. Ensure mMaintenance of documentation is with MCO, participant and natural supports.

When recipients of this population 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, then the MCOs will utilize their complex case team and complex case rounds protocol.

## MCO COORDINATION WITH 1915 (c) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS: DEVELOPMENTAL DISABILITIES, MEDICALLY FRAGILE, & MI VIA

The MCOs provide acute and ancillary medical and behavioral health services to the 1915 (c) HCBS recipients/MCO members. The MCO is responsible for ensuring a Comprehensive Care Plan is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO Comprehensive Care Plan.

### Overview of Medicaid 1915 (c) HCBS Waiver Programs

#### A. Developmental Disabilities Waiver Program

The Developmental Disabilities Medicaid Waiver (DDW) provides an array of home and community based services to help individuals with developmental disabilities live successfully in their community, become more independent, and reach their personal goals. New Mexico has used waiver funding to support people with developmental disabilities for over 26 years. The DDW serves individuals who meet an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Level of Care (LOC). DDW individuals have a COE 096.

The DDW provides the following long term care services: behavioral support consultation, case management, community integrated employment services, customized community supports, customized in-home supports, 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 therapies. DDW services are supplementary to early periodic screening, diagnostic, and treatment (EPSDT) benefits for recipients under the age of 21.

DDW services and budget are outlined in the recipient's Individual Support Plan (ISP). The ISPs are 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.

#### B. Medically Fragile Waiver Program

The Medically Fragile Waiver (MFW) serves individuals who have been diagnosed with a medically fragile condition which results in a prolonged dependency on skilled nursing. MFW individuals have a COE 095.

MFW provides the following-long term care services: behavior support consultation, case management, home health aide, respite care, nutritional counseling, skilled therapies for

adults, private duty nursing, and specialized medical equipment. MFW services are supplementary to early periodic screening, diagnostic, and treatment (EPSDT) benefits for recipients under the age of 21.

The UNM Health Sciences Center, Center for Development and Disability (UNM-CDD) has a medically fragile case management program which currently provides RN/case management services to both waiver and non-waiver (EPSDT) medically fragile persons state wide. UNM-CDD~~This~~ is the only provider for these specialized case management services for this population. UNM-CDD case managers create the MFW recipient~~d~~ individual support plans (ISP) which include services and budget amounts.

The MCOs are contracted with UNM-CDD to continue to provide RN/case management services for those individuals (~~both waiver and~~ non-waiver) who meet the medically fragile criteria.

### C. 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 Category of Eligibility (COE) of either COE 095 Medically Fragile or COE 096 Developmentally Disabled and a Setting of Care (SOC) of "MIV". The goal of Mi Via is to provide long-term 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 program that is operated separately from the Centennial Care Self-Directed Community Benefit 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, specialized therapies, and non-medical transportation. Mi Via services are supplementary to early and periodic screening, diagnostic, and treatment (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.

The MCO Comprehensive Care Plan & the 1915(c) HCBS Waiver Service Plan (ISP or the SSP)

A. Developmental Disabilities Waiver Program

The MCO Care Coordinator shall:

- a. Request a copy of the DDW LOC abstract (MAD 378 form) and client individual assessment (CIA) from the Medicaid Third Party Assessor (TPA) for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs. A Client Information Update (CIU) form is faxed to the TPA to request the LOC abstract and CIA. The Care Coordinator has no influence in regards to the DDW services and budget. The Care Coordinator cannot make recommendations or changes to the DDW ISP and Budget.
- b. Utilize the DDW LOC and CIA information from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the recipient/member.

B. Medically Fragile Waiver Program

The MCO Care Coordinator shall:

- a. Request a copy of the MFW LOC packet and/or ISP from the MF Case Management Program 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.
- b. Ensure that ~~t~~The MFW ISP ~~will~~ serves as the Comprehensive Care Plan for the MF member ~~population~~.
- c. Work with the MF Case Management Program to coordinate MFW LOC assessments and/or CNA visits at the same time in order to reduce the burden on these families.
- d. Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The MF Case Management Program will conduct monthly visits and provide the MCO with copies of the visit notes.
- e. Conduct the required annual in person visit and CNA for MF members.

C. Mi Via Self-Directed Waiver Program

The MCO Care Coordinator shall:

- a. Request a copy of the Mi Via LOC abstract (MAD 378 form) and client individual assessment (CIA) from the TPA for the purpose of obtaining a complete, comprehensive picture of the participant and their needs. A Client Information Update (CIU) form is faxed to the 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.

- b. Utilize the LOC and CIA information from the Medicaid TPA to complete certain portions of CNA prior to initiating a visit with the participant/member.
- c. Have knowledge that while the MCO is responsible for the annual CNA visits and 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.

### **TRANSITIONS OF CARE FROM THE BRAIN INJURY SERVICES FUND TO CENTENNIAL CARE MCO-MCOs**

The 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 (ABI). The MCO shall implement policies and procedures for ensuring that members with Brain Injury transition from the Brain Injury Services Fund (BISF) into benefits and services ~~care~~ that ~~is~~are fully covered under the MCO. At a minimum, the following must be addressed:

1. 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:

  - a. The HRA shall include probing questions about specific health diagnoses, including brain injury.
  - b. 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 present. During any HRA, information shall be requested by the reviewer about the member's specific needs and whether they are receiving services through the Brain Injury Service Fund or its currently contracted providers.
  - c. An HRA containing information about a self-reported Brain Injury shall trigger the scheduling of a CNA ~~N.A.~~ 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.
  - d. All parties are to ensure that a Release of Information has been signed by the member to effect the participation of the BISF Service Coordinator and/or other identified advocates in the member's transition.
  - e. In the event that 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.

- f. 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 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 related to the brain injury diagnosis can be readily implemented.
  - g. 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.

~~Through collaborative efforts with the BISF Service Coordinator, the MCO Care Coordinator is to develop and authorize the member's Care Plan along with the member or member's representative within fourteen (14) days of completion of the C.N.A. Collaboration may also include the member's family, friends, PCP, medical specialists, Behavioral Health providers, advocates, and interdisciplinary team experts.~~
  - h. The MCO Care Coordinator shall assume the responsibility of assisting the member in setting up the services identified on the member's Comprehensive Care Plan. The MCO Care Coordinator may consult with the BISF Service Coordinator regarding available service and community support providers. In the event that a member with brain injury is not receiving services through the BISF, the MCO may rely upon referrals through the NM Brain Injury Resource Center at the UNM School of Medicine's Center for Development and Disability.

~~All other standard requirements and protocols regarding transitions and implementation of services will apply.~~
2. Assume full responsibility for the member's transition plan, addressing the member's physical and behavioral health needs; the selection of providers in the community; housing needs; financial needs; interpersonal skills; and safety. The member's Care Plan shall include, but not be limited to, the needs identified in the member's C.N.A. Any additional recommendations made by the BISF Service Coordinator shall be noted in the member's file.
3. Maintain continuity of care and implement the Care Plan services and supports that are needed to support the independent functioning of the member in their home and community. The following criteria for inactivation from the BISF shall apply for the full transition of a BISF participant into Centennial Care:
- a. The BISF participant assessed at Level 1 shall be inactivated from the BISF program at the end of the calendar month in which the MCO Care Coordination contact information was supplied, unless the BISF Service Coordinator supports that the determination was made in error. In this eventuality, BISF services may be continued to assist with the Fair Hearing process, as described in the MCO's denial letter.

- b. A BISF Program Participant assessed at Level 2 or 3 shall not be inactivated from the BISF Program until the MCO Care Plan has been authorized by the MCO and the most critical services for addressing ADLs and behavioral health needs have been implemented (e.g., homemaker; home health aide, PT/OT/SLP, outpatient behavioral/mental health, etc.). All BISF services shall end upon the date of Comprehensive ~~MCO~~-Care Plan authorization, unless critical services appearing on the MCO Care Plan have not yet been implemented. With respect to the denial of essential services deemed by the BISF Service Coordinator to be in error, BISF services may be continued to assist with the Fair Hearing process, as described in the MCO's denial letter. The BISF Service Coordinator, BISF Life Skills Independence Coach, or other advocate may assist the MCO member with the Fair Hearing process ~~at any phase up until the MCO Care Plan has been authorized to include the essential services.~~
  - c. Communication between the MCO Care Coordinator and BISF Service Coordinator shall continue during any Fair hearing process to facilitate transition efforts and the best outcome for the member.
  - d. Inactivation of the BISF participant shall not be delayed for any members who wish to self-direct their care, while agency-based managed care is ongoing. The MCO shall have the primary responsibility in assisting members who identify that they wish to self-direct their care. ~~For the period that the member continues to receive services through the BISF under the conditions noted in Section 3.b.,~~ The MCO Care Coordinator and BISF Service Coordinator may work together in anticipation of a Self-Directed Community Benefit budget and SSP to meet the member's anticipated needs.
4. Receive training by the HSD on issues ~~r its assigns~~ including but not limited to general Brain Injury issues; communication strategies; how to conduct assessments that capture the needs of brain injury; how to develop a Care Plan that considers the needs of members with brain injury; and State and community resources that are available, including but not limited to the NM Brain Injury Resource Center. Training shall be required for any new Care Coordination staff within 3 months of employment, with renewed training to occur on a two year schedule.