

4 CARE COORDINATION

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

1. Conducting CNAs initially, semi-annually or annually;
- ~~1-2.~~ Administrating the Centennial Care Community Benefit Service Questionnaire (CBSQ) as applicable (see CBSQ Section);
- ~~2-3.~~ Semi-annual or quarterly in-person visits with the member;
- ~~3-4.~~ Quarterly or monthly telephone contact with the member; and
- ~~4-5.~~ 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:

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;
 - h. services are delivered;
 - i. service utilization is appropriate;
 - j. service gaps are identified and addressed;
 - 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, 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 MCO shall conduct the Human Services Department (HSD) standardized Health Risk Assessment (HRA) on all members who are newly enrolled in Centennial Care for the purpose of (i) introducing the MCO to the Member, (ii) obtaining basic health and demographic information about the Member, and (iii) confirming the need for a Comprehensive Needs Assessment(CNA).

The standardized HRA will be completed for each new Centennial Care Member within thirty (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 currently identified for Care Coordination Level 2 or Level 3 services.. The HRA may be conducted by telephone, in-person, or as otherwise approved by HSD; HRA information must be obtained from the Member or representative 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 will make reasonable efforts to contact Members to conduct an HRA and provide information about care coordination. Such efforts shall include, but shall not be limited to, engaging community supports such as Community Health Workers, CSAs and Centers for Independent Living. The MCO shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member using the Member's last reported residential address. The three (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 shall be included in the Member's file. Such attempts shall occur on not less than three (3) different Calendar Days, at different hours of the day, including day and evening hours and after business hours.

The HSD standardized HRA includes the following information:

A. 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.

B. Member Health Information

- Language preference, translation needs, and special preferences (cultural, religious, physical);
- Main health concern;
- Current or past physical and Behavioral Health conditions or diagnoses, including brain injury;
- Pending physical or Behavioral Health 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 level of care assessment or client individual assessment;
- Number of Medications;
- Living situation;
- Assistance with two (2) or more activities of daily living and type of need;
- Interest in and need for Long-Term Care services;
- Advance directives preference and interest in receiving information; and
- Interest in receiving care coordination.

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

Within seven (7) 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 to be included and the reason(s) for inclusion for State approval. Requests must be sent for approval to the Human

Services Department, Medical Assistance Division through the MCO's Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

For the purpose of the MCO completion of the HSD standardized HRA the following definitions apply:

Frequent emergency room use is defined as two (2) or more emergency room visits in a six (6) month period.

Poly-pharmaceutical use is defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class.

COMPREHENSIVE NEEDS ASSESSMENT (CNA)

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 Level 2 or Level 3 Care Coordination. The MCO shall schedule a CNA within fourteen (14) Calendar Days of completion of the HRA and complete the CNA within thirty (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 comprehensive needs assessment shall be monitored by the care coordination unit quarterly through predictive modeling software and available utilization and claims data to identify a Member's current and emergency needs related to a potential need for increased care coordination.

For members who reside in a nursing facility, rather than conduct a CNA, the MCO shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving Home and Community Based Services (HCBS).

The CNA will assess the Member's physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs and may also include a functional assessment, if applicable.

The CNA is the sole responsibility of the MCO care coordinator unless delegated to a HSD approved designee.

CNAs must be performed through the utilization of an assessment tool that has been approved by HSD for 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 primary 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:
 - a. Via unsecure email
 - b. To an email address other than HSD-QB-CCU-CNA@state.nm.us
 - c. 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 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, 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 the existence of other parties living in the home and possibly presenting support or risk to the Member.

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.

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, as approved by HSD/BHSD 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 (ADL) (mobility, grooming, bathing, eating, dressing, medications (i.e. self-administration and safety) and Instrumental ADLs/IADLs (i.e. money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, grocery shopping).
2. Assess Long-Term Care needs including but not limited to: environmental safety including items such as smoke detectors, pests/infestation, and trip and fall dangers and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the Community Benefit, the MCO shall assess for all Community Benefit services.
3. 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 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 Individualized 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.

COMMUNITY BENEFIT SERVICE QUESTIONNAIRE

As part of the CNA process, MCO care coordinators must administer the Community Benefit Services Questionnaire (CBSQ). The two documents include:

1. The CBSQ, and
2. The Centennial Care Community Benefit Member Agreement (CBMA).

The completed CBSQ and the CBMA are considered part of the member's CNA. The MCOs must ensure all care coordinators are trained in conducting this process. The MCOs will also submit an HSD approved monthly report to HSD that will include the total number of CBSQs and will include member refusals to participate in the CBSQ.

The CBSQ/CBMA will be administered for the following members:

- Allocated members receiving their first CNA, including members who are in the process of community reintegration.
- All annual CNAs for members with a current NF LOC (see note about CCL3 members below).
- Full Medicaid members without a NF LOC who request Community Benefit (CB) services.
- Full Medicaid members without a NF LOC who appear to meet NF LOC criteria during the CNA.

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

- Members who have not previously met NF LOC and are not requesting CB at the time of the CNA.
- Members who may meet a NF LOC for a short period of time due to a clinical episode (ie, pregnancy).
- Members not being assessed for a NF LOC.
- Members on the DD, Mi Via or MF Waiver (COEs 095 and 096).
- Members in a nursing facility (unless in the process of being allocated through community reintegration or member has other COE 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.

Care coordination level 3 (CCL3) members:

- For all members with CCL3 and 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 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.

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 but are not limited to, 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. The decision can be made via telephone contact or face to face visit with the member.

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. 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.

A. 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:

2. Coordination of the members health care needs through the development of the care plan;
3. 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;
4. 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
5. Verification of all decisions made regarding the member's needs and services, and ensures all information is documented in a written, comprehensive care plan.

B. Comprehensive Care Plan Development and Management

1. 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 to the extent possible
2. 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 unless the member is in a health home and/or using the Treat First model of care.
3. 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 member's 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 member's care plan.
 - d. Ensure timelines for the development and implementation and/or update

the care plan are met.

- 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.

4. 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. Member's 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.

5. 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 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.
6. 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).

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 MCO shall ensure its staff, subcontractor(s) or vendor(s) conducting the HRA, is adequately trained to effectively conduct the HSD standardized HRA. CNAs must be performed by primary 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), 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. 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:

- A. Care coordination level 2:
 - Members not residing in a nursing facility 1:75, and
 - Members residing in a nursing facility 1:125; and
 - Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit 1:100;
- B. Care coordination level 3:
 - Members not residing in a nursing facility 1:50; and
 - Members residing in a nursing facility 1:125; and
 - Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination 1:75; and
- C. Care coordination for Members who participate in the Self-Directed Community Benefit:
 - Members under age of twenty-one (21) 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. 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.~~

~~A. 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:~~

~~2.1. Coordination of the members health care needs through the development of the care plan;~~

~~3.1. 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;~~

~~4.1. 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~~

~~5.1. Verification of all decisions made regarding the member's needs and services, and ensures all information is documented in a written, comprehensive care plan.~~

~~B.A. Comprehensive Care Plan Development and Management~~

~~1. 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 to the extent possible~~

~~2.1. 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 unless the member is in a health home and/or using the Treat First model of care.~~

~~3.1. The Care Coordinator shall:~~

- ~~a. Ensure the member or member's legal representative understands, reviews, signs and dates the care plan.~~
- ~~b.a. Provide a copy of the member's 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.a. Confirm that family, providers, or any other relevant parties are included in the treatment and planning of the member's care plan.~~
- ~~d.a. Ensure timelines for the development and implementation and/or update the care plan are met.~~
- ~~e.a. 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.a. 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.a. Maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the member's care.~~
- ~~h.a. 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.a. 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.a. Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.~~
- ~~k.a. Educate members with identified disease management needs by providing specific disease management interventions and strategies.~~
- ~~l.a. 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.a. 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.a. 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.~~

~~4.1. The Comprehensive Care Plan Required Elements include the following:~~

~~a. Pertinent member demographics and enrollment data.~~

~~b.a. 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.a. Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.~~

~~d.a. Member's current status, including present levels of function in physical, cognitive, social, and educational domains.~~

~~e.a. Member or family barriers to receiving treatment, such as a member or family member's ability to travel to an appointment.~~

~~f.a. 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.a. Services recommended achieving the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member's desired outcomes.~~

~~h.a. 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.a. 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.a. 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.a. Reflect the member's strengths and preferences.~~

~~l.a. 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.a. Identify goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.~~

~~n.a. Include those services, the purpose or control of which the member elects to self-direct.~~

~~o.a. Prevent the provision of unnecessary or inappropriate services and supports.~~

~~5.1. 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;~~

~~2.1. Major medical change;~~

~~3.1. The loss of a primary caregiver or other significant person;~~

~~4.1. A serious accident, illness, injury or hospitalization that disrupts the implementation of the care plan;~~

~~5.1. Serious or sudden change in behavior;~~

~~6.1. Change in living situation;~~

~~7.1. Proposed change in services or providers (e.g. Community Benefit);~~

~~8.1. It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect or exploitation;~~

~~9.1. Any team member requests a meeting to propose changes to the care plan;~~

~~10.1. Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or~~

~~11.1. As requested by HSD.~~

~~b.a. 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.~~

~~6.1. 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.a. 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.~~

~~2.1. Ensure when a member's level of care coordination increases or decreases that continuity of care is always maintained.~~

~~3.1. Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.~~

- ~~4.1. Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member's goals and foster independence.~~
- ~~5.1. 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.~~
- ~~6.1. Education regarding service delivery through Medicare and/or Medicaid.~~
- ~~7.1. 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.~~
- ~~8.1. Proactively work to continue to achieve coordination of physical, behavioral health and long-term care services.~~
- ~~9.1. Maintain consistent communication and contact with member's PCP, specialists, and other individuals involved in the member's care.~~
- ~~10.1. Maintain and monitor the member's Community Benefit and provide assistance with complex services.~~
- ~~11.1. Consistently consider member and provider input to identify opportunities for improvement.~~
- ~~12.1. 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 maintenance 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. The MCOs are required to perform all care coordination functions described in this policy manual section including but not limited to: capturing the member's medical and behavioral health needs; developing a comprehensive care plan; and completing all required touch points identified by the member's current CC level. Exceptions to care coordination functions are specifically described below for members receiving 1915 (c) HCBS waiver services.

OVERVIEW OF MEDICAID 1915 (c) HCBS WAIVER PROGRAM

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 home and community based 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 Individualized Service 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 defined as a life threatening, chronic condition which results in a prolonged dependency on skilled nursing care at home. MFW individuals have a COE 095. MFW recipients meet an ICF/IID Level of Care (LOC) as well as established medically fragile parameters.

MFW provides the following long term care services: RN Case Management, private duty nursing (RN, LPN), home health aide, behavior support consultation, respite care, nutritional counseling, skilled therapies (PT, OT, SLP) for adults, 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 (MFCMP) that currently provides RN/case management services to both MF waiver and non-waiver (EPSDT) medically fragile persons state wide. Case Managers from the UNM/MFCMP assess the recipient for medically fragile parameters, compile the LOC forms, and submit the LOC packet to the Medicaid Third Party Assessor for an ICF/IID LOC determination. Case Managers also create the MFW recipient's Individualized Service Plan (ISP) that includes services and budget amounts determined by the LOC.

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 waiver 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, skilled therapies for adults, specialized therapies, related goods, 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.

MCO CARE COORDINATION ACTIVITIES & THE 1915 (c) HCBS WAIVER SERVICE PLAN (ISP OR SSP)

A. Developmental Disabilities Waiver Program

The MCO Care Coordinator shall:

1. Request a copy of the approved 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. A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC abstract and CIA.
 - b. 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.
2. The MCO will not complete a NF LOC on members enrolled in the DD 1915 (c) Waiver.
3. 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.
4. 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. Utilize only the physical health and behavioral health portion of the MCOs' Comprehensive Care Plan for members who are receiving home and community based services through the DD waiver.

B. Medically Fragile Waiver Program

The MCO Care Coordinator shall:

1. Request a copy of the approved MFW LOC packet and ISP packet from the UNM/MFCMP 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.
2. Ensure that the MFW ISP serves as the Comprehensive Care Plan for the MF member.
3. Work with the UNM/MFCMP to coordinate MFW LOC assessments and/or CNA visits at the same time in order to reduce the burden on these families.
4. The MCO will not complete a NF LOC on members enrolled in the MF 1915 (c) Waiver.
5. Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The UNM/MFCMP 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.
6. Conduct the required annual in person visit and CNA for MF members.
7. Utilize the MFW ISP as the Comprehensive Care Plan for the MFW recipient.

C. Mi Via Self-Directed Waiver Program

The MCO Care Coordinator shall:

1. Request a copy of the approved 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. A CIU/MAD 054 form is faxed to the Medicaid TPA to request the LOC abstract and CIA.
 - b. 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.
2. The MCO will not complete a NF LOC on members enrolled in the Mi Via 1915 (c) Waiver.
3. 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.

4. 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.
5. Utilize only the physical health and behavioral health portion of the MCOs' Comprehensive Care Plan for members who are receiving home and community based services through the Mi Via waiver.

MCO CARE COORDINATOR ACTIVITIES FOR MEDICALLY FRAGILE EPSDT (NON-WAIVER) MEMBERS CASE MANAGED BY UNM/MFCMP

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

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

1. Request a copy of the approved MF ISP from the 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.
2. The MCO will not complete a NFLOC assessment on MF EPSDT members.
3. Ensure that the MF ISP serves as the Comprehensive Care Plan for the MF member.
4. Work with the UNM/MFCMP to coordinate MF LOC assessments, annual re-assessments, and the CNA in-person visits at the same time in order to reduce the burden on these MF members and families.
5. Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The 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.
6. Conduct the required annual in person visit and CNA for MF members.

TRANSITIONS FROM THE BRAIN INJURY SERVICES FUND TO CENTENNIAL CARE MCO

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 that are covered under the MCO. The MCO may contact the BISF Service

Coordination Contractor to verify the status of a member's BISF eligibility. 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 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 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.
 - 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.
2. 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 HSD's Brain Injury Program to inactivate a BISF

participant from the BISF shall apply for the full transition of a BISF participant into Centennial Care:

- a. The BISF participant assessed to not need Level 2 or Level 3 care coordination 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 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.
 - 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. 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 brain injury training by the HSD including but not limited to: general brain injury issues and available state and community resources; 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. 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.