Policy Manual	2025
	CareLink NM HEALTH HOMES

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Introduction

The purpose of this Manual is to provide a reference for the policies established by the New Mexico ~~Human Services Department (HSD)~~ Healthcare Authority (HCA) for the administration of the CareLink NM Health Home (CLNM) program. The Manual was developed by the Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD) of ~~HSD~~ HCA to assist in the administration of the CLNM program and is intended to provide direction to the agencies who serve as CLNM providers.

The CareLink NM program provides services authorized by Section 2703 of the Patient Protection and Affordable Care Act (P.L. 111-148, ACA). Services are delivered through a designated provider agency to enhance the integration and coordination of primary, acute, behavioral, social, and long-term services and supports for individuals with Serious Mental Illness (SMI) and Severe Emotional Disturbance (SED) and Substance Use Disorder (SUD). The CLNM provider agency assists a CLNM member (member) by engaging him or her through more direct relationships and intensive care coordination resulting in a comprehensive needs assessment (CNA) and plan of care (service plan). The goals of the CLNM Health Homes are to:

1. Promote coordinated care for acute health conditions and improve long-term health;

2. Prevent risk behaviors;

3. Enhance member engagement and self-efficacy;

4. Improve quality of life for individuals with SMI, SED and SUD; and

5. Reduce avoidable utilization of emergency department, inpatient and residential services

Authority

New Mexico implemented ~~Centennial~~ Managed Care in 2014 to modernize New Mexico's Medicaid program and developed the CLNM Health Home benefit for some of the State's most vulnerable residents. The mission of CLNM is to promote self-management of care choices through a supportive learning environment. CLNM services also provide expanded supports such as case management and care coordination for physical and behavioral health, long-term care, and social needs such as housing, transportation, and employment. CLNM provides integrated care for Medicaid recipients and Managed Care Organization (MCO) members with chronic conditions, targeting a vulnerable population with behavioral health needs. The first phase of CLNM addressed services for Medicaid-eligible adults with SMI, and Medicaid-eligible children and adolescents with a SED; the second phase includes Substance Use Disorder to CLNM eligibility criteria. ~~HSD~~ HCA is leading the statewide initiative to provide coordinated care by a

CLNM provider for individuals with the aforementioned chronic conditions and all associated comorbidities.

The policies in this Manual will be reviewed periodically by Human Services Division. ~~HSD~~ HCA reserves the right to modify or supersede any policies and procedures. The CLNM Provider Policy Manual may be viewed or downloaded from MAD's home page website at ~~http://www.hsd.state.nm.us/providers/health-home-policy-manual.aspx~~ CareLink NM Health Homes – New Mexico Health Care Authority

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

Introduction to the CareLink Health Home Model

Overview

The CareLink NM service delivery model enhances integration and coordination of primary, acute, behavioral health, and long-term care services and supports across the lifespan for persons with chronic illness. The CLNM model builds on efforts made through the development and implementation of the ~~Centennial~~ Turquoise Care program to improve integrated care and member engagement in managing their health. In New Mexico's health home model, CLNM provider agencies (providers) enhance their current operating structure to provide care coordination by partnering with physical health providers and specialty providers. CLNM providers will utilize health information technology (HIT) to monitor care and provide comprehensive records management. Providers serve fee-for-service (FFS) recipients and MCO members already receiving behavioral health services as well as new individuals who are eligible to participate in the program.

Core Service Definitions

CLNM providers must demonstrate the ability to deliver all core services and meet all data and quality reporting requirements described in this Manual. Providers may elect to meet the service needs of members by providing integrated physical and behavioral health services through an on-site, co-location model, or through memoranda of agreements (MOA). MOA are required with at least one primary care practice that serves members less than 21 years of age and at least one primary care practice that serves members 21 years of age and older. Agreements are also required for local hospitals and residential treatment facilities. Other referral relationships are developed through less formal processes but are critical for the multi-disciplinary team approach to integrated care.

Providers must deliver services in six core categories to members: Comprehensive Care Management, Care Coordination, Prevention and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Community and Social Support Service Referrals. Providers also utilize CLNM health information technology. Following are descriptions of the core service categories:

Comprehensive Care Management

Comprehensive Care Management involves a comprehensive needs assessment and the development of an individualized comprehensive service plan with active participation from the CLNM member, family, caregivers and the health home team. Comprehensive care management services must also include:

- Assessment of preliminary risk conditions and health needs;
- Comprehensive service plan development, to include client goals, preferences, and optimum clinical outcomes, and identify specific additional health screenings required based on the individual's risk assessment;
- Assignment of health team roles and responsibilities;
- Development of treatment guidelines for health teams to follow across risk levels or health conditions;
- Oversight of the implementation of the comprehensive service plan which bridges treatment and wellness support across behavioral health, primary care and social health supports;
- Monitoring individual health status and service use through claims-based data sets to determine adherence to or variance from treatment guidelines; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Comprehensive care management activities include a needs assessment, as described below.

CLNM Comprehensive Needs Assessment (CNA)

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

Note: The CNA is not a psychiatric diagnostic evaluation (90791-92) to determine eligibility; it is a screening and assessment tool to establish service needs. If no diagnosis from previous records is available, a psychiatric diagnostic evaluation must also be completed. The CNA provides all the required data elements specified in the ~~HSD~~ HCA authorized CNA (one version for children and one for adults).

The CNA:

- Provides all the required data elements specified in the ~~HSD~~ HCA authorized CNA;
- Assesses preliminary risk conditions and health needs;

- Uses data from the risk management system (PRISM) to help determine care coordination levels;
- Requires outreach to potential CLNM members within 14 calendar days of receipt of a referral;
- Must document that a provider contacted and/or met with a member to at least begin assessment within the mandated 14-calendar day timeframe;
- May be conducted face-to-face in a member's home. If the member is homeless, the meeting may be held at a mutually agreed upon location; and
- Does not need to be completed during the first visit if the Treat First model is employed. The member would be assigned a "pending" status or assigned care coordinator level 8 until a diagnosis of SMI, SED or SUD is finalized and accepted by the member. The CNA can be completed over the course of four appointments; when completed, the care coordination level is updated. Level 9 for high fidelity Wraparound services for children/adolescents for designated Wraparound providers only, following a review process. Level 9 caseload recommendation is 1:8 – 1:10;
- Must be completed within 90 days of member opt-in. Once the CNA is completed, the member's care coordination level should be updated to "6", "7", "8", or "9". If a provider is unable to complete the CNA within the 90-day timeframe, they should opt-out the member in Star and notify the appropriate MCO. The exception to this is a member who has had two face-to-face encounters (in addition to Maintaining Engagement) with the provider within the 90-day period, and those services are documented in Star Service Tracking; and

- Includes the following health screens:
  - Clinical screen for depression;
  - C-SSRS for suicide risk;
  - Audit-10 for risk of alcohol abuse;
  - Questions related to past or current substance use, and
  - PC-PTSD for indications of post-traumatic stress disorder.

Note: For children involved with the NM Children, Youth and Families Department in Protective Services and/or Juvenile Justice, a Child and Adolescent Needs and Strengths assessment may also be indicated, however the CNA is still required.

Levels of Care and CNA Frequency

A MCO's Health Risk Assessment (HRA) is used to determine the need for a CNA. A CNA determines if care level 2 or 3 is appropriate. Level 2 or 3 determinations denote a CLNM referral if qualifying diagnoses are present. A member who has been determined to require level 1 care and has had BH services with a pertinent diagnosis, but whom a provider has not been able to contact, may also be referred.

Note: If a *significant change* in a member's condition leads to increasing service needs, the assessment timeframe is expedited, and service changes are instituted within ten calendar days. "Significant change" might include a member becoming medically complex or fragile, identification of a substance dependency, diagnosis of significant cognitive deficits, or identification of contraindicated pharmaceutical use. CLNM care coordinators should also consider changes in a member's housing, social supports or other nonmedical services that would impact a member's care or wellbeing.

The following establishes guidelines for frequency of needs assessments based upon care coordination levels, and outlines caseload recommendations by level:

- Care coordination levels 6 or 7, assigned by the CLNM provider, have similar attributes as MCO care coordination levels 1 and 2. The variation in numbering systems is for system tracking purposes;
- Level 8 care coordination is a temporary determination used for new admissions until the CNA and level determination are complete. Once the CNA has been completed, the CCL in BHSDStar should be updated to reflect the designated level ("6," "7," or "9");
- Level 6 care coordination requires a needs assessment at least annually (caseload recommendation is 1:51-100);
- Level 7 care coordination requires a needs assessment at least semi-annually (caseload recommendation is 1:30 – 1:50);
- ~~Level 9 for high fidelity Wraparound services for children/adolescents for designated Wraparound providers only, following a review process. Level 9 caseload recommendation is 1:8 – 1:10.~~

Care Coordination Level 6 Requirements

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

- A comorbid health condition;
- High emergency department (ED) use, defined as three or more visits within 30 calendar days;
- A mental health condition causing moderate functional impairment;
- Requirement for assistance with two or more activities of daily living (ADL) or instrumental activities of daily living (IADL) living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues;
- Poly-pharmaceutical use, defined as simultaneous use of six or more medications from different drug classes and/or simultaneous use of three or more medications from the same drug class.

Care Coordination Level 7 Requirements

Based on the results of the CNA, the provider shall assign care coordination level 7, at a minimum, to members with one of the following:

- Determination of medical complexity or fragility;
- Excessive ED use (four or more visits within a 12-month period);
- A mental health condition causing high functional impairment;
- Untreated comorbid substance dependency based on the current DSM or other functional scale determined by the State;
- Requirement of assistance with two ADL or IADL and living in the community at medium to high risk;
- Significant cognitive deficits;
- Contraindicated pharmaceutical use.

Care Coordination Level 9 Requirements (for NM Wraparound CARES members)

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

- Diagnosis of Serious Emotional Disturbance (SED); and
- Current or historic multi-system involvement in at least two of the following: child welfare, Juvenile Justice, special education services, or behavioral health; and
- At risk of or in out-of-home placement OR previous out of home placement, incarceration, or acute hospitalization within a two-year period prior to evaluation.

CLNM Service Plan

The service plan template in BHSDStar maps a member's path toward self-management of physical and behavioral health conditions and is specifically designed to help meet member needs and achieve goals. The service plan is intended to be updated frequently to reflect member needs, communicate services a member will receive, and serve as a shared plan for the member, their family or representatives, caregivers, service providers, and other relevant stakeholders. The plan is intended to be supplemented by treatment plans developed by practitioners. The service plan:

- Requires active participation from members, family, caregivers, and CLNM team members;
- Requires consultation with interdisciplinary team experts, primary care providers, specialists, behavioral health providers, and other participants in a member's care;
- Identifies additional recommended health screenings;
- Addresses long-term and physical, behavioral, and social health needs;
- Is organized around a member's goals, preferences and optimal clinical outcomes, including self-management. The plan includes as many short- and long-term goals as needed;
- Specifies treatment and wellness supports that bridge behavioral health and primary

care;

- Includes a backup plan that addresses situations when designated providers are unavailable and provides contact information for people and agencies identified in the backup plan. This is primarily for members receiving home- and community-based services where there is a nursing facility level of care (NF LOC) determination. There is no required template; the plan is uploaded as a file into the State's web-based data collection tool, BHSDStar (please refer to the "Heath Information Technology" section of this manual on page 37 for information on BHSDStar);

- Includes a crisis/emergency plan listing steps a member and/or representative will take that differ from the standard emergency protocol in the event of an emergency. These are individualized plans entered into BHSDStar;

- Is shared with members and their providers; and

- Is updated with status and plan changes.

CLNM Team Roles

The following list describes the roles of the CLNM team members:

- Develop treatment guidelines for health teams that establish clinical pathways across risk levels or health conditions;

- Oversee the implementation of service plans;

- Report on progress toward meeting outcomes, e.g. client satisfaction, health status, service delivery, and costs;

- Monitor individual and population health status and service use to determine adherence to or variance from service plans and best practice guidelines; and

- Use claims-based data sets and other tools to track population-based care.

CLNM Care Coordination

These services are conducted by care coordinators with members, their identified supports, medical, behavioral health, and community providers. Care is coordinated across care settings to implement the individualized, culturally appropriate, comprehensive service plan. Care is coordinated through appropriate linkages, referrals, and follow-up to promote integration and cooperation among service providers and reinforces treatment strategies that support members' motivation to better understand and actively self-manage his or her health conditions. Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients' and family members' ability to manage care and live safely in the community and enhancing the use of proactive health promotion and self-management. Specific activities include but are not limited to:

- Outreach and engagement of CLNM members;

- Communication with members, their family, other providers and team members, including a face-to-face visit to address health and safety concerns;

- Ensuring members and their identified supports have access to medical, behavioral health, pharmacology, age-appropriate resiliency and recovery support services, and natural and community supports;
- Ensuring that services are integrated and compatible as identified in the service plan;
- Coordinating and providing access to substance abuse services;
- Coordinating primary, specialty, and transitional health care from ED, hospitals and psychiatric residential treatment facilities;
- Making referrals, assisting in scheduling appointments, and conducting follow-up monitoring;
- Arranging for transportation to medically-necessary services;
- Developing self-management plans with members;
- Delivering health education specific to a member's chronic conditions;
- Easing the transition to long-term services and supports;
- Coordinating with the MCO care coordinator when a member has a NF LOC determination; and
- Conducting a face-to-face in-home visit within two weeks of a NF LOC determination;
- Interrupting patterns of frequent hospital emergency department use and reducing hospital admissions.

Prevention, Health Promotion, and Disease Management
These services are designed to prevent and reduce health risks and provide health promoting lifestyle interventions associated with CLNM-member populations. Services address an array of health challenges including substance use prevention and or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention and early intervention, STD prevention and early intervention, family planning and pregnancy support, chronic disease management, nutritional counseling, obesity reduction and prevention. Health promotion activities assist CLNM members to participate in the implementation of their treatment and medical services plans, and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion activities include, but are not limited to:
- Use of member-level, clinical data to address a member's specific health promotion and self-care needs and goals. Some data are available from the data warehouse and assessment data in BHSDStar;
- Development of disease management and self-management plans with members;
- Delivery of health education specific to a member's health conditions;
- Education of members about the importance of immunizations and screenings for general health conditions;
- Development and delivery of health-promoting lifestyle programs and interventions for topics such as substance use prevention, reduction and treatment, resiliency and

recovery, independent living, STD prevention, improving social networks, self-regulation, parenting, life skills, and more;

- Use of evidence-based, evidence-informed, best emerging and/or promising practices curricula for prevention, health promotion, and disease management programs and interventions that integrate physical and behavioral health concepts and meet the needs of the population served;

- Providing classes or counseling, which can be in a group or individual setting;

- Increasing the use of proactive health promotion and self-management activities. Includes reinforcing strategies that support a member's motivation to better understand and actively self-manage chronic health conditions; and

- Tracking success of prevention, health promotion, and disease management programs and interventions, as well as identifying areas of improvement.

Note: MCOs and the Department of Health are potential referral sources for health promotion activities when agency and network providers cannot meet a specific health promotion need.

Comprehensive Transitional Care

CLNM providers are responsible for taking a lead role in transitional care. Comprehensive transitional care focuses on the movement within different levels of care, settings, or situations and is bidirectional, diverting members from levels of care such as ED services, residential treatment centers, and inpatient hospitalization, and transitioning members to outpatient services. Transitional services help to reduce barriers to timely access, inappropriate hospitalizations, time in residential treatment centers, and nursing home admissions. Additionally, these services interrupt patterns of frequent ED use and prevent gaps in services which could result in (re)admission to a higher level of care or a longer stay at an unnecessarily higher level of care. All Health Home providers are expected to register with Collective Medical's Emergency Department information Exchange (EDIE). Through the EDIE system, providers receive notification when members are admitted to the ED or a hospital as inpatients. Providers may select the method by which notifications are sent (e.g. email, text) so they made provide necessary transitional care services.

Unplanned discharges for Health Home members trigger a team meeting convened by Care Coordinators, who are the designated points of contact. ~~Wraparound Facilitators are the points of contact for discharges from congregate care settings and out-of-home placements for Health Homes members enrolled in NM Wraparound CARES. The New Mexico Administrative Code 7.20.11.23(H)(3) addresses unplanned discharges for minors: "If the child's parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is affected. If the child's family refuses to take~~

~~physical custody of the child, the agency refers the case to the department " [Children Youth and Families Department].~~

Providers of transitional services should be mindful of a member's transition from childhood to adulthood. When developing a service plan, providers should consider a member's shift from pediatric to adult medical providers, or issues such as independent living arrangements. The provider agency will proactively work with CLNM members reaching the age of majority to ensure appropriate supports and services are in place in the member's plan to assist in the successful transition to adulthood. Comprehensive transitional care activities include, but are not limited to:

- Supporting the use of proactive health promotion and self-management;
- Participating in all discharge and transitional planning activities;
- Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, Indian Health Services (IHS), Tribal programs and others to continue implementing or modifying the service plan as needed;
- Implementing appropriate services and supports to reduce use of hospital EDs, domestic violence and other shelters, and residential treatment centers. Services should also support decreased hospital admissions and readmissions, homelessness, and involvement with State agencies such as Juvenile Justice, Protective Services, and Corrections;
- Coordinating with members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports;
- Sharing critical planning and transition documents with all providers involved with an individual's care via web-based tools, secure email or hard copy; and
- Facilitating critical transitions from child to adult services, or to long-term services and supports.

Individual and Family Support Services
Individual and family support services reduce barriers to CLNM members' care coordination, increase skills and engagement, and improve health outcomes. Services also increase health and medication literacy, enhance one's ability to self-manage care, promote peer and traditional and foster care family involvement and support, improve access to education and employment supports, and support recovery and resiliency. Individual and family support activities include, but are not limited to:

- Supporting a member and their family in recovery and resiliency goals;
- Teaching members and families self-advocacy skills and how to navigate systems to access needed services;
- Supporting families in their knowledge of a member's disease and possible side effects of medication;

- Enhancing the abilities of members and their support systems to manage care and live safely in the community;
- Providing peer support services, which are especially critical in treating members with substance use disorders;
- Assisting members in obtaining and adhering to medication schedules and other prescribed treatments;
- Assisting members in accessing self-help activities and services;
- Identifying resources for individuals to support them in attaining their highest level of health and functionality within their families and in their community; and
- Assessing impacts of a member's behaviors on families and assisting in obtaining respite services as needed.

Referral to Community and Social Support Services

Referrals to community and social support services help overcome access and service barriers, increase self-management skills, and improve overall health. Providers identify available and effective community-based resources and actively link and manage appropriate referrals. Linkages support the personal needs of members and are consistent with the service plan. Community and social support service referral activities may include, but are not limited to:

- Identifying and partnering with community-based and telehealth resources such as medical and behavioral health care, durable medical equipment (DME), legal services, housing, respite, educational and employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, personal needs, wellness and health promotion services, specialized support groups, supports for substance use prevention and treatment, and culturally-specific programs such as veterans' or IHS and Tribal programs;
- Developing referral and communication protocols as outlined in MOA: Referrals for partnerships with a MOA shall include acknowledgment of the referral and follow-up with the member by both participating partners. Once a referral is made, the healthcare provider may have access to relevant data on the member including his or her CLNM assessment and service plan, unless the member does not authorize a data exchange;
- Making referrals and assisting members to establish and maintain eligibility for services. Common linkages could include continuation of healthcare and disability benefits, educational supports, and other personal needs consistent with recovery goals and the treatment plan;
- Actively managing appropriate referrals and access to care; and
- Confirming members' and providers' encounters and following up post-referral.

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Use of Best Practices

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

- Provide quality-driven, cost-effective, culturally-appropriate, and person- and family-centered services;

- Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice guidelines;

- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

- Coordinate and provide access to mental health services;

- Coordinate and provide access to comprehensive care management, coordination, and transitional care across settings including facilitating transfer from a pediatric to an adult healthcare system;

- Coordinate and provide the practice and use of trauma responsive care to more effectively support youth and adults impacted by toxic stress and trauma;

- Participate in members' discharge planning including appropriate follow-up from inpatient to other settings;

- Coordinate and provide access to disease management, education and strategies for members with chronic illnesses and comorbidities, including providing self-management supports to members and their families;

- Coordinate and provide access to community referrals, social supports recovery services, and access to long-term care supports and services;

- Develop and maintain a Service plan for each member to integrate the whole-person model of healthcare needs and services that is culturally appropriate for the individual;

- Demonstrate ability to use HIT to link services and facilitate communication between team members and providers;
- Establish a continuous quality improvement program and demonstrate the ability to collect and report on data to evaluate member outcomes.

Use of Health Information Technology to Link Services

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

BHSDStar is used to collect and monitor information for tracking and care integration. To support use of BHSDStar and other web-based data tools, the provider agency must have computers and an internet connection.

As outlined in the Health Information Technology section of this Manual, the BHSDStar data collection tool will be used to create member records specific to CLNM.

Target Populations

The target population of the CLNM program is individuals enrolled in Medicaid, including Medicaid recipients in FFS and MCO, who are diagnosed with Serious Mental Illness (SMI), Severe Emotional Disturbance (SED) as defined by the State of New Mexico (criteria are listed in Appendix B, beginning on page 47) or Substance Use Disorder (SUD) per the Diagnostic and Statistical Manual of Mental Disorders DSM-5 (DSM-5) described beginning on page 51 of this manual. To be eligible for enrollment in CLNM, an individual must be enrolled in ~~Centennial Care~~ Turquoise Care or Medicaid FFS, and have one or more SMI, SED or SUD diagnoses. Once enrolled in CareLink, participants are referred to as members, but should not be confused with FFS recipient or MCO member, which refers to an individual's type of Medicaid participation. ~~If approved by HSD or the CLNM Steering Committee, Health Homes may also implement NM Wraparound CARES in addition to serving the members described above. Separate member projections and PMPM rates are developed for this population of vulnerable children and youth ages 4-21 who meet the following conditions to be eligible for this program:~~

- ~~Diagnosis of Severe Emotional Disturbance (SED) for youth younger than 18, or Serious Mental Illness (SMI) for youth ages 18-21, and~~
- ~~Current or historical multi-system involvement, i.e. involvement with two or more systems including Juvenile Justice, child welfare, special education or behavioral health; and~~
- ~~At risk of or in out-of-home placement OR previous out-of-home placement, incarceration, or acute hospitalization within a two-year period prior to evaluation, or is precariously housed.~~

~~Health Homes will identify potential Wraparound clients through relationships and referrals through community stakeholders such as local CYFD Juvenile Justice and Protective Services offices, schools, Treatment Foster Care providers, residential treatment centers and MCO. CLNM Wraparound does not require preauthorization. Rather, in addition to meeting the criteria described above, a committee comprised of staff members from CYFD Wraparound, MCO and the Health Home (and optionally additional people who may inform a youth's circumstances) must approve a candidate's eligibility for Wraparound.~~

Participation Requirements for Providers

Enrollment as a Medicaid Provider and Contracting with MCO

Services offered to CLNM members are furnished by a variety of providers and provider groups. A CLNM provider must first be enrolled as a New Mexico Medicaid provider and meet all applicable standards and must either update existing contracts with all Medicaid MCO or develop a new contract if none exists. To be designated a CLNM provider applicants must also:

- Hold a Comprehensive Community Support Services (CCSS) certification or an attestation that the agency has received all required training for certification;

- Meet all provider qualifications and standards outlined in this Manual;

- Complete a CLNM application;

- Provide services in a county approved for Health Homes by the Centers for Medicare & Medicaid Services (CMS) through a State Plan Amendment (SPA);

- Have a full-time Director responsible for oversight of the program.~~Executive Director and full-time Clinical Director who hold one of the following licenses: Board-certified or Board-eligible psychiatrist; licensed psychologist; licensed independent social worker; clinical nurse specialist in psychiatric nursing; licensed, certified nurse practitioner in psychiatry; clinical nurse specializing in psychiatric nursing, licensed professional clinical mental health counselor; licensed marriage and family therapist; or licensed, independent school psychologist.~~

- Administrative infrastructure, financial viability and infrastructure, and IT infrastructure to support the role of CLNM. ~~including managed care experience.~~ IT capability must include electronic billing/accounting capacity;

- Have a Quality Improvement program with capacity specifically to address quality issues for care planning and coordination, including process improvement, data collection, and program fidelity;

- Successfully complete a readiness review process.

Provider Application Process

To apply to be a CLNM provider, an agency must complete an application that will be reviewed by the CLNM Steering Committee (please refer to the section below and to page 35 for information on the Steering Committee). The CLNM application includes the following:

- General information about the service provider;
- Description of population served;
- An overview of behavioral and physical health integration activities;
- A screening and treatment service checklist;
- A plan for provider and partner outreach and engagement;
- General financial and business information;
- Additional relevant information as requested by the Steering Committee.

The applicant must also agree to comply with all Medicaid program requirements. The CareLink provider application can be found at the following link: ~~http://www.hsd.state.nm.us/uploads/files/CareLink%20NM%20Provider%20Agency%20Application.pdf~~ CareLink NM – New Mexico Health Care Authority
Guidelines for submitting the application can be found at the following link: ~~http://www.hsd.state.nm.us/uploads/files/CLNM%20Application%20Guidelines.pdf~~ CareLink NM – New Mexico Health Care Authority

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

Readiness Requirements

The Steering Committee will conduct readiness reviews with all selected applicants to evaluate their capacity to meet CLNM service requirements. The Readiness Review Protocol is comprised of the following twelve sections:

- The Health Home population;
- Health Home Referral Relationships and Network Management;
- Health Home Services – Comprehensive Care Management;
- Health Home Services – Care Coordination;
- Health Home Services – Prevention, Health Promotion and Disease Management;
- Health Home Services – Comprehensive Transitional Care;
- Health Home Services – Individual and Family Support Services;
- Health Home Services – Referral to Community and Social Support Services;
- Staffing and Other Organizational Matters;

- Systems;

- Integration of Physical and Psychiatric Health Consultants; and
- ~~NM Wraparound CARES capacity (applicable only to those who wish to provide Wraparound and are approved by HSD, CYFD, and the CLNM Steering Committee).~~

Additional readiness guidelines and information will be provided to applicants selected for site visits prior to those visits.

Staffing Requirements

Each provider must employ specific staff positions to meet CLNM requirements. Some positions may be hired as contractors rather than employees. Following is a list of essential positions, qualifications, and where applicable, the number of individuals required to comply with staff-to-patient ratios:

1. A *Director* with three years' experience with the Health Home population who is specifically assigned to CLNM service oversight and administrative responsibilities. The director is responsible for overall service oversight, financial performance and quality management.

2. A *Health Promotion Coordinator* with a bachelor's-level degree in a human or health services field and experience in curricula development and delivery. The health promotion coordinator manages health promotion and risk prevention services and resources appropriate for the CLNM population. Typical programs are substance use prevention and cessation, psychotropic medication management, nutritional counseling, healthy weight management, diabetes, pulmonary and hypertensive care. Programs are developed based on the prevalent conditions and comorbidities of the regional population. This role explores and manages relationships with outside providers such as the Department of Health and the MCOs for additional referral opportunities not available in the CLNM Health Home. This position also identifies gaps in disease management programming based on the specific CLNM population.

3. *Care Coordinators*, who are behavioral health practitioners licensed by Regulation and Licensing Department (RLD) or hold a human services bachelor's or master's level degree with two years of behavioral health experience, or is a registered nurse in New Mexico, or is approved through the Health Home Steering Committee. A Care Coordinator develops and oversees a member's comprehensive care management and the planning and coordination of all physical, behavioral, and support services. Care coordinators, working with MCOs, are responsible for researching, investigating, and reporting grievances, appeals, and critical incidents involving a member.

The provider agency must employ a sufficient number of care coordinators to meet the recommended ratios and the needs of members. Recommended ratios for care coordinators to members are based on care coordination levels indicated below:

Care Coordination Level 6 - chronic conditions not yet stabilized: 1:51–1:100;

Care Coordination Level 7 - multiple chronic conditions with few self-management skills: 1:30 – 1:50;

Care Coordination Level 8 – Pending evaluation: 1:50

~~*Care Coordination Level 9* – NM Wraparound CARES (High Fidelity Wraparound): 1:8 - 1:10 Individual caseloads for Wraparound facilitators may vary based on the needs of individual members and distance from the practice a care coordinator must travel to serve members.~~

4. A bilingual **Community Liaison** who speaks a language used by a majority of non-fluent English-speaking CLNM members, and who is experienced with resources in a member's local community. The community liaison works with an eligible recipient's care coordinator in appropriately connecting and engaging the member with needed community services, resources, and providers, including IHS and Tribal programs.

5. **Certified Peer Support Workers** (CPSW) hold a certification from the New Mexico Credentialing Board for Behavioral Health Professionals as a Certified Peer Support Workers. CPSW have lived experience and have successfully navigated his or her own behavioral health experiences and is willing to assist his or her peers in their recovery processes. CPSW provide several individual and family support services and can also be employed on a contract basis or full-time for other positions for which they are qualified. Following is contact information for entities that can help connect providers with peer and family support workers: New Mexico Credentialing Board for Behavioral Health Professionals (info@nmcbbhp.org); BHSD's Office of Peer Recovery and Engagement (opre.bhsd@state.nm.us).

6. **Family Peer Support Specialists** (FPSS) are trained by CYFD's Behavioral Health Services Division and certified by New Mexico Credentialing Board for Behavioral Health Professionals as a certified family support worker. FPSS provide support services to individuals and families and can be employed on a contract basis or full-time for other positions for which they are qualified. Following is contact information for entities that can help connect providers with family support specialists: CYFD Behavioral Health Services (cyfd.org/behavioral-health).

7. A *Clinical* **Supervisor** who provides supervision and serves as a clinical review or resource for the care coordination staff, community liaison staff, health promotion coordinator and peer and family support staff. Supervisors are independently licensed behavioral health practitioners as described in 8.321.2 NMAC and have direct service experience in working with both adult and child populations. Physical health and psychiatric consultants must comply with their respective licensing boards' requirements for supervision.

8. A **Physical Health Consultant** who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC. The consulting clinician will be available to the care team on a consulting basis related to member mental health or substance use conditions. Physical health consultants must comply with their licensing board's requirements for supervision. Either the consulting MD/PCP or the consulting psychiatrist must have the ability to

consult with an addiction specialist or UNM's Project ECHO, which connects community providers with specialists at centers of excellence in real-time collaborative sessions.

9. A *Psychiatric Consultant* who is a physician (MD or DO) licensed by the Board of Medical Examiners or Board of Osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC. The consulting psychiatrist will be available to the care team on a consulting basis related to member mental health or substance use conditions. The psychiatric consultant must comply with their licensing board's requirements for supervision. Either the consulting MD/PCP or the consulting psychiatrist must have the ability to consult with an addiction specialist or UNM's Project ECHO, which connects community providers with specialists at centers of excellence in real-time collaborative sessions.

10. A *Wraparound Supervisor-Coach* must be a Certified Wraparound Facilitator and have completed or be enrolled in the Coach in Training (CIT) track to receive a coaching endorsement. Wraparound Supervisor-Coaches develop and manage individuals and a team of Wraparound facilitators. They are responsible for coordinating the implementation to fidelity of the NM Wraparound CARES model at their agency.

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

For additional information on Wraparound staff qualifications and responsibilities, please access the NM Wraparound CARES Program Manual and Provider Implementation Guide at: www.BHS.NMSU.EDU

A provider that delivers both physical health and behavioral health services on-site may already employ required staff. Examples include: nurses, physician's assistants, pharmacists, social workers, nutritionists, dietitians, Tribal practitioners, licensed complementary and alternative medicine practitioners and exercise specialists. These specialized staff members may also provide services even if not co-located, however these services are not required.

BHSDStar Data Tracking and Requirements

The CLNM provider agency is responsible for collecting data that track care integration services, opt in/opt out affirmations, member authorized data sharing agreement information, assessments, CLNM service plans, and procedures for a continuous quality improvement program. Data must be sufficient to fully inform ongoing quality measurements and include an evaluation of coordination of care and chronic disease management on individual-level clinical

outcomes, and experience and quality of care outcomes at the population level. Specific health home quality indicators are mandated by CMS, and additional state-defined criteria are outlined in the "Compliance and Oversight" section on page 44 of this Manual.

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

To support use of Star, the provider agency must have computers with an internet connection. Additional information on entering data into BHSDStar and OmniCaid systems can be found in the Health Information Technology Section of this manual on page 37.

~~CYFD Wraparound staff work with Health Home providers and participating teams to use Wraparound-specific evaluation tools to measure program fidelity and ensure quality assurance. Please refer to the Compliance and Oversight section of this manual on page 43 for specific tools and measures.~~

Health Home Operations

Identifying Members

Medicaid, Diagnosis Eligibility
Individuals identified for enrollment in CLNM must meet the following criteria:
1. Be a Medicaid enrollee in a "full" eligibility category (excluding partial coverage in family planning, Emergency Medical Services for Aliens (EMSA), and Qualified Medicare Beneficiaries), including Fee for Service recipients or MCO members, who are 18 years of age or older and meet the criteria for Serious Mental Illness; or
2. Be a Medicaid enrollee in a "full" program eligibility category including FFS recipients or MCO members, who are under age 18, or 21 years of age if services were received prior to age 18, who meets criteria for Severe Emotional Disturbance; or
3. Be a Medicaid enrollee in a "full" program eligibility category (excluding partial coverage in family planning, Emergency Medical Services for Non-Citizens (EMSNC), and Qualified Medicare Beneficiaries) including FFS recipients or MCO members, and meet the criteria for Substance Use Disorder, including but not limited to alcohol, opioids, benzodiazepines, cocaine, and methamphetamines.

Note: A member's Medicaid eligibility can be checked in the New Mexico Medicaid Portal: https://nmmedicaid.portal.conduent.com/static/index.htm#ProviderEnrollment

"Full" Medicaid coverage for CLNM purposes includes most categories of eligibility (COE). For a list of those categories *not* covered, please refer to Appendix F, page 73 of this manual.

The criteria for SMI, SED, and SUD diagnoses can be found in Appendix B, beginning on page 47 of this Manual. Individuals eligible for enrollment in CLNM will be broadly identified by ~~HSD~~HCA, MCO, CLNM providers, community members, and ED. Following are additional enrollment considerations:

- A Medicaid recipient can participate in CLNM if he or she is in FFS or Managed Care;
- A member cannot be enrolled with more than one CLNM Health Home simultaneously;
- MCO staff may not enroll a Medicaid recipient into CLNM; only CLNM providers may complete this task.

Identifying Wraparound Members

NM Wraparound CARES serves youth and adolescents with the most complex behavioral health needs, so it is important for CareLink providers to establish relationships with an array of service providers to identify potential clients. Examples of referral sources include: CYFD Child Protective Services and Juvenile Justice Services, schools, residential treatment centers, and treatment foster care providers. MCO may also provide referrals for clients enrolled in either in- or out-of-state residential treatment centers. The Health Home Community Liaison (and other staff) will work with a variety of community providers to inform them of Wraparound and to develop a robust referral network for all members. Health Home and CYFD Wraparound staff will hold "Wraparound 101" education and information sessions for providers, community members, and other community stakeholders to inform them of the Wraparound program and help build referral sources.

To participate in Wraparound, clients must meet the eligibility criteria outlined on page 16 of this manual. Anyone making a referral to a Wraparound provider must complete a Wraparound Referral Form for a prospective client; a formal review conference for each potential client is mandatory. Referral review teams should be comprised of the following members: the individual who made the referral, a representative from the Health Home facilitating care coordination, staff from CYFD Behavioral Health Services, the relevant MCO, appropriate family members or caregivers, and other stakeholders familiar with the client's situation (e.g. agencies or systems with which the client has been involved). Referral review meetings should be held within two (2) business days of the provider's receipt of the Wraparound Referral Form.

For additional information on NM Wraparound CARES, please refer to the NM Wraparound Cares High Fidelity Implementation Plan, available from Children Youth & Families Department, (505) 827-8008 or at www.BHS.NMSU.EDU.

MCO Referral Process

New members may be identified by MCO or other agencies and referred to a CLNM provider. MCOs will refer new members to CLNM Health Homes throughout the year either after the health risk assessment or after the comprehensive needs assessment has been conducted if chronic behavioral health issues have been identified or suspected. In counties with more than one CLNM provider, MCO will implement the procedure below to refer clients not enrolled in a Health Home to the most appropriate provider. MCO will provide information on both Health Homes to help clients make an informed choice, and make a referral based on the following criteria:

- Geography;
- Cultural or linguistic preferences;
- Provider specialties (e.g. MST or IOP if indicated);
- Capacity (to avoid putting a client on a wait list).

MCOs will provide all referral information to the appropriate Health Home, which can reach out to the member.

Enrolling Members

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

Enrollment of ~~*Centennial*~~ *Turquoise Care Members*

Phase 1:

For members enrolled in ~~Centennial~~ Turquoise Care who are eligible for CLNM services and *are already engaged with a CLNM provider for other services*, the provider will identify clients they believe may meet CLNM enrollment criteria and contact them to determine interest in and eligibility for enrollment in CLNM.

Phase 2:

For counties in which there is only one CLNM Health Home

MCOs and providers will work to engage and enroll MCO members potentially eligible for CLNM services who *have not engaged directly with a CLNM provider*. For those members, ~~HSD~~ HCA will

provide MCOs with a list of members who have a behavioral health diagnosis within the SMI/SED/SUD criteria and are not enrolled in Health Homes. MCOs will send a letter (template to be provided by ~~HSD~~HCA) to members from the lists who live in an eligible county. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the provider to describe the program and determine their interest in participating. The lists of potential members will also be sent to each CLNM provider in the appropriate counties.

CLNM providers will contact MCO members to arrange an appointment to determine eligibility and interest and will opt-in members who express interest and meet eligibility criteria. Opt-in determinations will be transmitted through OmniCaid to MCOs on a nightly basis, and MCOs will transfer care coordination to the CLNM provider for those members who opt-in to the Health Home program. Those who do not meet the SMI/SED criteria after evaluation will be advised by Health Home care coordinators that they will continue to receive care coordination services through their MCO.

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

For counties in which there is more than one CLNM Health Home
The MCO will send a letter to members living in an eligible county who have a behavioral health diagnosis within the SMI/SED criteria. The letter will inform them of the CLNM program, their potential eligibility, and that they will be contacted by the provider of their choice to introduce the program and ascertain their interest in participating. The letter will contain a brief description and location of each health home in their county, and request they contact ~~HSD~~ HCA to select a provider. ~~HSD~~ HCA staff will refer individuals to the appropriate provider and advise the provider of the member's interest. Health Home providers will follow-up with members to determine interest and eligibility. From that point forward, the enrollment process described above should be followed.

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

Medicaid recipients enrolled in FFS Medicaid who are not engaged with a provider
For counties in which there is one CLNM provider

~~HSD~~ HCA will send a letter to recipients who live in an eligible county and have a behavioral health diagnosis within the SMI/SED spectrum to inform them of the CLNM program and their potential eligibility. The letter will advise individuals that they will be contacted by the area provider to introduce the program and determine their interest in participating. Simultaneously, the list of potential CLNM members will be uploaded to the BHSDStar system and individuals described as "registrant" (care coordination level 8). The provider will contact FFS individuals to arrange an appointment for an evaluation to determine eligibility and interest. Providers will opt in referred individuals identified through this process who wish to participate.

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

For counties in which there is more than one CLNM provider

~~HSD~~ HCA will send a letter to recipients who live in an eligible county and have a behavioral health diagnosis within the SMI/SED criteria to inform them of the CLNM program, their potential eligibility, and a description of each CLNM provider in the county. The letter will advise the member they can be referred to any providers on the list, and that they will receive a call to follow-up on their interest in the program and choice of providers. Those interested will be referred to the appropriate provider and advised they will be contacted to schedule an appointment. ~~HSD~~ HCA will provide registration lists to the appropriate providers. From that point forward, the process described on page 24 should be implemented.

Enrollment of Walk-in Clients

Individuals who are not CLNM members and are being seen for the first time by a CLNM provider should be screened to determine their potential eligibility for the program. The provider may introduce CLNM and opt the individual in if they are interested and eligible.

Members who do not sign release of information forms

If an eligible individual refuses to sign consent forms or data sharing agreements necessary to share confidential information with and among providers, the provider agency should inform the individual that information sharing is necessary for their care management. If the individual still refuses to sign the agreement, the provider agency has the option of not enrolling the member. The provider agency should note the reason for the opt-out in BHSDStar.

Enrollment Timing/Documentation

A form documenting that CLNM members have affirmatively agreed to opt-in to CLNM must be retained on file for the provider to receive reimbursement for delivery of CLNM services. The activation information can be entered in BHSDStar at any time and will be automatically transmitted to the OmniCaid system and subsequently to MCOs on a daily basis, however, the effective date of enrollment can only be the first day of a month. It is the responsibility of the provider agency to communicate this information to potential CLNM members. If the delivery of services, including a diagnostic evaluation to determine eligibility, occurs before enrollment or before the first day of the month, the CLNM agency will bill the MCO or Conduent for each service rendered.

Information from MCO to provider upon member enrollment

In cases where the MCO is already providing services to the CLNM member, the following documents/information may be transferred from the MCO to the CLNM via the DMZ file, secure e-mail, or any other secure method the two parties have agreed upon. The DMZ contains folders for each MCO within each of the CLNM providers' folders. If documentation is unavailable, the MCO is to note the reason such as, "CNA not completed" or "no signed release of information". Documents to be transferred to providers:

- HRA if no CNA;
- Most recent CNA;
- Comprehensive care plan;
- NF LOC service plan;
- Client contact special considerations (e.g. notes/alerts for vicious animals)
- Established power of attorney;
- Emergency plan (e.g. plan for client in the event of a weather emergency, loss of electricity, etc.);
- A cover sheet to indicate no documents are available;
- Back-up plan (the plan to provide services if a caregiver is ill or designated support system is unavailable).

Transitioning a Member who relocates

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

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

If the original CLNM provider rendered any of the six core services during the month the member relocates, they should bill the PMPM for that month. If the new provider also provides services to the same member, they can bill for other services (e.g. diagnostic evaluation, therapy, and group therapy) using the CMS 1500 form. They cannot bill for any of the six core CLNM services. CLNM providers should notify each other of a member's relocation so the member can be opted out of the first Health Home and opted in to the second.

Disenrolling Members

Opting out from CLNM does not affect an individual's access to services, with the exception of CLNM-specific services offered only to participants in the CLNM program. Documentation that Medicaid members have elected to opt out of CLNM must be retained on file. To disenroll a member the CLNM provider will enter the opt-out information in the BHSDStar activation module. The Star interface will transmit this information through OmniCaid, which will then transmit the information to the relevant MCO. The MCO will also change the member's care coordination level back to a "2" or "3". Additionally, the CLNM provider will notify the MCO, and work with them to deliver a "warm transfer" of the individual to the MCO to assume or resume its care coordination activities.

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

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

CLNM providers should check the Medicaid portal each time a member has an appointment to verify Medicaid eligibility and MCO. Members may lose Medicaid eligibility or fail to renew ~~renew~~ their Medicaid, and may not necessarily notify their provider or MCO of the change in eligibility status. Once a provider establishes a member's ineligibility, the provider will: (1) help the individual renew Medicaid eligibility if appropriate, or (2) disenroll the individual in BHSDStar with an effective end date of the end of that month. The CLNM provider should notify the MCO any time they disenroll a member, and transmit all documents related to the member's health and services through the DMZ.

Service Accessibility for CLNM Members—Hours of Operation

Each provider shall have a plan for providing necessary care coordination services outside of regular business hours (9:00 AM – to 5:00 PM). "Outside of regular business hours" operations mean compliance with Section 8.321.2 of New Mexico Administrative Code (NMAC). This section states that a specialized behavioral health provider "must maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the Medicaid-eligible recipient, make referrals as necessary and provide follow-up to the Medicaid eligible recipient." CLNM members should be provided with information about how to reach their care coordinator or other qualified. member of the CLNM team in the event of an emergency that may occur evenings or weekends.

HIPAA

The provider agency must comply with applicable provisions of the federal Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191). This includes, but is not limited to, the requirement that the provider agency's management information system (MIS) complies with applicable certificate of coverage, data specifications, and reporting requirements promulgated pursuant to HIPAA.

The provider agency must also comply with HIPAA electronic data interchange (EDI) requirements and notification requirements, including those set forth in the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act, P.L. 111-5). The provider agency shall notify the MCO and ~~HSD~~ HCA of all breaches or potential breaches of unspecified PHI, as defined by the HITECH Act, without unreasonable delay and in no event later than thirty (30) calendar days after discovery of the breach or potential breach. If, in ~~HSD~~ HCA's determination, the CLNM provider has not provided notice in the manner or format prescribed by the HITECH Act, ~~HSD~~ HCA may require the provider to provide such notice.

Disclosure and Confidentiality of Information
Confidentiality
The provider agency, its employees, agents, consultants or advisors must treat all information obtained through a CLNM provider's delivery of services including, but not limited to, information relating to CLNM members, potential recipients of ~~HSD~~ HCA services and the associated providers, as confidential information to the extent that confidential treatment is provided under State and federal law, rules, and regulations.
The provider is responsible for understanding the degree to which information obtained through the performance of this service is confidential under State and federal law, rules, and regulations.

The provider and all consultants, advisors or agents shall not use any information obtained through performance of this service in any manner except as is necessary for the proper discharge of obligations and securing of rights under this service.

Within 60 calendar days of the effective date of service implementation, the provider shall develop and provide to the CLNM Steering Committee for review and approval written policies and procedures for the protection of all records and all other documents deemed confidential. Any disclosure or transfer of confidential information by the provider will be in accordance with applicable law. If the provider receives a request for information deemed confidential under this Agreement, the provider will immediately notify the MCO or MAD of such request and will make reasonable efforts to protect the information from public disclosure.

In addition to the requirements delineated in this Section, the provider shall comply with any policy, rule, or reasonable requirement of ~~HSD~~ HCA that relates to the safeguarding or disclosure of information associated with CLNM members, the provider's operations, or the provider's performance of this service.

In the event of the expiration of this service or termination thereof for any reason, all confidential information disclosed to and all copies thereof made by the provider shall be returned to ~~HSD~~ HCA or, at ~~HSD~~ HCA's request, erased or destroyed. The provider agency shall provide ~~HSD~~ HCA with certificates evidencing such destruction.

The provider's contracts with practitioners and other providers shall explicitly state expectations about the confidentiality of ~~HSD~~ HCA's confidential information and CLNM member records. The provider shall afford CLNM members and/or representatives the opportunity to approve or deny the release of identifiable personal information by the provider agency to a person or entity outside of the provider, except to duly authorized providers or review organizations, or when such release is required by law, regulation or quality standards.

The obligations of this Section shall not restrict any disclosure by the provider pursuant to any applicable law, or under any court or government agency, provided that the provider shall give prompt notice to ~~HSD~~ HCA of such order.

Disclosure of ~~HSD~~ HCA's Confidential Information
The provider will immediately report to ~~HSD~~ HCA and MCO as appropriate any and all unauthorized disclosures or uses of confidential information of which it or its consultants or agents is aware or has knowledge. The provider acknowledges that any publication or disclosure of confidential information to others may cause immediate and irreparable harm to ~~HSD~~ HCA and may constitute a violation of State or federal statutes. If the provider, its consultants or agents should publish or

disclose confidential information to others without authorization, ~~HSD~~ HCA will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. ~~HSD~~ HCA will have the right to recover from the provider all damages and liabilities caused by or arising from the providers', its representatives', consultants', or agents' failure to protect confidential information. The provider will defend with counsel approved by ~~HSD~~ HCA, indemnify and hold harmless ~~HSD~~ HCA from all damages, costs, liabilities, and expenses caused by or arising from the providers', representatives', consultants' or agents' failure to protect confidential information. ~~HSD~~ HCA will not unreasonably withhold approval of counsel selected by the CLNM Health Home.

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

Member Records
The provider shall comply with the requirements of State and federal statutes, including the HIPAA requirements set forth in this Agreement, regarding the transfer of CLNM member records.

The provider shall have an appropriate system in effect to protect substance abuse CLNM member records from inappropriate disclosure in accordance with 42 U.S.C. § 300x-53(b), 42 U.S.C. § 290-dd-2 and regulations (42 C.F.R. Part 2), and 45 C.F.R. § 96.13(e).

If this Agreement is terminated, ~~HSD~~ HCA may require the transfer of CLNM member records, upon written notice to the provider, to another entity, as consistent with federal and State statutes and applicable releases.

The term "member record" for this Section means only those administrative, enrollment, case management and other such records maintained by the provider and is not intended to include patient records maintained by participating contract providers.

Requests for Public Information
When the provider produces reports or other forms of information that the provider believes consist of proprietary or otherwise confidential information, the provider shall clearly mark such information as confidential information or provide written notice to ~~HSD~~ HCA that it considers the information confidential.

If ~~HSD~~ HCA receives a request, filed in accordance with the New Mexico Inspection of Public Records Act (IPRA), NMSA 1978, 14-2-1 et seq. seeking information that has been identified by the provider as proprietary or otherwise confidential, ~~HSD~~ HCA will deliver a copy of the IPRA request to the provider.

Unauthorized Acts
Each Party agrees to:

- Notify the other parties promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any confidential information or any information identified as confidential or proprietary;

- Promptly furnish to the other parties full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Parties in investigating or preventing the recurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of confidential information;

- Cooperate with the other Parties in any litigation and investigation against third parties deemed necessary by such party to protect its proprietary rights; and

- Promptly prevent a recurrence of any such unauthorized possession, use, or knowledge of such information.

Information Security

CLNM and all its consultants, representatives, providers and agents shall comply with all applicable statutes, rules, and regulations regarding information security, including without limitation the following ~~Centennial~~ Turquoise Care Agreement Requirements:

7.26.6.1.1   Health and Human Services Enterprise Information Security Standards and Guidelines;
7.26.6.1.2   HIPAA;
7.26.6.1.3   HITECH Act;
7.26.6.1.4   NMAC 1.12.20 et seq.

Referrals and Communication

The provider agency is required to meet the integrated physical, behavioral, and long-term health needs of its CLNM members by partnering with physical and behavioral health providers, support service agencies, and long-term care providers. This will require referral and communication protocols, which in some cases, are to be outlined in MOAs. MOAs are required for the following: at least one primary care practice in the area that serves members less than 21 years of age; at least one primary care practice that serves members age 21 and older; local hospitals, and residential treatment facilities. MOAs are not required for support services agencies such as food banks.

MOA and other referral and communication protocols will be submitted to the Steering Committee for review as part of the application or readiness review process. For partnerships that require MOA, the referral process shall include acknowledgment of the referral and follow-up with the member by both participating partners. Once a referral is made, the provider may request relevant data on the CLNM member, including his or her service plan, unless the member does not authorize such data exchange. For example, if a member is referred for follow-up primary care, the provider will work with the CLNM member and its primary care partner to schedule follow-up care. Once the referral is finalized, the primary care office may request relevant health data on the member and will provide necessary follow-up care. If after-care is

scheduled, the CLNM provider will confirm that the appointment occurred and check on outstanding care or treatment issues that arose during the appointment. As part of the provider's reporting requirements, the communication loop of referrals and follow-up will continue to be tracked.

For partnerships where *MOA are not required*, a good faith effort should be made by the provider to ensure that support services are delivered. The provider agency must identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up activities post-engagement. Common linkages include assistance with continuation of healthcare benefits eligibility, disability benefits, housing, legal services, educational supports, employment supports, IHS and Tribal programs, DME, and other personal needs consistent with recovery goals and the Service plan. The care provider or care coordinator will make referrals to community services, link clients with natural supports and ensure that these connections are solid and effective. For referrals such as durable medical equipment, a care coordinator will work with the member's physical health providers and MCO to obtain necessary equipment. Care coordinators are responsible for documenting outcomes of referrals, including notation of follow-up activities and any additional recommendations resulting from referrals.

Grievances and Appeals

CLNM care coordinators are responsible for assisting members with appeals and grievances, including, but not limited to, explaining the right of appeals process and reporting grievances. Coordinators will contact a member's MCO and/or ~~HSD~~ HCA for instructions on the process for filing a grievance or appeal, including timeframes and contact information. Procedures for grievances and appeals shall follow the requirements described in 8.308.15 NMAC.

Critical Incident Reporting

All providers delivering Medicaid-funded services to individuals receiving Home- and Community-Based Services, including CLNM providers, are required to report critical incidents to the State.

MCOs are required to research and investigate critical incidents and will collaborate with CLNM care coordinators to fulfill this requirement when a CLNM member is involved. New Mexico State statutes and regulations define the expectations and legal requirements for properly reporting recipient-involved incidents in a timely and accurate manner. The provider agency is responsible for understanding and complying with these requirements and are required to attend annual critical incident training held by the MCOs.

To assist providers in understanding and complying with critical incident reporting, guidelines and forms for CI reporting are available at: ~~http://www.hsd.state.nm.us/ providers/critical-incident-reporting.aspx~~ Critical Incident Reporting – New Mexico Health Care Authority

For questions about reporting or to obtain passwords and access to the reporting portal email the ~~HSD~~HCA Critical Incident team at: ~~HSD-QB-CIR@state.nm.us~~HCA-QB-CIR@hca.nm.gov.

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The ~~HSD~~ HCA Critical Incident Portal ~~email address~~ link is:[Critical Incident Reporting – New Mexico Health Care Authority](#)

MCO Role

The MCO shall comply with Section 2703 of the Patient Protection and Affordable Care Act (PPACA) and in accordance with the Medicaid State Plan Amendment to provide a comprehensive system of care coordination for Medicaid-eligible individuals with chronic conditions targeting a vulnerable population with behavioral health care needs through CLNM Health Homes.

The MCO will serve a complementary, but not duplicative, role in the delivery of CLNM services, beginning with identifying and contacting their members who meet CLNM eligibility requirements and referring interested MCO members to providers for enrollment in CLNM. The MCO shall ensure that Health Homes provide the delegated care coordination functions for members enrolled with a Health Home. Delegated Health Home Care Coordination responsibilities include the following:

- Perform a Comprehensive Needs Assessment (CNA) for Health Home Members who meet the criteria. For members in a Health Home that uses the Treat First Model, an in-home visit will be required within 6 months;
- Assign Care Coordination levels for each Health Home member;
- Adhere to Care Coordination activities for level 2 or level 3 as set forth in the ~~HSD~~ HCA Policy Manual;
- Develop and implement Comprehensive Care Plans (CCP) for members in Care Coordination levels 2 and 3 to monitor, on an ongoing basis, the effectiveness of the care coordination process;
- Develop and implement policies and procedures for ongoing identification of members who may be eligible for a higher level of care coordination, and refer them to an appropriate Health Home;
- Develop and implement policies and procedures for ongoing care coordination to ensure that members receive all necessary and appropriate care;
- Monitor and evaluate a member's emergency room and behavioral health crisis services utilization;
- Participate in the institutional setting's care planning and discharge planning processes;
- Maintain individual case files for each member;
- Provide training required to perform the care coordination activities, and;
- Ensure that members transition to another MCO in accordance with ~~HSD~~ HCA's protocols.

The MCO will provide available member documentation to the Health Home, including but not limited to:

- HRA if no CNA;
- Most recent CNA;

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

Documents may be uploaded to the DMZ for secure transfer; all CLNM providers have folders for each MCO in their DMZ folder.

Additionally, MCO are responsible for:
- Conducting initial HRA for members, including initial recommendations and referrals to CLNM providers;
- Processing prior authorization requests from CLNM providers;
- Processing and oversight of all CLNM member claims and/or encounter data;
- Conducting the NF LOC assessment, including the ~~Centennial~~ Turquoise Care Community Benefit Service Questionnaire (CBSQ) with the CLNM care coordinator, and providing results to Health Homes to be incorporated into Service plan (please refer to the NF LOC section below for more information); and
- Establishing per-member-per-month (PMPM) payment agreements on the pass through of care coordination reimbursements from the State to the provider agency;
- Appointing one representative and one alternate representative to participate on the CLNM Steering Committee to help provide direction to and oversight of CLNM providers;
- Assisting CLNM providers in developing MOU with providers and identifying a referral network for CLNM Members; Collecting and reporting on CLNM Member outcome measures identified by the CLNM Steering Committee, and
- Sponsoring the Emergency Department Information Exchange program (EDIE) so CLNM providers may receive real-time notifications of a Member's admission to an ED or a hospital.

MCO are also responsible for developing a contract amendment template to be used to amend MCO contracts with CLNM providers. The contract amendment template should include the following information: that CLNM members are excluded from the MCO care coordination ratio requirements; varying timelines are allowed for completing a CNA and Service plan for CLNM members, and HRA requirements for the MCO are waived if the HRA has not been completed.

Emergency Department, Inpatient Admissions and Residential Services

CLNM providers are responsible for taking a lead role in transitional care activities for members, including interrupting patterns of avoidable hospital ED use, inpatient stays and unplanned readmissions. Provider agencies will work with additional healthcare providers and CLNM members to support proactive health promotion and self-management activities that help ensure timely follow-up appointments, prevention of non-emergency use of the ED, and unplanned readmissions. When a member uses ED services, participating hospitals are required by Section 2703 of the ACA to refer the patient to a provider agency. Referral protocols should be established in MOA with hospitals in the geographic vicinity. CLNM providers will subscribe to the Emergency Dept. Information Exchange (EDIE) service to receive timely notifications of a member's admission to an ED or as a hospital inpatient (see p. 39 for additional information).

Nursing Facility Level of Care (NF LOC)

MCOs will provide training to Health Home providers on the criteria indicating eligibility for a NF LOC designation. If a CNA indicates that a member may qualify for community-based long-term services and supports, the care coordinator must ask the member if they wish to be evaluated for a NF LOC. A MCO care coordinator will identify indicators that may signal a member's eligibility for NF LOC, and relay that information to the provider. If the member is interested in a NF LOC evaluation, the CLNM care coordinator shall arrange for the evaluation with the assigned MCO and will accompany the MCO care coordinator for the member's assessment. If a FFS recipient needs a NF LOC assessment for long-term services and supports, the State requires that the member must enroll with a MCO.

Factors that might indicate a member may be eligible for a NF LOC designation include the following:

- The individual is unable to self-administer "life preserving" medications;
- The individual has a cognitive or physical impairment that limits abilities to complete activities of daily living independently, such as getting dressed, bathing, grooming, eating, and acquiring or preparing food. Mobility and incontinence issues may also be present.

The MCO will be responsible for completing a NF LOC assessment, including the ~~Centennial~~ Turquoise Care Community Benefit Service Questionnaire, for those CLNM members who qualify for Community Benefit Services. If NF LOC criteria are met, the MCO will be responsible for completing the allocation tool which is used to determine the number of hours of personal care services a member receives. The MCO will also develop the community benefit care plan. MCOs will provide the NF LOC assessment and care plans to the CLNM provider to coordinate and monitor utilization of Community Benefit Services. When a NF LOC is established, the care coordinators from the MCO and CLNM provider agency will jointly conduct an in-home assessment. If the

member is eligible for community benefits, the MCO will retain the self-directed care budget, but the CLNM care coordinator will conduct the care management and care coordination.

The MCO will conduct a NF LOC reassessment at least annually, unless the member has an approved Continuous NF LOC eligibility status. A NF LOC reassessment shall also be conducted within five business days of learning of a change in a member's functional or medical status. The CLNM care coordinator is responsible for tracking these dates and ensuring communication regarding the member's needs.

CLNM members who meet the NF LOC designation have access to community-based long-term services and supports including:

- Community Benefits as deemed appropriate based on the CNA;
- The option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit. Members who select the Agency-Based Community Benefit will have a choice of using the consumer-delegated model or consumer-directed model for personal care services.

The CLNM care coordinator shall be familiar with these benefits and ensure the member's choices are reflected in the member's service plan. While the MCO is responsible for the NF LOC assessment, the CLNM care coordinator should be aware that the MCO must complete the CNA and NF LOC determinations within 60 calendar days of the Primary Freedom of Choice (PFOC). The MCO is also responsible for ensuring that the CNA process is initiated within 120 days of the NF LOC-determination expiration. For more information on NF LOC criteria, and instructions from the State, please refer to:
~~https://www.hsd.state.nm.us/providers/nursing-facility-level-of-care.aspx~~ [Nursing Facility Level of Care (NFLOC) – New Mexico Health Care Authority](#)

Health Information Technology

The BHSDStar web-based data collection tool is used to create HIT linkages for provider agencies and ancillary care providers. The modules that support care management activities are comprised of registration and activation and include the member's level of care, a CLNM comprehensive needs assessment that requires behavioral and physical health screenings, and imminent clinical risk assessment, and comprehensive health history and information gathering over the course of four appointments. The care coordinator and member develop a service plan inclusive of short- and long-term goals, service requirements and expected outcomes. BHSDStar modules were developed for use with laptops or tablets.

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

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

CLNM NMStar Modules

Manuals and user guides for staff registration and CareLink client registration, assessments, billing, and data upload may be accessed at: http://www.bhsdstar.org/manuals-guides

Training for the CLNM portion of the Star system may be accessed at the following link:

bhsdstar.org

If you need additional information on the Star system, please contact Star Support at: support@bhsdstar.org

Registration and activation modules

These modules are used to enter basic client contact information and levels of care coordination to enroll a member in the CLNM program. The Member Profile module includes MCO affiliation and Medicaid ID number; this information should be confirmed (and frequently checked) in the New Mexico Medicaid Portal:

https://nmmedicaid.portal.conduent.com/static/index.htm#ProviderEnrollment

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

Client Services Module

Provider staff will use this module to track activities contained within the six core services of the Health Home program, as defined by CMS. The module contains a checklist of all activities within each of the six services, and a field for staff to record time spent conducting each activity. A table on page 41 of this Manual lists CLNM procedural codes for billing.

CLNM Comprehensive Needs Assessment

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

CLNM Service Plan

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

Quality

The provider agency is responsible for collecting and using data that support a continuous quality improvement program. Data must be sufficient to fully inform the following:

- Ongoing quality measurements;
- An evaluation of coordinated, integrated care and chronic disease management on individual-level clinical outcomes;
- Experience of care outcomes;
- Quality of care outcomes at the population level.

Please see the "Quality and Outcomes" section on page 43 for more information. Appendix C of this manual (page 60) contains evaluation criteria for the CLNM program.

EDIE PreManage

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

PRISM Risk Management

PRISM, a predictive risk management tool based on 15 months of rolling claims data affords CLNM providers with options to target care management services based on predictive risk scores and utilization data. Using this tool, care coordinators can review the relationship between PRISM predictive risk scores and alternative methods of targeting based on prior ED or inpatient utilization patterns. Considerations include further prioritizing engagement within the target population or use of predictive risk scores to differentiate levels of care coordination intensity, with corresponding staffing ratio targets. To register for PRISM access, Health Homes will request access from the CLNM Steering Committee through the Program Manager.

Project ECHO

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

https://hsc.unm.edu/echo/get-involved/join-an-echo/

For information about ECHO MAT institutes, please email: RsAlKhafaji@salud.unm.edu.

Meaningful Use

A core service of the CLNM program is the use of HIT to link services for members. To facilitate the use of HIT, CLNM providers are expected to adopt meaningful use practices outlined by the Office of the National Coordinator (ONC). ONC defines "meaningful use" as the use of EHR technology to:

- Improve quality, safety and efficiency, and reduce health disparities;
- Engage patients and families;
- Improve care coordination, and population and public health; and
- Maintain privacy and security of patient health information.

Provider agencies will adopt meaningful use of HIT to:

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

Health Home Reimbursement

PMPM

CLNM providers are reimbursed through a per-member per-month (PMPM) payment specific to each CLNM provider. CLNM-dedicated services include the six core service categories that are not duplicative of ~~Centennial~~ Turquoise Care services. A provider will bill for the approved list of CLNM core services using the CMS 1500. Additional Medicaid-covered services provided to members are billed and reimbursed separately from the approved list of CLMN core services. It is important that providers check a member's Medicaid eligibility frequently to ensure CLNM services will be covered by Medicaid, and that the correct MCO is listed in the member's records.

The PMPM rate will be updated as needed based upon results of analyses, including member enrollment and claims experience. ~~HSD~~ HCA reserves the right to update PMPM rates as

deemed

necessary. The PMPM reimbursement is paid for each CLNM member, regardless of whether the member is enrolled with an MCO or in FFS Medicaid. The provider is responsible for verifying a member's affirmative agreement to participate and opt-in for CLNM services. To be reimbursed, providers must retain a signed opt-in statement in a member's file.

Billing Instructions

- For reimbursement of the PMPM, the G9001 code must be billed with one other service code listed in the table below on the same claim;
- The six services codes shall be billed with a $0.01 price indicated, but will pay $0.00;
- All service codes are to be billed with the actual dates of service and correct time units;
- The facility NPI may be used in the rendering provider field as well as in the billing provider field;
- FQHC that bill other services utilizing a UB claim form and a revenue code shall bill the CLNM codes on a CMS 1500 claim form using HCPCS codes listed below. FQHC will need to obtain a separate NPI and facility ID for CLNM services;
- IHS and 638 tribal facilities will be billing other services utilizing the OMB rate, and shall bill CLNM codes on a CMS 1500 claim form utilizing the HCPCS codes listed below.

Codes for common CLNM-approved services are listed below. Each month, G9001 ~~and/or G9003~~ code~~s~~ and one or more of the six CLNM core service codes listed below must be rendered and claimed to receive a PMPM payment for that month.

CareLink NM Health Care Common Procedure Coding System (HCPCS) codes

Code	Modifier	CareLink NM Code Description	Units
S0280		**Comprehensive Care Management (CCM)** Identify high risk individuals to ensure individuals and their families actively participating in the CNA and service planning. Monitor the implementation of the Service plan and: 1) evolution into member's health care and self-management; 2) use of services; 3) prioritization of transitional care activities. Assign appropriate CLNM team to lead member's care.	15 minutes
T1016	U1	**Care Coordination (CC)** Assigned team leaders coordinate activities of team and local providers to implement the Service plan. Reinforce treatment strategies to increase the individual's motivation to actively self-manage chronic health conditions.	15 minutes
T1016	U2	**Comprehensive Transitional Care** Maximize a member's ability to live safely in the community and minimize the use of out-of-home placements and ED. Assure continuation of the treatment plan across all levels of care such as early discharge planning and proactive prevention of avoidable readmissions. Require effective point-of-service exchange of information, including medication reconciliation and access.	15 minutes
T1016	U3	**Individual and Family Support** Assist members to attain the highest level of health and functionality within the family and broader community. Ensure individual engagements support recovery and resiliency, and involve peer, family and other support groups, Tribal programs, and formal self-care programs as needed.	15 minutes

Code	Modifier	CareLink NM Code Description	Units
T1016	U4	**Referral to Community and Social Support Services** Identify available community-based resources and actively manage appropriate referrals. Engage other community and social supports and follow up post-engagement. Referral may include service providers for: disability benefits, housing, IHS and Tribal programs, legal services, and other personal needs consistent with recovery goals and treatment plans.	15 minutes
T1016	U5	**Prevention and Health Promotion** Coordinate individual, group and environmental strategies aimed at disseminating information to support healthy living and reducing health consequences associated with chronic conditions such as substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.	15 minutes
G9001		**Coordinated care fee**	Capitation PMPM

Compliance and Oversight
Quality and Outcomes

Quality and health outcome measures of CLNM members are crucial. In addition to being a federal requirement of the Health Home program, measurements also provide essential information to the State and eligible providers on program impact to support the underlying goals of the program.

HSD HCA will monitor a set of core health measurements to evaluate health outcomes of CLNM members. The chart of Evaluation Criteria (Appendix C on page 54) lists required health performance measures, designating outcomes as clinical and social determinants of health, experience of care, quality of care, utilization of services, or cost of care. Please note the table is organized by the following five overriding goals of the CLNM program:

1. Promote improvement in acute and long-term health conditions;

2. Prevent risk behaviors;
3. Enhance member engagement and self-efficacy;
4. Improve quality of life for individuals with SMI/SED;
5. Reduce avoidable utilization of emergency departments, inpatient, and residential services.

Much of this information will be captured through providers' use of the BHSDStar service module; other information will be collected through MCO HEDIS data, ~~HSD~~ HCA claims data, and member surveys. Quality reports will be monitored by the Steering Committee at regular intervals to determine program efficacy and as the basis of practice improvement plans if large gaps in health outcomes are identified. ~~HSD~~ HCA will monitor Health Home enrollment, staffing, and caseload ratios monthly and provide data to ~~HSD~~ HCA leadership and Steering Committee members. MCO may monitor enrollment and capacity through these data and BHSDStar tracking.

~~CYFD will work with Health Home providers employing the Wraparound model to use the following additional tools to ensure program fidelity, quality assurance, and quality improvement protocols are in place:~~
1. ~~Wraparound Fidelity Index;~~
2. ~~Wraparound Document Assessment and Review Tool;~~
3. ~~Wraparound Team Evaluation Tool.~~

Monitoring and Oversight
The Steering Committee, comprised of leaders from MAD, BHSD, ~~CYFD~~, UNM Psychiatric Center, and MCOs, is charged with selection of participating agencies, oversight of program implementation, and monitoring of activities.

Monitoring and oversight are intended to monitor agency activities and data to determine conformance to expectations. Expectations are outlined throughout this Policy Manual and in agency-specific plans. ~~An annual year site visit will be conducted with each Health Home provider conducted by a team comprised of representatives from HSD and one representative from each MCO.~~ BHSD publicly funded programs are subject to random site visits. The frequency of these visits varies by service type and is determined by the Health Care Authority. This schedule may change. In addition, BHSD may conduct site visits at its discretion. Factors that may influence visit frequency include program performance, quality improvement needs, provider requests, or requests from the Office of the Secretary. The visit will include monitoring and oversight protocols to review membership, comprehensive case management, care coordination, health promotion and disease management, comprehensive transitional care, individual and family support services, referral to community and social support services, wraparound, integration of behavioral health and physical health, staffing, caseload ratios, and other aspects of program implementation.

Monitoring this information enables the Program Manager and Steering Committee to identify

challenges and barriers, and to work with providers to develop practice improvement strategies when needed.

Data and information sources include:

1. System data derived from BHSDStar ~~HSD~~ HCA claims data and member surveys. Star data include quality and outcome evaluation metrics as well as well as measures that track service delivery and referrals (e.g., numbers of members receiving each service, frequency, and amounts).

2. Qualitative case review information derived from BHSDStar and provider-specific EHR that will allow for comparisons of the Comprehensive Needs Assessment (CNA), the service plan, service delivery, and referrals for consistency.

3. Interviews with and/or reports from providers that yield descriptions and explanations of findings from system data and case reviews. This will include ~~HSD~~ HCA oversight of staffing levels and compliance with caseload ratio recommendations (listed on page 8).

Findings from oversight and monitoring will help inform future CLNM strategies with ~~HSD~~ HCA leadership. Any deficiencies noted in oversight and monitoring will be presented to the CLNM Steering Committee for review and further action. Additional education and technical support may be provided to Health Homes to address noted issues. Tools and measures used for monitoring and oversight shall be shared with providers to facilitate and foster proactive, continuous quality improvement efforts.

CLNM Member files (paper or electronic) must at minimum include the following:

- Participation agreement;
- Initial CNA and all reassessments;
- Initial CLNM service plan and subsequent updates;
- Service tracking of member;
- Referral tracking of member;
- All releases of information signed by the member;

Long-term Evaluation

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

Health Home Appendices

Appendix A – Acronyms

ACA	Patient Protection and Affordable Care Act
AOD	Alcohol or Other Drugs
BHA	Behavioral Health Agency
BHSD	Behavioral Health Services Division
~~CANS~~	~~Child and Adolescent Needs and Strengths assessment~~
CBSQ	Community Benefit Service Questionnaire
CCSS	Comprehensive Community Support Services
CLNM	CareLink New Mexico
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNA	Comprehensive Needs Assessment
COE	Category of Eligibility
CRA	Comprehensive Risk Assessment
CSA	Core Service Agency
EDIE	Emergency Department Information Exchange
EHR	Electronic Health Records
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HIPAA	Health Information Portability and Accountability Act
HIT	Health Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HRA	Health Risk Assessment
~~HSD~~ HCA	New Mexico ~~Human Services Department~~ Healthcare Authority
ICF/MR/DD	An individual with an intellectual or developmental disability with an intermediate care facilities level of care.
IHS	Indian Health Services
IPRA	New Mexico Inspection of Public Records Act
MAD	Medical Assistance Division
MCO	Managed Care Organization
MIS	Management Information System
MMIS	Medicaid Management Information System
NF LOC	Nursing Facility Level of Care
NMAC	New Mexico Administrative Code
NMSA	New Mexico Statutes Annotated
PFOC	Primary Freedom of Choice
PHI	Protected Health Information
PMPM	Per Member Per Month
PPA	Provider Participation Agreement
ROI	Release of Information
ROI	Return on Investment

SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorder
UR	Utilization Review

Appendix B – Criteria for SMI, SED and SUD

Criteria for Severe Emotional Disturbance Determination

Age
Less than 18 years of age, or between ages of 18 and 21, who received services prior to eighteenth birthday, was diagnosed with a SED, and demonstrates a continued need for services.

Diagnoses must meet category A or B below
A. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM). Please note: diagnoses that are included are only those providing a primary reason for receiving public system behavioral health services.
    - Neurodevelopmental Disorders (299.00, 307.22, 307.23, 307.3, 307.9, 314.00, 314.01, 315.4, 315.35, 315.39, 315.8, 315.9, 319)
    - Schizophrenia Spectrum and other Psychotic Disorders (293.81, 293.82, 295.40, 295.70, 295.90, 297.1, 298.8, 293.89, 298.8, 301.22)
    - Bipolar and Related Disorders (293.83, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.89)
    - Depressive Disorders (296.99, 293.83, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 300.4, 31, 625.4)
    - Anxiety Disorders (293.84, 300.00, 300.01, 300.02, 300.09, 300.22, 300.23, 300.29, 309.21, 300.23)
    - Obsessive-Compulsive Related Disorders (294.8, 300.3, 300.7, 312.39, 698.4)
    - Trauma-and Stressor Related Disorders (308.3, 309.0, 309.24, 309.28, 309.3, 309.4, 309.81, 309.89, 309.9, 313.89)
    - Dissociative Disorders (300.12, 300.13, 300.14, 300.15, 300.6)
    - Somatic Symptom and Related Disorders (300.11, 300.19, 300.7, 300.82, 300.89
    - Feeding and Eating Disorders (307.1, 307.50, 307.51, 307.52, 307.53, 307.59)
    - Elimination Disorders (307.6, 307.7, 787.60, 788.30, 788.39
    - Disruptive, Impulse Control and Conduct Disorders (312.32, 312.33, 312.34, 312.81, 312.89, 312.9, 313.81)
    - Substance-Related and Addictive Disorders (292.9, 303.90, 304.00, 304.20, 304.30, 304.40, 304.50, 304.60, 304.90)
B. The term *complex trauma* describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. To qualify as a complex trauma diagnosis, the child must have experienced one of the following traumatic events:
    - Abandoned or neglected;
    - Sexually abused;
    - Sexually exploited;

- Physically abused;
- Emotionally abused;
- Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events listed above, there must also be an *exparte* order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

Functional Impairment
The child/adolescent must have a functional impairment in two of the listed capacities:
- Functioning in self-care: Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
- Functioning in community: Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.
- Functioning in social relationships: Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.
- Functioning in the family: Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, in- ability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by: rarely or minimally seeking comfort in distress; limited positive affect and excessive levels of irritability, sadness or fear; disruptions in feeding and sleeping patterns; failure, even in unfamiliar settings, to check back with adult caregivers after venturing away; willingness to go off with an unfamiliar adult with minimal or no hesitation; regression of previously learned skills;
- Functioning at school or work: Impairment in school/work function is manifested by an inability to pursue educational goals in a normal timeframe (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

Symptoms
Individuals manifest symptoms in one of the following categories:
- Psychotic symptoms: Symptoms are characterized by defective or lost contact with reality, often with

hallucinations or delusions;

- Danger to self, others and property as a result of emotional disturbance: The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property;
- Mood and anxiety symptoms: The disturbance is excessive and causes clinically significant distress which substantially interfere with or limit the child's role or functioning in family, school, or community activities;
- Trauma symptoms: Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:
  - a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns;
  - under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial;
  - under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse;
  - over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed;
  - episodes of recurrent flashbacks or dissociation that present as staring or freezing.

Duration
The disability must be expected to persist for six months or longer.

Criteria for Serious Mental Illness Determination
Age
The individual must be an adult 18 years of age or older.

Diagnoses
The individual must have one of the diagnoses specified in the list below as defined under the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.* The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.

- Schizophrenia (295.90)
- Other Psychotic Disorders
  - Delusional Disorder (297.1);
  - Schizoaffective Disorder (295.70)
  - Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (298.8)
  - Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (298.9)
- Major Depression and Bipolar Disorder
  - Major Depressive Disorder (296.xx)

- Bi-Polar Disorders (296.xx except Unspecified Bi-Polar and Related Disorder 296.80)

- Other Mood Disorders
  - Cyclothymic Disorder (301.13)
  - Persistent Depressive Disorder (300.4)
- Anxiety Disorders
  - Panic Disorder (300.01)
  - Generalized Anxiety Disorder (300.02)
- Obsessive Compulsive & Related Disorders
  - Obsessive Compulsive & Related Disorders (300.3)
- Trauma and Stressor-Related Disorders:
  - Posttraumatic Stress Disorder (309.81)
- Eating Disorders
  - Anorexia Nervosa (307.1)
  - Bulimia Nervosa (307.51)
- Somatic Symptom and Related Disorders
  - Conversion Disorder (300.11)
  - Somatic Symptom Disorder (300.82)
  - Factitious Disorder Imposed on Self (300.19)
- Dissociative Disorders
  - Dissociative Amnesia (300.12)
- Dissociative Identity Disorder (300.14)
- Personality Disorders (for which there is an evidence-based clinical intervention)
  - Borderline Personality Disorder (301.83)

Functional Impairment
The disturbance is excessive and causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.

Duration
Duration of the disorder is expected to be six months or longer.

In order to receive a diagnosis of SMI, a person must meet one of the following criteria in Section A or Section B in addition to one of the diagnoses listed above.

A. Symptom Severity and Other Risk Factors:
- Significant current danger to self or others or presence of active symptoms of a SMI;
- Three or more emergency room visits or at least one psychiatric hospitalization within the last year;
- Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions, emotional/behavior/cognitive conditions;
- Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic

event.

B. Co-occurring Disorders
- Substance Use Disorder diagnosis and any mental illness that affects functionality;
- SMI or Substance Use Disorder and potentially life-threatening medical condition (e.g., diabetes, HIV/AIDS, hepatitis);
- SMI or Substance Use Disorder and Developmental Disability.

Criteria for Substance Use Disorder Determination

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

A brief description of ASAM levels of care follows. For a detailed description of services typically offered in each level of care, the care setting, and how to identify which patients would benefit best from services based on an ASAM dimensional needs assessment, please refer to *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (Third Edition, 2013).*

- ASAM Level 0.5 – Early Intervention for Adults and Adolescents, this level of care constitutes a service for individuals who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder.
- ASAM Level 1 – Outpatient Services for adolescents and adults, this level of care typically consists of less than nine hours of service per week for adults, or less than six hours per week for adolescents that focus on recovery or motivational enhancement therapies and strategies. Level 1 encompasses organized services that may be delivered in a wide variety of settings.
- ASAM Level 2.1 –Intensive Outpatient Services for adolescents and adults, this level of care typically consists of nine or more hours of service per week or six or more hours for adults and adolescents, respectively, to treat multidimensional instability. Level 2 encompasses services that can meet the complex needs of people with addiction and co-occurring conditions. This level is comprised of organized outpatient services that deliver treatment services during the day, before or after work or school, in the evening, and/or on weekends.
- ASAM Level 2.5 – Partial Hospitalization Services for adolescents and adults, this level of care typically provides 20 or more hours of service per week for multidimensional instability that does not require 24-hour care. Level 2 encompasses services that can meet the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services usually during the day as day treatment, or partial hospitalization services.

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services, this adolescent and adult level of care typically provides a 24-hour living support and structure with available trained personnel and requires a minimum of five hours of clinical service per week in recovery skills development. This level is often a step-down from a higher level of care and prepares the recipient for transition to the community and outpatient services.
- ASAM Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services, this adult-only level of care typically offers 24-hour care with trained counselors to stabilize multidimensional imminent danger along with less intense milieu and group treatment for those with cognitive or other impairments who are unable to use full active milieu or therapeutic community.
- ASAM Level 3.5 – Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults. This level of care provides 24-hour care with trained counselors to stabilize individuals in multidimensional imminent danger and prepare for outpatient treatment.
- ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services for adolescents and Medically Monitored Intensive Inpatient Services Withdrawal Management for adults, this level of care provides 24-hour evaluation and monitoring services. Organized services are delivered by medical and nursing professionals under the direction of a physician or clinical nurse practitioner who is available by phone 24 hours per day. Patients in this level of care require medication and have a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter continuing addiction treatment. This is the appropriate setting for patients with subacute biomedical and emotional, behavioral, or cognitive problems that are so severe they require inpatient treatment.

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

Levels of Care – Withdrawal Management
- ASAM 3.2-WM - Clinically managed residential withdrawal management services as specified in *The ASAM Criteria,* requiring 24-hour support for moderate withdrawal; managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions; facility has an ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health, and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The recipient remains in a level 3.2 withdrawal management program until: withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipients' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated.
- ASAM 3.7-WM - Medically monitored inpatient withdrawal management services as specified in *The ASAM Criteria*. This level of care requires 24-hour nursing care and physician visits as needed for severe withdrawal; services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician.

Recipients are monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions. Providers must have the ability to arrange for appropriate laboratory and toxicology tests and provide a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. The recipient remains in a level 3.7 withdrawal management program until: withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or the recipients' signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal

- management service is indicated.

Sources: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document*, and* Desk Reference to the Diagnostic Criteria from DSM-5. *Page 1 of 5*

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – Persistent (chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention –Deficit/Hyperactivity Disorder: Predominantly inattentive presentation
Neurodevelopmental Disorders	314.01	F90.1	Attention –Deficit/Hyperactivity Disorder: Predominantly hyperactive/impulsive presentation
Neurodevelopmental Disorders	314.01	F90.2	Attention –Deficit/Hyperactivity Disorder: Combined presentation
Neurodevelopmental Disorders	314.01	F90.8	Attention –Deficit/Hyperactivity Disorder: Other Specified Attention –Deficit/Hyperactivity Disorder
Neurodevelopmental Disorders	314.01	F90.0	Attention –Deficit/Hyperactivity Disorder: Unidentified Attention –Deficit/Hyperactivity Disorder
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder or Unspecified Catatonia
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify: With manic features or with manic hypomanic-like episode
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition– With mixed features
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders Due to Another Medical Condition (80)– with depressive features
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders Due to Another Medical Condition (80) -with major depressive-like episodes
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders Due to Another Medical Condition (80) – with mixed features
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder Due to Another Medical Condition

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive Related Disorder, Unspecified Obsessive-Compulsive Related Disorder
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions and conduct
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other Specified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma- and Stressor-Related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom) Disorder. Specify: with attacks of seizures; or with special sensory loss

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom Disorder – with anesthesia or sensory loss)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom Disorder – with mixed symptoms)
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and Related Disorders
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa - Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa– Binge-eating/Purging type
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct Disorders	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct Disorders	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct Disorders	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct Disorders	312.89	F91.8	Other Specified Disruptive Impulse-Control, and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	312.9	F91.9	Unspecified Disruptive, Impulse Control and Conduct Disorder
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild, Moderate, Severe
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available] for SMI	301.83	F60.3	Borderline Personality Disorder

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder –Phencyclidine Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders - Moderate, Severe

Appendix C - CLNM Evaluation Criteria

Domains to be evaluated:

1. Clinical & social determinants of health outcomes (OC)
2. Experience of care (EOC)
3. Quality of care (QOC)
4. Utilization of services (SU)
5. Cost of care ($)

Goal I: Prevent Risk Behaviors
Screen for common chronic conditions and risk behaviors in individuals with SMI/SED, SUD

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

Screening for clinical depression and follow up plan [CDF] **CMS criteria**	B Ages 12 & >	QOC	Semi-annual	% of members age 12+ screened for clinical depression using an age-appropriate standardized depression screening tool, and if positive, had a follow-up plan documented on the date of the positive screen	+/-	Star service Tracking
Adult Body Mass Index Assessment (BMI) – adults [ABA] **CMS criteria**	A	QOC	Annual	% of members 18-74 years (those with at least one outpatient visit during the measurement year) who had their BMI documented during the measurement year or the year prior to the measurement year	BMI value	Star Service Tracking
Weight Assessment Children – (BMI)	C	QOC	Semi-annual	% of members ages 3-17 who had visit and had 9 BMI documented during the measurement year or the year prior to measurement year (NOTE: actual BMI will be graphed over time)	BMI value	Star Service Tracking
Diabetes screening for adults that are overweight or obese	A	QOC	Annual	% of adults ages 40-70 who are overweight or obese that had a glucose test or HbA1c	HbA1c or glucose value	Star Service Tracking
Diabetes screening for people who are on atypical anti-psychotics (HbA1C)	B [18+ = Adults?	QOC	Semi-annual	% of members ages 18 & > having a glucose test or an Hba1c during the measurement year	HbA1c or glucose value	Star Service Tracking
Physical examination within 1 month of admission to HH or transfer of records current within the last 12 months	B	QOC	Annual	% of members w physical exam w/in 1 month of HH opt-in	Date of exam	Star Service Tracking
Serum lipid profile for adults with SMI who are on atypical anti-psychotics	A	QOC	Annual	% of members ages 18-74 who had serum lipid profile done	Actual value	Star Service Tracking
Screening for cervical cancer	A	QOC **HEDIS**	Annual	% of women ages 21-64 meeting the criteria	+/-	MCO
Screening for breast cancer	A	QOC **HEDIS**	Annual	% of women ages 50-74 who had a mammogram to screen for breast cancer in measurement year or 2 years prior	+/-	MCO

Effective 1/1/2020

Screening for colon cancer	A Ages 50-75	QOC **HEDIS**	Annual	% of members ages 50-75 who had appropriate screening for colorectal cancer in measurement year & 1 year prior	+/-	MCO
Screening for chronic infectious diseases: HIV	B Ages 11 & >	QOC	Annual	% of members age 11 & > screened	+/-	Star Service Tracking
Screening for chronic infectious diseases: Hepatitis B	B Ages 11 & >	QOC American Assoc of Pediatrics	Annual	% of members ages 11 & > screened	+/-	Star Service Tracking
Screening for chronic infectious diseases: Hepatitis C	B Ages 11 & >	QOC American Assoc of Pediatrics	Annual	% of members ages 11 & > screened	+/-	Star Service Tracking
Metabolic monitoring for children & adolescents on antipsychotics	C	QOC **HEDIS**	Annual	% of members ages 1–17 (in 3 age stratifications: 1-5 yrs; 6-11 yrs; 12-17 yrs & total) who had 2 or more anti-psychotic prescriptions and had metabolic testing	2 actual values	MCO
Child abuse screening	B	QOC	Annual	% of members screened for past or present child abuse within the measurement year	+/-	Star Service Tracking
Intimate Partner Violence screening	B	QOC	Annual	% of members all ages screened for domestic violence within the measurement year	+/-	Star Service Tracking

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

Intermediate Actions	Adult/ child/ both	Domain	Reporting Frequency	Measure	Value	Data source
Control of diabetes for individuals with a diagnosis of type 1 or type 2 diabetes mellitus	B	QOC	Semi-Annual	% of members with a diagnosis of type 1 or type 2 diabetes mellitus with a hemoglobin A1c (HbA1c) > 9.0% % of members with a diagnosis of type 1 or type 2 diabetes mellitus with a hemoglobin A1c (HbA1c) < 8.0	HbA1c value	Star Service Tracking
Follow-up plan for positive suicide risk screening	B	QOC	Semi-annual	% of members with a plan documented in care plan	y/n	Star Service Tracking
Follow-up plan for positive depression screen (see above, part of **CMS criteria**)	B Ages 12+	QOC	Semi-annual	% of members ages 12 & > with a plan documented on date of positive depression screen	y/n	Star Service Tracking
Treatment plan for BMI >30	B	QOC	Semi-annual	% of members with BMI > 30 who have a treatment plan to address obesity		Star Service Tracking
Treatment plan for BMI < 17.5	B	QOC	Semi-annual	% of members with BMI < 17.5 with a treatment plan to address weight & nutrition		Star Service Tracking
Controlling high blood pressure (Source NCQA) **CMS criteria**	A	OC **HEDIS**	Annual	% of members ages 18-85 with SMI who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year *Note*: measure requires medical chart review	Actual value	Star Service Tracking

Initiation and engagement of alcohol and other drug dependence treatment **CMS criteria**	B Ages 13 & >	QOC **HEDIS**	Annual	% of members ages 13 & > with a new episode of alcohol or other drug (AOD) dependence who 1) initiated treatment through an IP AOD admission, OP visit, IOP encounter, or partial hospitalization within 14 days of diagnosis 2) initiation of treatment and had 2 or more additional services with a diagnosis of AOD within 30 days of the initiation visit engagement of AOD treatment	y/n	MCO
Tobacco cessation follow-up	B Ages 8 & >	OC	Semi-annual	% of members ages 8 & > reporting a reduction or cessation of smoking	y/n	Star Service Tracking
Follow-up after hospitalization for mental illness 7 days (see below, part 2 of 2) **CMS criteria**)	B Ages 6 & >	QOC **HEDIS**	Annual	% of discharges for members ages 6 & > who were hospitalized for treatment of mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge	y/n	MCO
Follow-up after hospitalization for mental illness 30 days **CMS criteria**	B	QOC **HEDIS**	Annual	% of discharges for members who were hospitalized for treatment of mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge	y/n	MCO
Care coordinator involved in discharge planning for IP admissions, residential, NF, or correctional facility	B	QOC	Annual	% of discharges with active participation of HH staff	y/n	Star Service Tracking

Antidepressant medication management (AMM)	A	OC **HEDIS**	Annual	% of members ages 18 & > who were treated with antidepressants, had a dx of major depressive disorder (MDD) and who remained on anti-depressant medication for at least 84 days (12 weeks)	y/n	MCO
Quarterly medication reconciliation with adolescents, adults and PCP	B	QOC	Semi-annual	% of members for whom medications were reconciled by a prescribing practitioner, clinical pharmacist or registered nurse	y/n	Star Service Tracking
Multidisciplinary care management meetings	B	QOC	Semi-annual	% of members that had a multi-disciplinary care team meeting	date	Star Service Tracking
Completed visits for referral	B	QOC	Semi-annual	Composite % of all visits for members for whom referrals have been made and the referral appt. was kept	y/n	Star Service Tracking
Coordinate with school (with parental permission) related to setting of care transitions	C	QOC	Semi-annual	% of care transitions for youth where coordination with school is indicated	y/n	Star Service Tracking

Goal III: Enhance member engagement and self-efficacy (power or capacity to produce a desired effect)

Intermediate Actions	Adult/child/ both	Domain	Reporting Frequency	Measure	Value	Data source
Peer Support	B	QOC EOC	Annual	% of members reporting positive experience w peer support services	y/n	Star Service Tracking & member survey
Family Support	B	QOC EOC	Annual	% of family members reporting positive experience w/family support services		Member survey
Care planning with member/family	B	EOC	Annual	% of members and/or family reporting inclusion in goal development and care planning	y/n	Member survey
Education	B	QOC	Annual	% of members and/or family who report having adequate or higher level of knowledge re: reason, symptomology, and remediation of side effects of prescribed medications	y/n	Member survey
Education Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A	OC **HEDIS**	Annual	% of individuals ages 18 & > with schizophrenia or schizoaffective disorder who had at least 2 rx drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).		MCO
Antidepressant medication management	A	QOC **HEDIS**	Annual	% of members ages 18 and > who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment	y/n	MCO

Knowledge of condition(s)	B	EOC	Annual	% of members and/or family who report having adequate or higher level of knowledge of condition(s)	y/n	Member survey

Goal IV: Improve quality of life for members with SMI/SED (Recovery & Resiliency)

Intermediate Actions	Adult/child/ both	Domain	Reporting Frequency	Measure	Data source
Achievement in goals & activities identified by member	B	OC EOC	Annual	% of members reporting positive progress in identified goals & activities	Member survey
Skills development	B	QOC EOC	Annual	% of members reporting learned coping skills that work	Member survey

Goal V: Reduce avoidable utilization of emergency department, inpatient and residential services
(Right time, right place, right service)

Intermediate Actions	Adult/child/ both	Domain	Reporting Frequency	Measure	Data Source
Plan All Cause Readmission Rate [PCR] **CMS criteria**	A	$ SU	Annual	% of acute inpatient stays during the measurement year for HH Members age 18 and older that were followed by an unplanned acute readmission for any diagnosis within 30 days.	MCO
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite [PQ192]: **CMS criteria** (AHRQ)	A	OC $ SU	Annual	Rate of inpatient hospital admissions for HH Members 18 years or more for ambulatory care sensitive chronic conditions per 100,000 enrollee months (includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary	MCO

				disease, asthma, hypertension, heart failure, or angina without a cardiac procedure)	
Follow-up after hospitalization for mental illness HEDIS **CMS criteria**	B Ages 6 & >	QOC	Annual	% of discharges ages 6 & > who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days and 30 days of discharge.	MCO
Follow-up after residential treatment	C	QOC	Annual	% of discharges from residential treatment to a lower level of care followed up with a behavioral health visit within 30 days.	MCO
Ambulatory Care – Emergency Department Visits [AMB] **CMS criteria**	B	$ SU	Annual	Rate of emergency department visits during the measurement year per 1,000 enrollee months.	~~HSD~~ HCA Claims Data
Inpatient Utilization [IU] **CMS criteria**	B	$ SU	Annual	Rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) during the measurement year per 1,000 enrollee months.	~~HSD~~ HCA Claims Data
Utilization of ED **CMS criteria**	B	$ SU	Annual	% of Members with 2 or more ED visits within 6 months for a behavioral health condition including substance abuse	MCO

Nursing Facility Utilization [NFU] **CMS criteria**	A	$ SU	Annual	Two rates: • Rate of admissions to a nursing facility from the community that resulted in a short-term (less than 101 days) during the measurement year per 1,000 enrollee months. • Rate of admissions to a nursing facility from the community that resulted in a long-term stay (equal to or greater than 101 days) during the measurement year per 1,000 enrollee months.	~~HSD~~ HCA Claims Data

Name: **Client Name**	Medicaid ID # **12345**	Page 1 of 2
Client Participation Agreement		Date: **12/3/18**

CLNM AGENCY NAME

CARELINK NM HEALTH HOME PARTICIPATION AGREEMENT

I understand that I can join the CareLink New Mexico (CLNM) Health Home program. The program will help arrange care I get from my Managed Care Organization (MCO), primary care provider, and behavioral health provider. It also applies to others named in my Comprehensive Needs Assessment (CNA) and Care Plan (CP).

I grant CLNM AGENCY NAME the right to share my health records. These may include alcohol- and substance-abuse records under 42 CFR, Part 2. These may be used to enroll me, prove I am eligible, and arrange care. They may be used for billing and payment. MCO may share my past care records with CLNM AGENCY NAME. I release CLNM AGENCY NAME and related groups from liability. That includes employees and directors. What is shared will be kept strictly private. This conforms to federal and state privacy laws.

I understand that I may revoke this consent at any time. But I know that if I do so, I might not get care through CLNM Health Home.

I understand that I can join this program or not. Not joining will not affect the services I am now getting. At this time, I:

□ Choose to participate

□ Decline to participate

I understand that CLNM AGENCY NAME will notify my MCO of my decision. Identified MCO:

□ Blue Cross Blue Shield

□ Presbyterian Health Plan

□ United Healthcare

□ Molina Healthcare

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☐ Western Sky Community Care

CLIENT or legal representative SIGNATURE:

_____
(Relationship to Client)   **(Date)**

STAFF SIGNATURE:_____
(Staff Name)   **(Date)**

MCO NAME can share all health and care records. This includes information relating to:

_____initial here	care for alcohol or substance abuse
_____initial here	behavioral health services/psychiatric care records
_____initial here	HIV or AIDS or other sexually transmitted disease records

These records are for the time period of _____. I understand I can cancel this at any time. I must do so in writing to CLNM AGENCY NAME. If I cancel, it will not apply to information already released. Nor will it apply when the law grants my insurer the right to contest a claim under my policy. Unless I cancel, it will expire on this date, or given this event or condition: _____. If I fail to name a date, event, or condition, this consent will expire in one (1) year from the date I sign it.

I know that once information is shared, it may be re-shared by the party that receives it. Then federal and state privacy laws may not protect it.

Signing this form is voluntary. I do not have to sign it to get care or benefits. I do not have to sign it to enroll or pay. I have a right to a copy of this signed form.

SIGNATURE: _____DATE _____

(Relationship to Client)

Readability grade level as edited: 6

Text from the bill that supports, affirms, and advances trauma informed care throughout the United States:

Whereas traumatic experiences affect millions of people in the United States and can affect a person's mental, emotional, physical, spiritual, economic, and social well-being;

Whereas adverse childhood experiences (ACEs) can be traumatizing and, if not recognized, can affect health across the lifespan and, in some cases, result in a shortened life span;

Whereas ACEs are recognized as a proxy for toxic stress, which can affect brain development and can cause a lifetime of physical, mental, and social challenges;

Whereas ACEs and trauma are determinants of public health problems in the United States such as obesity, addiction, and serious mental illness;

Whereas trauma informed care is an approach that can bring greater understanding and more effective ways to support and serve children, adults, families, and communities affected by trauma;

Whereas trauma informed care is not a therapy or an intervention, but a principle-based, culture-change process aimed at recognizing strengths and resiliency as well as helping people who have experienced trauma to overcome those issues in order to lead healthy and positive lives;

Whereas adopting trauma informed approaches in workplaces, communities, and government programs can aid in preventing mental, emotional, physical, and/or social issues for people impacted by toxic stress and/or trauma;

Whereas trauma informed care has been promoted and established in communities across the United States, including the following different uses of trauma informed care being utilized by various types of entities:

(1) The State of Wisconsin established Fostering Futures, a statewide initiative partnering the State with Tribes, State agencies, county governments, and nonprofit organizations to make Wisconsin the first trauma informed State. The goal of Fostering Futures is to reduce toxic stress and improve lifelong health and well-being for all Wisconsinites.

(2) The Menominee Tribe in Wisconsin improved educational and public health outcomes by increasing understanding of historical trauma and childhood adversity and by developing culturally relevant, trauma informed practices.

(3) In Chicago, Illinois, schools of medicine provide critical trauma informed care, including the University of Illinois at Chicago Comprehensive Assessment and Response Training System, which improves the quality of psychiatric services provided to youth in foster care, and the University of Chicago Recovery & Empowerment After Community Trauma Initiative, which helps residents who are coping with community violence.

 (4) In Philadelphia, Pennsylvania, service providers, academics, and local artists use art to engage their community to educate and involve citizens in trauma informed care activities.

(5) In San Francisco, California, the city's public health department aligned its workforce to create a trauma-informed system.

(6) In Kansas City, Missouri, schools worked to become trauma informed by encouraging teachers and children to create their own self-care plans to manage stress. They have implemented broad communitywide, trauma informed culture change.

(7) In Tarpon Springs, Florida, the city crafted a community effort to gather city officials, professionals, and residents to coordinate multiple trauma informed activities, including a community education day.

(8) In Worcester, Massachusetts, community members worked with the Massachusetts State Department of Mental Health to create a venue with peer-to-peer support to better engage individuals dealing with trauma or extreme emotional distress.

(9) In Walla Walla, Washington, the city and community members launched the Children's Resilience Initiative to mobilize neighborhoods and Washington State agencies to tackle ACEs.

(10) The State of Oregon passed the first law to promote trauma informed approaches to decrease rates of school absenteeism and understanding and promoting best practices to leverage community resources to support youth.

(11) The State of Massachusetts passed a law to promote whole-school efforts to implement trauma informed care approaches to support the social, emotional, and academic wellbeing of all students, including both preventive and intensive services and supports depending on students' needs.

(12) The State of Washington implemented the ACEs Public-Private Initiative, a collaboration among private, public, and community organizations to research and inform policies to prevent childhood trauma and reduce its negative emotional, social, and health effects;

Whereas the Substance Abuse and Mental Health Services Administration provides substantial resources to better engage individuals and communities across the United States to implement trauma informed care; and

Whereas numerous Federal agencies have integrated trauma informed approaches into their programs and grants and could benefit from closer collaboration: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes the importance, effectiveness, and need for trauma informed care among existing programs and agencies at the Federal level; and

(2) encourages the use and practice of trauma informed care within the Federal Government, its agencies, and the United States Congress.

Appendix F – Medicaid Categories of Eligibility - Limited Funding

<table>
<tr><th colspan="4">MEDICAID CATEGORIES OF ELIGIBILITY - LIMITED FUNDING</th></tr>
<tr><th>Category</th><th>Description</th><th>Benefit Type</th><th>Benefit Details</th></tr>
<tr><td>007</td><td>Children's Medical Services</td><td>Limited</td><td>State funded through Public Health Division of Dept. of Health</td></tr>
<tr><td>029</td><td>Family Planning Only Medicaid</td><td>Limited</td><td>Family planning for women</td></tr>
<tr><td>041</td><td>Qualified Medicare Beneficiary - age 65 and over</td><td>Limited</td><td>Services limited to payment of Medicare premiums, coinsurance and deductibles for Medicare-covered services</td></tr>
<tr><td>042</td><td>Specified Low-income Medicare Beneficiaries, Qualified Individuals</td><td>Limited</td><td>Coverage is limited to payment of Medicare Part B premium; individuals do not receive a Medicaid card</td></tr>
<tr><td>044</td><td>Qualified Medicare Beneficiary - under age 65</td><td>Limited</td><td>Services limited to payment of Medicare premiums, coinsurance, and deductibles for Medicare-covered services</td></tr>
<tr><td>045</td><td>Specified Low-income Medicare Beneficiaries, Qualified Individuals</td><td>Limited</td><td>Coverage is limited to payment of Medicare Part B premium; individuals do not receive a Medicaid card</td></tr>
<tr><td>046</td><td>CYFD Foster Care, placed out-of-state</td><td>Limited</td><td>All services require prior authorization; individual does not receive a Medicaid card; CYFD category</td></tr>
<tr><td>047</td><td>CYFD Adoption Subsidy (IV-E), placed out-of-state</td><td>Limited</td><td>All services require prior authorization; individual does not receive a Medicaid card; CYFD category</td></tr>
<tr><td>050</td><td>Qualified Disabled Working Individuals</td><td>Limited</td><td>Coverage limited to payment of Medicare part A premium</td></tr>
<tr><td>081</td><td>Institutional Care - Aged</td><td>Full Benefits</td><td>**For individuals requiring institutional care**</td></tr>
<tr><td>083</td><td>Institutional Care Blind – full Medicaid coverage</td><td>Full Benefits</td><td>**For individuals requiring institutional care**</td></tr>
<tr><td>084</td><td>Institutional Care Disabled – full Medicaid coverage</td><td>Full Benefits</td><td>**For individuals requiring institutional care**</td></tr>
<tr><td>085</td><td>EMC for Undocumented Aliens</td><td>Limited</td><td>Coverage for emergency services for certain undocumented non-citizens who meet all eligibility criteria for a Medicaid category *except* for their alien status.</td></tr>
</table>