4. Care Coordination

4.1. General Information

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

4.2. Care Coordination Functions

The following primary Care Coordination functions are requirements for Care Coordination that must be performed by staff employed by the MCO or entities designated as Care Coordination delegates.

- Conducting Health Risk Assessments (HRAs) for Members newly enrolled in Turquoise Care or Members who have had a change in circumstance or change of health condition that requires an assessment for a higher level of care and who are not currently identified for Care Coordination Level 1 or 2 services, including those with retroactive eligibility;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semiannually, annually, or upon a change in health condition that may warrant a higher level of care;
- Administer the Community Benefit Service Questionnaire (CBSQ) as applicable (see Section 4.5 CBSQ);
- Semiannual in-person visits with the Member;
- Quarterly telephone contact with the Member;
- Coordinating Member access to Covered Services as needed (e.g., scheduling appointments, arranging transportation, making referrals);
- Communicating and exchanging information with Providers;
- Comprehensive Care Plan (CCP) development and updates; and
- Targeted Health Education, including disease management (per 4.4.8 of contract), based on the Member's individual diagnosis.

MCOs may delegate care coordination functions, per 4.4.10 of the Agreement.

The MCOs may not delegate the NF level of care (LOC) assessment and may not delegate Care Coordination for Members who are in the SDCB model or who are Children in State Custody (CISC) members.

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

- The Care Coordination tools and protocols are consistently and objectively applied, and outcomes are continuously measured (frequency and methodology stated in the policies and procedures such as interrater reliability) to determine effectiveness and appropriateness of processes.
- Competencies will be evaluated in the following areas, but not limited to:
  - NF LOC assessments and reassessments occur on schedule in compliance with the Agreement and are submitted to the lead or supervising Care Coordinator;
  - CNAs and reassessments, as applicable, occur on schedule in compliance with the contract;
  - Comprehensive Care Plans (CCPs) are developed and updated on schedule in compliance with the Agreement;
  - CCPs reflect needs identified in the CNA and reassessment process;
  - CCP goals are Member centric, and agreed upon by the Member;
  - CCPs are appropriate and adequate to address the Member's needs including the need for all Community Benefit (CB) services;
  - Services are delivered in a person-centered, holistic, strength-based, and well-coordinated manner as described in the CCP and authorized by the MCO;
  - Services are appropriate to address the Member's needs; including culturally responsive treatments and supports for Native American children and youth in CYFD Protective Services (PS) custody;
  - Services are delivered;
  - Service utilization is appropriate;
  - Service gaps are identified and addressed;
  - Minimum Care Coordinator contacts are conducted;
  - Care Coordinator to Member ratios are appropriate per 4.4.5.7.1 of the Agreement;
  - Service limits are monitored (as described in the policies and procedures) and appropriate action is taken if a Member is nearing or exceeds a service limit; and

- CBSQ is administered as appropriate.

- The MCO, or its delegate, will use an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the 1115(a) Waiver, Federal and State statutes, regulations, the Agreement and the MCO's policies and procedures. The functionality will include but not be limited to the ability to:
  - Capture and track enrollment dates, date of development of the CCP, date of authorization of the CCP, date of initial service delivery for each service in the CCP, date of each NF LOC and needs reassessment, date of each update to the CCP, and dates regarding transition from an institutional facility to the community;
  - Capture Care Coordination level assignments and track compliance with minimum Care Coordination contacts as specified in the Agreement;
  - Notify the care coordinator of eligibility end date, date for annual NF LOC reassessment, date of comprehensive needs reassessment, and date to update the CCP;
  - Capture and track eligibility/enrollment information, NF LOC assessments and reassessments, and needs assessments and reassessments;
  - Capture and monitor the CCP
  - Track requested and approved service authorizations, including Covered Services and VAS, as applicable;
  - Document all referrals received by the care coordinator on behalf of the Member for Covered Services and VAS, as applicable, needed to ensure the Member's health, safety and welfare, and to delay or prevent the need for more expensive institutional placement. Include notes regarding how such a referral was handled by the care coordinator, including any additional follow up;
  - Establish a schedule of services for each Member identifying the time that each service is needed and the amount, frequency, duration, and scope of each service;
  - Track service delivery against authorized services and providers;
  - Track actions taken by the care coordinator to immediately address service gaps;
  - Document case notes relevant to the provision of Care Coordination; and
  - Allow the HCA or its designee to have remote access to case files.

4.3. Health Risk Assessment

The MCO or its delegate shall conduct HCA's standardized HRA (see Appendix 4.15.1) on all Members who are newly enrolled in Turquoise Care for the purpose of: introducing the MCO to the Member, obtaining basic health and demographic information about the Member, and confirming the need for a CNA to determine if the Member should be assigned to Care Coordination Level ~~1~~0, 1 or Level 2.

The standardized HRA (Section 4.15.1.) will be completed for each new Turquoise Care Member within 30 calendar days of notification to the MCO of the Member's enrollment in the MCO. MCOs may request to add additional questions to the HRA to meet the requirements of regulatory and accrediting bodies by submitting the additional questions and the reason(s) for inclusion for HCA approval. Requests must be sent for approval to HCA/MAD through the MCO's Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).
The HRA and the CNA may be performed concurrently.

Additionally, an HRA will be completed upon a change in the Member's health condition if the Member is not in Care Coordination Level 1 or Level 2. The HRA may be conducted by telephone or in person; HRA information must be obtained from the Member or the Authorized Representative (AR) and must be documented in the Member's file. The MCO shall ensure its staff, subcontractors, or vendor(s) conducting the HRA are adequately trained to effectively conduct the HCA standardized HRA.

The MCO or its delegate will make reasonable efforts to contact Members to conduct an HRA and provide information about Care Coordination. Such efforts shall include, but not be limited to, engaging community supports such as Community Health Workers (CHWs), Community Health Representatives (CHRs), Core Service Agencies (CSAs), 1915 (c) HCBS Waiver Case Managers and Consultants, New Mexico Brain Injury Resource Center, and Centers for Independent Living. For CYFD Protective Services (PS) and/or Juvenile Justice Services (JJS) involved children/youth, the MCO or its delegate will collaborate with the assigned CYFD Permanency Planning Worker (PPW), Juvenile Probation Officer (JPO), and Community Behavioral Health Clinician (CBHC) for physical and behavioral health services. The MCO or its delegate shall document at least three attempts to contact a Member which includes at least one attempt to contact the Member at the most recently reported phone number. The three attempts

shall be followed by a letter sent to the Member's most recently reported address that provides information about Care Coordination and how to obtain an HRA. Documentation of the three attempts shall be included in the Member's file. Such attempts shall occur on not less than three different calendar days, at different hours of the day, including day and evening hours and after business hours.

After these attempts have been made and documented, and if the Member has not been engaged, the Member is categorized as "Unable to Reach" (UTR) and is assigned to CCL0. The MCO will conduct quarterly claims mining for these Members and will renew attempts to reach the Member if claims indicate a possible need for Care Coordination.

If the MCO has made three documented attempts to contact and has reached the Member at least once, but the Member fails to engage with the completion of the HRA or CNA, the Member is categorized as "Difficult to Engage" (DTE) and is assigned to CCL0. If the Member is categorized as a CCL1 or CCL2 based on the most recent CNA but fails to engage in two consecutive contract required touch points (telephonic or in person), the Member is then categorized as DTE (CCL0), with appropriate documentation in the Member's file. The MCO will perform quarterly claims mining for these Members and will renew attempts to reach Members if claims mining indicates a possible need for care coordination.

For Difficult to Engage (DTE – CCL0) and Unable to Reach (UTR – CCL0) Members transitioning from an inpatient level of care setting including general hospital, psychiatric hospital, skilled nursing, or residential treatment centers or who have had two (2) or more Behavioral Health readmissions within thirty (30) Calendar Days, the MCO shall make and document a face-to-face outreach attempt by a care coordinator with behavioral health experience. If those efforts are unsuccessful, the MCO shall send a letter to the Member's most recently reported address that provides information about Care Coordination, the importance of completing an HRA, and how to complete the HRA.

The MCO shall perform quarterly Data Mining Reviews (DMRs) for all Members to determine if there is a change in the Member's health status that warrants the need to reinitiate Member outreach efforts or to perform an updated HRA or CNA.

Within ten calendar days of completion of the HRA, all Members shall be informed of the need for a CNA. Members requiring a CNA shall receive contact information for the CONTRACTOR's Care Coordination unit, the name of the assigned care coordinator (if applicable), and a time frame during which the Member can expect to be contacted by the Care Coordination unit or individual care coordinator to complete the Comprehensive Needs Assessment. The MCO shall schedule a CNA within 10 calendar days of completion of the HRA and complete the CNA within 30 calendar days of completion of the HRA unless the Member is in a model approved for Delegated, Treat First, CARA, or JUST Health Care Coordination with other State-approved guidelines.

4.4. Comprehensive Needs Assessment

HCA's standardized CNA is conducted for Medicaid Members eligible for managed care who are identified through the HRA as having significant health conditions and risk indicators signifying the potential need for CCL1 or CCL2.

Members who are identified as not needing a CNA shall be monitored by the MCO Care Coordination unit quarterly through predictive modeling software and available utilization and claims data to determine if the Member had a change in health status and is in need of an HRA or CNA. Such claims could include a positive pregnancy test, Substance Use Disorder (SUD), or Serious Mental Illness (SMI).

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

The MCO shall use the New Mexico Medicaid NF LOC Criteria and Instructions to determine NF LOC for Members.

The CNA is the sole responsibility of the MCO care coordinator unless delegated to another entity via a Delegation Model.

CNAs must be performed through the utilization of the HCA standardized CNA for assessing the Member's medical/PH, BH, LTC, and social needs. MCOs may request to add additional questions to the CNA to meet the requirements of regulatory and accrediting bodies by submitting the additional questions and the reason(s) for inclusion for State approval. Requests must be sent for approval to HCA/MAD through the MCO's Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

The CNA must be conducted in the Member's primary place of residence or facility for Members reintegrating back into the community. The MCO or its delegate will involve collateral respondents when scheduling the CNA, including family members, caregivers, CHRs, CHWs, and/or other significant social support individuals, with the consent of the Member. For CYFD PS and/or JJS involved children/youth, the MCO or its delegate, will collaborate with the assigned CYFD Permanency Planning Worker (PPW), Juvenile Probation Officer (JPO), and Community Behavioral Health Clinician (CBHC) for all medically necessary services including behavioral health services. The MCO, or its delegate, must evaluate the need for translation, including signing or communication boards when scheduling the CNA.

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

The CNA may be conducted face-to-face in an alternate location without requesting an exception from the State under the following conditions:

- If the Member is homeless, or in a transition home or youth shelter and the assessment can be conducted in a private setting at a location, mutually agreeable to the Member, such as a church meal site program, community nonprofit organization center, community MH agency, food bank site, etc.;
- If the Member is receiving treatment in an out of state facility;
- If the Member is a newborn in an inpatient setting;
- If the Member is currently part of the prison or jail involved population preparing for release; or
- If the Member is in a Health Home.

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

- Complete the Turquoise Care CNA Exception Request form (MAD 601) (see Appendix 4.17.2);
- Alternate locations must be submitted to HCA for review and should be assessed for privacy to ensure the Member's Protected Health Information (PHI) is not jeopardized;
- Send the completed MAD 601 by secure email to: ~~HSD~~HCA-QB-CCU-CNA@hsd.nm.gov;
- HCA will review the request and respond to the specific MCO requestor within two business days;
- If an exception is approved, it shall only be valid for six months, or until the next CNA is needed, whichever comes first; and
- Requests **will not** be reviewed or approved if submitted:
  - Via unsecure email;
  - To an email address other than ~~HSDQBCCUCNA~~HCA-QB-CCU-CNA@hca.nm.gov~~@hsd.nm.gov;~~ ~~a~~and
  - Via any format other than the MAD 601 Form.

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

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

outdoor hazards due to overgrown weeds and undergrowth of yards/trees. The practice of conducting in home CNAs further allows for observation of the existence of other parties living in the home and possibly presenting support or risk to the Member.

When a Member, currently categorized as a CCL1 or a CCL2, refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the CNA with the Member, emphasizing this assessment makes the determination of useful resources to meet the Member's needs, such as the CB for personal care assistance, special home environment modifications and adaptive equipment. The MCO will ensure the Member signs the HCA-approved Care Coordination Declination Form and maintain the signed form in the Member's file (~~S~~see Appendix 4.17.3). If the Member refuses to sign the Care Coordination Declination Form, the MCO shall document such refusal in the Member's record. The MCO will perform quarterly claims mining for these Members and will renew attempts to reach the Member if claims mining indicates a possible need for Care Coordination. The Member who has refused Care Coordination will not be assigned to Care Coordination Level 1 or Level 2. In documented refusal circumstances, the MCO will submit a proposal to the Member outlining a basic CCP with minimum services outlined and suspend any requests for increased services/personal care hours until a CNA and NF LOC is conducted and completed.

4.5. Community Benefit Service Questionnaire

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

The completed CBSQ and the CBMA are considered part of the Member's CNA. The MCOs must ensure all Care Coordinators are trained in administering these documents. The MCOs must have a process in place to monitor that CBSQs and CBMAs are completed correctly and in accordance with Section 4.5 of the Managed Care Policy Manual.

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

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

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

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

CCL2 Members:

- For all Members with CCL2 and a NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the Care Coordinator.
- For Members with CCL2 but without a NF LOC, follow the criteria above.

In any circumstances not covered by the criteria, the Care Coordinator should use his/her judgment and consult with his/her supervisor as necessary to determine appropriate use of the CBSQ. Care Coordinators should use the CBSQ as a tool to guide the discussion with the Member and/or the Member's representative to inform them of the availability of CB services.
HCA will audit CBSQ and CBMA completion to ensure that these requirements are met.

Members who wish to receive fewer PCS hours than initially authorized ~~would~~ should discuss with their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA). In this agreement, they would specify the reduced number of hours they require and any additional comments about the reduction. Subsequently, both the agency and the Member can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment.

The request for a reduction in hours must be Member-driven. Reduction in hours should not be considered if reduction request is due to provider agency inability to staff, provider agency or caregiver coercion, or due to dereliction of duties/ poor performance of the caregiver. Members must be informed of their right to request a new or additional caregiver or new provider when available. A Member's request for a reduction in hours should not be made for temporary or otherwise short-term periods. A Member must understand the request for reduced hours will be for the remainder of their budget/care plan year. However, if the Member has a change in condition, change to natural supports, or otherwise needs to increase their hours back to the original assessed number, they may work with their Care Coordinator to do so. Any reduction of underutilization of PCS hours shall not be used as justification to reduce any future assessment of services needed by the Member.

Members must willingly agree to and sign the CBMA for the reduced PCS hours, with the MCO maintaining a record of this agreement. MCOs can then update the PCS authorization in AuthentiCare to align with the mutually agreed-upon lower number of PCS hours. In addition, the provider agency must be informed of this change in hours. This streamlined approach reduces the administrative workload on PCS agencies.

4.6. CNA Reassessments

The CNA shall be conducted at least annually for level 1 Care Coordination and at least semi-annually for level 2 Care Coordination, to determine if the CCP is appropriate for the Member and if a higher or lower Care Coordination Level may be needed.

Additional CNAs may also be conducted, as the care coordinator deems necessary, as requested by the Member, provider, family Member or legal representative, or as a result of a change in health status and/or social support situation including changes in placement for children in CYFD PS custody.

Specific indicators warranting a need for conducting a new CNA may include but are not limited to: significant changes in Member's medical and/or BH condition (decline or improvements in health status); changes in setting of care (SOC), such as hospitalization, rehabilitation and/or short--term NF admission (long--term NF stay(s) require administration of the MDS): residential treatment facility admission; changes in the Member's family or natural/social support system (such as~~,~~ sudden illness and/or convalescence or death of a family caregiver); living arrangement disruption (loss of residence, eviction, fire/flooding, move to another family home); involvement of Adult Protective Services (APS), Child Protective Services, Juvenile Justice Services, Behavioral Health Services and/or other New Mexico Children, Youth & Family Department (CYFD) interventions; and changes in the amount of caregiver services requested and requested amount exceeds the range of hours corresponding with Member's existing assessment score. These events may ~~at times~~ not require a new CNA be completed. If a new CNA is not conducted, the Member's record should clearly establish why the triggering event did not result in the MCO conducting a new CNA. The decision can be made via telephone or in-person contact ~~or face to face visit~~ with the Member.

4.7. Comprehensive Care Plan Requirements

The MCO or its delegate shall complete the HCA's standardized CCP (~~S~~see Appendix 4.17.4). This policy is in conjunction with all elements described in the CCP Requirements outlined in the Agreement, which defines the processes for development, implementation, and management of a CCP for all Members in levels 1 and 2 of Care Coordination. The MCO or HCA-approved designee -is responsible for ensuring a CCP is initiated upon enrollment and must oversee the care coordinator who is responsible for coordinating all services in the CCP.

- CCP Scope and Process. The MCO or HCA approved designee must establish a process to ensure coordination of care for Members that includes:
  - Coordination of the Member's PH, BH, and long-term health care needs through the development of the CCP;
  - Collaboration with the Member, Member's friends and family (at Member's request), Member's PCP, specialists, BH providers, other providers, communities, and interdisciplinary team experts including the Individualized Planning Meeting Team for children and youth in CYFD PS custody, as needed when developing the CCP, including documentation of all attempts to engage providers and other individuals identified in the development of the CCP;
  - With the Member's consent to share information, the CCP should be shared and utilized by those involved in providing care to the Member (e.g., BH providers should be aware and take into consideration the Member's PH care issues when working with the Member);
  - Verification of all decisions made regarding the Member's needs and services, and ensures all information is documented in a written~~,~~ CCP;
  - The MCO or HCA~~ ~~approved designee shall develop the CCP within 14 business days of completion of the initial CNA and update the CCP within 5 days of subsequent CNAs unless the Member is in a health home and/or using the Treat First model of care; and
  - The Member may designate his/her representative to have a participatory role, as needed, and as defined by the Member, unless the representative has decision making authority, under law. This information may be accepted verbally; however, it must be clearly ~~. Clearly~~ documented ~~it with clear documentation~~ in M~~m~~ember's file.
  - The Care Coordinator shall:
    - Ensure the Member or Member's legal representative understands, reviews, signs and dates the CCP;~~.~~
    - Provide a copy of the completed CCP to the Member, Member's legal representative as applicable or other providers authorized to deliver care to the Member in a format that is easily readable (e.g., 12 font);~~.~~

- With the Member's and/or parent, legal guardian and/or CYFD worker's (if in CYFD Custody) consent, confirm family, providers, or any other relevant parties are included in the treatment and planning of the Member's CCP;~~,~~
- Ensure timelines for the development, implementation, and/or updating the CCP are met;~~,~~
- Facilitate treatment and coordinate with providers to assist the Member and his or her family and CYFD lead worker (if in CYFD custody) with navigating the system including scheduling appointments, arranging transportation, or advocating for the Member as needed;~~,~~
- Verify services have been initiated and/or continue to be provided as identified in the CCP and ensure services continue to meet the Member's needs;~~,~~
- With Member's consent, maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the Member's care;, and~~,~~
- Identify, address, and evaluate service gaps to determine their cause and minimize any gaps going forward and ensuring backup plans are implemented and effectively working; including strategies for solving conflicts or disagreements, and provide clear conflict of interest guidelines for all planning participants.

Identify and list specific risk factors and changes to Member's risk, address those changes and update the Member's risk agreement and CCP as necessary to include measures to minimize the identified risks.

- Inform each Member of his or her Medicaid eligibility status and end ~~date, and~~date and assist the Member with the process for eligibility redetermination;~~,~~
- For children and youth in CYFD PS custody, inform Native American children and youth and their Permanency Planning Worker (PPW) of opportunities to receive culturally responsive treatments, interventions and supports, including those that are non-medicalized;~~,~~
- Educate Members with identified disease management needs by providing specific disease management interventions and strategies;~~,~~
- Educate the Member about his or her ability to have an Advance Directive and ensure the Member's decision is well documented in the Member's file;~~,~~

- Educate Member about non-Medicaid services available as appropriate (e.g., Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant MH), and.
- Reflect cultural considerations of the Member and conduct the CCP process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

- CCP Revisions
  - The CCP will be revised when the Member experiences one of the following circumstances:
    - Risk of significant harm: within one business day of the MCO receiving notification, the Care Coordination team will convene, in person or by teleconference,; and, if necessary, the CCP will be modified accordingly within 72 hours;
    - Major medical change;
    - The loss of a primary caregiver or other significant person;
    - A serious accident, illness, injury or hospitalization that disrupts the implementation of the CCP;
    - Serious or sudden change in behavior;
    - Change in living situation, including out of home placements, removal from the home by CYFD or changes in CYFD placements, and subsequent discharges;
    - Proposed change in services or providers (e.g., CB);
    - It has been confirmed by APS or CYFD that the Member is a victim of abuse, neglect, or exploitation;
    - Any team Member requests a meeting to propose changes to the CCP;
    - Criminal justice involvement on the part of the Member (e.g., arrest, incarceration, release, probation, parole); or
    - As requested by HCA.
  - Within five business days of completing a reassessment of a Member's needs, the MCO or HCA approved designee shall authorize and initiate services in the updated CCP.
- Ongoing Care Coordination
  - This policy along with all elements described in Ongoing Care Coordination outlined in the Agreement, defines how the MCO or HCA approved designee shall perform real time and ongoing Care Coordination to ensure all Members receive the appropriate care.

- CCL1 and CCL2 Members shall receive quarterly telephonic touchpoints and bi-annual in-person visits.
- Ongoing Care Coordination functions shall include all elements defined in the Agreement including the following:
  - Identify gaps and address the needs of the Member, including develop and/or update the CCP as needed;~~,~~
  - Ensure when a Member's Care Coordination Level increases or decreases that continuity of care is always maintained;~~,~~
  - Maintain a single point of contact for the Member to ensure coordination of all services and monitoring of treatment;~~,~~
  - Maintain face-to-face and telephonic meetings with the Member to ensure appropriate support of the Member's goals and foster independence;~~,~~
  - Coordinate and provide access to specialists, as needed~~;~~ (relevant long-term specialty providers, relevant emergency resources, relevant rehabilitation therapy services, relevant non-Medicaid services, etc.),
  - Education regarding service delivery through Medicare and/or Medicaid;~~,~~
  - Measure and evaluate outcomes designated in the CCP and monitor progress to ensure covered services are being received and assist in resolution of identified problems;~~,~~
  - Achieve coordination of physical, BH, and LTC services;~~,~~
  - Maintain consistent communication and contact with Member's PCP, specialists, and other individuals involved in the Member's care. The MCO shall maintain consistent communication and contact with the assigned CYFD Permanency Planning Worker (PPW) for protective services involved children and youth, Juvenile Probation Officer (JPO) for juvenile justice involved youth, and Community Behavioral Health Clinician (CBHC) for CYFD involved children and youth;~~,~~
  - Maintain and monitor the Member's CB and provide assistance with complex services;~~,~~
  - Consider Member and provider input to identify opportunities for improvement, and~~,~~
  - Collaborate and/or cooperate with representatives of the Independent Consumer Support System.

4.8. Staffing Requirements and Delegations

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

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

- CCL1 – 1:75
- CCL2 – 1:50
    a. self-directed

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

- The number of care coordinators, Care Coordination supervisors, other Care Coordination team ~~M~~members the MCO plans to employ;
- The ratio of care coordinators to Members;
- The MCO's plans to maintain ratios as outlined by Care Coordination Level and the explanation of the methodology used for determining such ratios;
- How the MCO will ensure such ratios are sufficient to fulfill the Agreement requirements;
- The roles and responsibilities for each Member of the Care Coordination team;

- A strategy that encourages the use of Native American care coordinators and limits duplication of services between Indian Health Service, Tribal Health Providers, and Urban Indian Providers (I/T/U) and non-I/T/U providers;
- How ratios are adjusted to accommodate travel requirements for those care coordinators serving Members in rural/frontier areas of the State and/or for those Members that require extraordinary efforts from the assigned care coordinator; and
- How the MCO will use care coordinators to meet the needs of New Mexico's unique population.

The MCO or its delegate shall ensure Members have a telephone number for direct contact with their care coordinator and/or a Member of their Care Coordination team, (without being routed through several contact points), during normal business hours (8:00 a.m. – 5:00 p.m. Mountain Standard Time). When the Member's care coordinator or a ~~M~~member of the Member's Care Coordination team is not available, the call shall be answered/facilitated by another qualified staff person in the MCO's or its delegate's Care Coordination Unit. Calls requiring immediate attention shall be "warm" transferred directly to another care coordinator, not letting the call go to voice mail. After normal business hours, calls requiring immediate attention by care coordinator shall be handled by the Member services line, as stipulated by Section 4.15.3 of the Agreement.

When Native American Members request a Native American care coordinator, the MCO must employ or contract with a Native American care coordinator or contract with a CHR to serve as the care coordinator.

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

- Assigned care coordinator is no longer employed by the MCO or its delegate;
- There is a conflict of interest preventing neutral support for the Member;

- Care coordinator is on temporary leave from employment; or
- Caseload of the assigned care coordinator must be adjusted due to its size or intensity.

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

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

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

4.9. Engagement of Members

HCA recognizes there may be a select few managed care Members who present challenges to the service delivery system due to the complexity of their needs. This policy is designed for Members who demonstrate inappropriate behaviors and/or frequent contact of State and MCO staff, and/or have been unresponsive to traditional Care Coordination efforts and noncompliant with recommended BH services. This group of "high health risk/high resource utilization" (HHR/HRU) is different than other populations and individuals in the care system because denying or delaying care to them has significant immediate negative consequences to their health and safety. The risk to the individual can be documented in assessments, contact notes, and CCPs. Responding to the challenges presented by this category of Members requires monitoring of attempted delivery of care, documenting interactions, and thresholds of behavior or conditions that escalate events to a higher level of response and identifying appropriate teams to design and implement responses. Consistent, well--crafted responses to concerns are essential when providing care or addressing resistance to care. This will minimize excessive use of State, MCO, and provider resources, as well as minimizing risk to the individual's health and safety.

The following protocol is to be utilized across MCOs, agency providers, and State employees and programs for each ~~recipient~~ Member identified as part of the HHR/HRU population. The expected result is a more efficient use of resources to achieve an optimal outcome for the individual. This is intended to

free time and energy to manage all complex individuals in the care system and to achieve optimal levels of health and safety for all individuals.

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

At the threshold of risk agreed upon by the MCO, a meeting is arranged with the ~~individual~~Member and appropriate participants ~~recipients~~ of the care team. For CYFD involved clients, include the CYFD community behavioral health clinician (CBHC) and the child's PPW. This team must include the care coordinator, a management level staff of the MCO and a high-level clinician~~al staff Member~~ of the MCO. The Member may request one or two people to be in attendance. The intention of the meeting with the Member ~~participant~~ is to:

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

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

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

4.10. MCO Care Coordination with 1915(c) HCBS Waivers: Developmental Disabilities (DD), Mi Via, Supports Waiver and Medically Fragile (MF) Waivers

The MCOs provide acute and ancillary medical and BH services to the 1915 (c) HCBS recipients/MCO Members. The MCO is responsible for ensuring a CCP is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO CCP. The MCOs are required to perform all care coordination functions described in this Manual section including but not limited to: capturing the Member's medical, BH, and ancillary needs; explaining to the Member, family, and/or guardian, the Medicaid benefits that are available from the MCO, and how the MCO care coordinator can assist with coordinating services with the case manager or consultant; developing a CCP; and completing all required touch points identified by the Member's current care coordination level. Exceptions to care coordination functions are specifically described below for Members receiving 1915(c) HCBS waiver services.

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

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

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

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

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

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

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

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

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

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

- **Supports Waiver**

  New Mexico's new Supports Waiver (SW) is a Home and Community Based Services (HCBS) waiver that is an option for individuals who are on the Developmental Disabilities (DD) Waiver Wait List. Supports Waiver services are intended to complement unpaid supports that are provided to individuals by family and others. Participants on the Supports Waiver do not lose their spot on the DD Waiver Wait List. Similar to Community Benefit, the Supports waiver offers participants the choice between agency-based or self-directed model of service delivery. Services offered under the Supports Waiver are community supports coordinator; customized community supports individual and group; employment supports; personal care; assistive technology; behavior support consultation; environmental modifications; non-medical transportation; respite; and vehicle modifications.

  Supports Waiver services and budget are outlined in the participant's Individual and Support Plan (ISP). The ISPs are developed through a person-centered planning process which allows participants to select services that will help them achieve personally defined outcomes in the most integrated community setting. The ISP is created by the Supports Waiver participant with the assistance of their Community Supports Coordinator (CSC). CSCs provide information, support, guidance, and assistance to participants during the Medicaid eligibility process and afterwards during ISP development. CSC ~~serve to~~ help the participant identify supports, services, and goods that meet their need for Supports Waiver services and are specific to the participant's qualifying condition.

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

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

The MFW provides the following HCBS: RN case management; private duty nursing (RN, licensed practical nurse [LPN]); home health aide; behavior support consultation; respite care; nutritional counseling; skilled therapies (physical, occupational, and speech) for adults; environmental modifications; individual directed goods and services; specialized therapies; and specialized medical equipment. MFW services are supplementary to EPSDT benefits for recipients under the age of 21. The UNM Health Sciences Center, Center for Development and Disability has a Medically Fragile Case Management Program (MFCMP) that currently provides RN/case management services to both MF waiver and nonwaiver (EPSDT) MF persons statewide. Case managers- from the UNM/MFCMP assess the recipient for MF parameters, compile the MFW LOC forms, and submit the MFW LOC packet to the Medicaid Third Party Assessor (TPA) for an ICF/IID LOC determination. Case Managers also create the MFW recipient's ISP that includes services and budget amounts determined by the LOC.

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

- Members who transition from Community Benefits to a 1915 (c) HCBS Waiver
    - Coordination between the MCO and 1915 (c) Waiver program must be coordinated to avoid gaps in home and community-based services (i.e. Community Benefits and 1915 (c) Waiver) during the transition.
    - The MCO Care Coordinator shall work proactively with the Member and Member's 1915 (c) case manager/consultant to coordinate the transition dates for the Member to move seamlessly from Community Benefits to the 1915 (c) waiver service plan.
- Members in the DD Waiver program
    - The MCO Care Coordinator shall request a copy of the approved DDW LOC packet, consisting of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) abstract (MAD 378 form) and related waiver assessments from
    - the Medicaid TPA for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs;~~.~~
    - A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC packet;~~.~~
    - The MCO Care Coordinator cannot make changes to the Member's DDW ISP and Budget;~~.~~

- The MCO will not complete a NF LOC on Members enrolled in the DD 1915 (c) waiver, unless the Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the Member's DDW case manager in the event of a NF long-term permanent placement;~~.~~
- The MCO will utilize the DDW LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the Member;~~.~~
- The MCO Care Coordinator shall have knowledge that while the MCO is responsible for annual CNA visits, the DD waiver case manager assists the Member with the DD waiver LOC assessment process and ISP and Budget development. The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for Members who are receiving HCBS through the DD waiver.

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

and LOC in-home assessment at the same time in order to reduce the burden to the participant~~/Member~~ and the participant's family;~~.~~

- The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for Members who are receiving HCBS through the Mi Via waiver.

- Members in the Supports Waiver program
  - The MCO Care Coordinator shall request a copy of the approved Supports Waiver LOC packet, consisting of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) abstract (MAD 378 form) and related waiver assessments from the Medicaid TPA for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs.;
  - A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC packet.;
  - The MCO Care Coordinator cannot make changes to the Member's Supports Waiver ISP and Budget.;
  - The MCO will not complete a NF LOC on Members enrolled in the Supports Waiver 1915 (c) waiver, unless the Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the Member's Supports Waiver CSC in the event of a NF long-term permanent placement;~~.~~
  - The MCO will utilize the Supports Waiver LOC obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the Member;~~.~~
  - The MCO Care Coordinator shall have knowledge that while the MCO is responsible for annual CNA visits, the Supports Waiver CSC assists the Member with the Supports Waiver LOC assessment process and ISP and Budget development. The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for Members who are receiving HCBS through the Supports Waiver.

- MCO Members in the MFW Program
  - The MCO Care Coordinator shall request a copy of the approved MFW LOC packet and ISP packet from the MFW case management agency prior to the completion of the CNA. The

MCO will utilize the LOC and ISP information to complete as much of the CNA as possible prior to the visit;~~.~~

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

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

The MCOs are contracted with the MFW case management agency to continue to provide RN/case management services for those individuals (nonwaiver) who meet the MF criteria. The same MF parameters are utilized for nonwaiver Members.

For MF EPSDT (nonwaiver) clients, the MCO Care Coordinator shall:

- Request a copy of the approved MF ISP from the MFW case management agency prior to the completion of the CNA. The MCO will utilize the information in the ISP to complete as much of the CNA as possible prior to the annual visit.
- Not complete a NF LOC assessment on MF EPSDT Members.
- Ensure the MF ISP serves as the CCP for the MF Member.
- Work with the MFW case management agency to coordinate the CNA in-person visits at the same time in order to reduce the burden on these MF Members and families.

- Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF Members. The MFW case management agency will conduct monthly visits or phone conference calls with the MCO Care Coordinator and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CCP as needed.
- Conduct the required annual in-person visit and CNA for MF Members.

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

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

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

Member's file. These efforts are intended to preserve the history of brain injury and ensure that care needs are related to the brain injury diagnosis.

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

4.15 MCO Care Coordination for CARA infants and mothers

4.15.1 Care Coordination Teams

The Contractor is directed to fully delegate care coordinator functions for CARA members (infants) and mothers, as with all other perinatal members. No services shall be withheld while waiting for completion of the HRA or CNA. If the infant is in the mother's custody, infant and mother should have the same care coordinator.

Timelines

Contact with the guardian of the infant in the CARA program should occur within 24 hours of the discharge from the hospital. The HRA should be completed inpatient whenever possible and if not possible should be completed at the call done within 24-hours. CNAs should be done in the Member's home within 7 days of discharge from the hospital. Three attempts to contact the guardian should be made within the first 48 hours of discharge. If the care coordinator is unable to reach the mother and the baby is in the mother's custody, the care coordinator must contact the CARA navigation team.

Communications

The CARA care coordinators should regularly meet with CARA Member assigned pediatricians, hospitals, and home visiting agencies in their community to discuss communication challenges and processes. The care coordinator is required to submit the POC created by the hospital, to the infant's PCP (pediatrician, midwife, or family medicine provider) within 5 business days from receiving notification of a new POC. The HRA and CNA must be submitted to the PCP within 14 business days of discharge. The

CARA care coordinator must create a transition plan when the CARA program ends at the one-year mark for the CARA navigation team to ensure continuity of care for the infant.

This must be completed within the 60 days before the graduation date.

Reporting

The CARA infant's parent/legal guardian has the right to refuse Care Coordination for themselves and/or the infant, and the MCO care coordinator should obtain a Declination Form from the individual refusing Care Coordination in accordance with 4.4.1.5 of the New Mexico Health Care Authority Medicaid Managed Care Services Agreement. In addition, the MCO care coordinator will email the CARA DUR Member Form (MAD 902) to the CARA navigator at ~~CARA.CYFD@cyfd.nm.gov~~~~CARA.CYFD@cyfd.nm.gov~~CARA.CYFD@cyfd.nm.gov-DOH-CARA@DOH.NM.GOV (~~S~~see Appendix 4.17.5).

4.15.2. Care Coordination Presence in Hospitals

The Contractor is directed to assign Members of their Care Coordination team to each of the following hospitals ~~identified below~~:

- University of New Mexico Children's Hospital Level IV,
- Lovelace Women's Hospital Level III,
- Presbyterian Main Hospital Level III,
- Memorial Medical Center Level II, and
- Mountain View Medical Center Level II.

To ensure all eligible CARA infants, birth mothers, and legal guardians are provided the information on the services and supports available, HCA is directing the Contractors to implement the process below:

- Assign a care coordinator to conduct in person daily rounds at each of the facilities above to~~n~~ identify infants admitted to the NICU and the mother/baby unit, who are eligible for care coordination through the MCO.
- The MCO care coordinator will make contact with the staff in the NICU and mother/baby unit, including both social workers and nurses, and obtain a complete list of all Medicaid Members that are currently enrolled or presumptively enrolled with the MCO.

~~Members that are currently enrolled or presumptively enrolled with the MCO.~~

~~unit, including both social workers and nurses, and obtain a complete list of all Medicaid Members that are currently enrolled or presumptively enrolled with the MCO.~~

- The MCO care coordinator will obtain a complete list of infants identified as enrolled or presumptively enrolled with the MCO and born exposed to substances and ensure that a plan of care (POC) has been written by the hospital staff and submitted through the New Mexico Healthy Families portal.

The MCO care coordinator will visit every birth mother and/or CARA infant's legal guardian identified as enrolled or presumptively enrolled with the MCO in the unit and, with consent, discuss services covered by Medicaid and services available to the Member that are not covered by Medicaid, that are available for both mother and infant. Although CARA infants are the focus of this program, every person who has birthed an infant and every infant born who is enrolled or presumptively enrolled in Medicaid should receive an in-person visit from a care coordinator within these 5 hospitals.

If permitted, the MCO care coordinator will attend any discharge planning rounds and team meetings within the unit to make connections to staff to be fully updated on the healthcare status of mothers and infants enrolled or presumptively enrolled with the MCO.

The MCO care coordinator will inform the infant's parent/legal guardian of the full range of services and resources available and provide the name and contact information of the care coordinator assigned to the infant. Whenever possible, the Contractor shall align the mother's Care Coordination with the infant's Care Coordination, as well as any other family Members engaged in Care Coordination with the MCO, by assigning the same care coordinator to all Members of the family.

When feasible, the care coordinator will perform the Health Risk Assessment (HRA) during this initial contact. Services, supports, and resources that should be offered shall include but are not limited to the following:

- Care Coordination;
- Medicaid/Non-Medicaid Home Visiting Programs;
- Value Added Services (VAS) such as infant car seats and diapers offered by the Contractor;
- Housing supports, Supplemental Nutrition Assistance Program (SNAP), and Income Support;

- Substance use disorder counseling and Behavioral Health services, and
- Referrals and scheduling assistance with a pediatrician/Primary Care Provider (PCP) for both infant and mother.

4.16 MCO Care Coordination for Prenatal and Postpartum Members

The Contractor must offer the Full Delegation Model of Care Coordination for all prenatal and postpartum Members, but this Full Delegation Model does not require a specific Value Based Purchasing (VBP) level. The Contractor may offer the Full Delegation Model within Level 1, Level 2, or Level 3 VBP arrangements. If an MCO offers the Full Delegation Model under a Level 3 (Full Delegation), VBP arrangements must outline a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes.

The Assignment to other than a model of full delegation may occur only with HCA prior written approval. The Contractor must have a reasonable justification for not placing the Member in a full delegation model and may request an exception through the Contract Manager in an encrypted email or password protected document as an attachment to an email and must include the following:

- Member name;
- Member Medicaid ID;
- Member DOB;
- Member address;
- Reason for requesting the exception;~~.~~
- Completion date of HRA/~~CNA~~can;
- CCL level (if applicable), and
- Describe how member will ~~be~~ receive~~ing~~ Care Coordination Services from the MCO.

4.17. Appendix

4.17.1 Health Risk Assessment (HRA)

4.17.2 MAD 601: Turquoise Care CNA Exception Request

4.17.3 MAD 869: Care Coordination Declination Form

4.17.4 MAD 866 HCA Standardized CCP

4.17.5 MAD 902 CARA DUR Member Notification Form

4.17.1. Health Risk Assessment

TURQUOISECARE

Health Care Authority (HCA)
Health Risk Assessment (HRA)
CNA Required for Items in BLUE*

Demographic Information			
Member's Name (First, Middle, Last)	**Date of Birth**	**Medicaid ID**	**Assessment Date**

Race/Ethnicity
☐Asian or Pacific Islander ☐Black or African American ☐Hispanic or Latino
☐White or Caucasian non-Hispanic ☐Multiracial or biracial ☐A race/ethnicity not listed
☐Native American or Alaskan Native Tribal Affiliation if applicable:

Has the Member given permission for another person to complete this form?	**Name of person completing/assisting with the completion of this assessment and their relationship to Member (the HRA must be completed by the guardian for Members under the age of 14)**
☐Yes ☐No	

Member's Address	**Member's Telephone**
Street: **City:** **State/Zip:**	**Cell:** **Home:** **Other:**

Email Address	**Preferred Method of Contact**
	☐Voice ☐Text ☐Mail ☐Email

Name of Emergency Contact	**Phone**	**Relation to Member**

Assessment Method
☐Telephonic ☐In-person ☐Other (describe):

Assessment Type
☐Initial assessment ☐Change in health status

	Question	Response
1.	Does the Member have a language need other than English? Do they need translation services?	☐Yes ☐No ☐Yes ☐No If yes, describe
2.	Does the Member have any special preferences we should be aware of?	☐Cultural preference: if yes, describe ☐Hearing Impairment: if yes, describe ☐Literacy: if yes, describe ☐Religion/spiritual needs or preferences: if yes, describe ☐Visual Impairment: if yes, describe ☐None ☐Other: if yes, describe
3.	What is the Member's main health concern right now?	
4.	Does the Member have any current or past physical and/or behavioral health conditions or diagnoses?	☐Behavioral health diagnosis (CNA required*) ☐Substance Use Disorder (SUD) (CNA required*) ☐Comorbid conditions (CNA required*) If yes, describe: ☐Residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (CNA required*) ☐Transplant patient (CNA required*) ☐Medically Fragile Waiver Program (CNA required*) ☐Other Waiver Program (CNA required*) ☐Medically Frail (CNA required*) ☐Traumatic Brain Injury/Acquired Brain Injury

		(TBI/ABI) (CNA required*) ☐Dementia/cognitive deficits (CNA required*) ☐Other acute or terminal disease (CNA required*) If yes, describe: ☐Other chronic condition (CNA required*) ☐None
5.	What sex was the Member assigned at birth, on their original birth certificate?	☐ Male ☐ Female ☐ X or intersex ☐ Decline/prefer not to answer
6.	*For individuals over 10 years of age:* What is the Member's current gender?	☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Non-binary ☐ Other: if yes, describe ☐ Decline/prefer not to answer ☐N/A *We ask this for reporting only. Your response will not have an effect on your benefits.*
7.	*For individuals over 10 years of age:* What is the Member's Sexual Identity?	☐ Gay or lesbian ☐ Straight, that is not gay or lesbian ☐ Bisexual ☐ Other: if yes, describe ☐ Decline/prefer not to answer ☐N/A *We ask this for reporting only. Your response will not have an effect on your benefits.*
8.	*For individuals over 10 years of age:* Is the Member pregnant?	☐Yes ☐No ☐N/A (if yes, CNA required*)
9.	Home Visiting is a program that can give you tips to help your baby sleep safely, breastfeeding and nutrition support, finding child care, preparing for school, and more. Home visitors come to see you in the convenience of your home or via remote telehealth sessions at no cost to you. Is the Member interested in being referred to Home Visiting?	☐Yes ☐No ☐N/A if yes, enter Home Visiting Provider Member was referred to:
10.	*For individuals over 10 years of age:* Does the Member currently use tobacco and/or nicotine products? If yes, are they interested in receiving information on or participating in a tobacco cessation program? Does the Member have a history of using tobacco and/or nicotine products?	☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A
11.	What are the Member's most significant needs today?	
12.	Does the Member need help finding a physical or behavioral healthcare provider?	☐Yes ☐No (if yes, refer to Member services)
13.	Has the Member visited the Emergency Room in the past 12 months?	☐Yes ☐No

	If yes, how many visits?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more (if 4 or more, CNA required*)
14.	Has the Member stayed overnight in the hospital in the past 6 months? If yes, was the Member readmitted within 30 days of discharge?	☐Yes ☐No ☐Yes ☐No (if yes, CNA required*)
15.	How many medications is the Member currently taking?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more (if 6 or more, CNA required*)
16.	Is the Member in any of the following situations?	☐Justice involved ☐Children, Youth, and Families Department (CYFD) custody ☐Working with the Department of Health on a Plan of Care for the Comprehensive Addiction and Recovery Act (CARA) (if yes to any, CNA required*)
17.	What is the Member's current living situation?	☐Living alone ☐Living with family/spouse ☐Living with others unrelated ☐Homeless (CNA required*) ☐Living in shelter (CNA required*) ☐Living in group home ☐Lives in out of state facility (CNA required*) ☐Dependent child in out of home placement (CNA req.*) ☐Living in a nursing facility ☐Living in assisted living facility ☐Other: if yes, describe
18.	Does the Member need assistance with 2 or more of the following?	☐Yes ☐No (if yes, CNA required*) ☐Bathing ☐Dressing ☐Grooming ☐Toileting ☐Transfer ☐Bowel/bladder ☐Eating ☐Mobility assistance ☐Meal preparation ☐Daily medication ☐Light housekeeping ☐Other: _____
19.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Does the Member have a living will or an advance directive in place? Could I send the Member more information?	☐Living will ☐Advance directive (for medical care) ☐Advance directive (for psychiatric care) ☐No living will or advance directive in place ☐Declined discussion ☐Requested further information

20.	Guidelines for Assessor explanation of Care Coordination: • A care coordinator is your main point of contact for information about services covered by [MCO name]. • These services include medications, doctor's appointments, physical therapy, medical equipment, hospital visits, vision and dental services and transportation to medical appointments. • Your care coordinator can help you find out if you qualify for Community Benefits. These benefits might include someone coming to your home to help you prepare meals or make home repairs that you need to stay safe. • Your care coordinator will help you find extra care and services from providers or community programs that are not covered by [MCO name]. • Your care coordinator will work with you and those who care for you to create a care plan. A care plan can help you meet your health goals. • There are two types of Care Coordination – Level 1 and Level 2. Level 1 is for people who need assistance with some of their health needs. Level 2 is for people with higher needs. • Your care coordinator will visit you in-person to do a Comprehensive Needs Assessment, or CNA. • The CNA will help find out what services you can receive. • Your care coordinator will check in with you by telephone as needed. • Your care coordinator will visit you in your home at least once a year. • You can ask for a higher level of Care Coordination at any time. • Native American Members have the right to request a Native American care coordinator.	
21.	Is the Member interested in receiving Care Coordination Services?	☐Yes ☐No (If yes, CNA required*)
22.	*For the Assessor: Inform the Member about specific next steps, such as scheduling the CNA, transferring the Member to Member Services, or supplying contact information for Income Support Division (ISD) for assistance with any issues that were discussed during the HRA.*	

4.17.2. MAD 601: Turquoise Care CNA Exception Request

Health Care Authority (HCA)
Comprehensive Needs Assessment (CNA)
Exception Request

TURQUOISECARE

Member Information	
Member's Name (First, Middle, Last)	**Medicaid ID**
Request Date	**Proposed Assessment Date**
Date of last *In-Person In-Home* CNA	**Does the Member have NFLOC?**

Requestor Information		
Name	**Title**	
Email Address		**Phone Number**

Member Diagnoses

Reason for Request

Proposed Alternate Location
Name of location: **Street address:** **City:** **State/Zip:** **Phone:**

Notes/Plan for Monitoring Home Environment

4.17.3 MAD 869: Care Coordination Declination Form

Health Care Authority (HCA)
Care Coordination Declination

Member's Name (First, Middle, Last)	Medicaid ID

Care Coordination Supports

You told us that you did not want Care Coordination support. You have the right to decline this Turquoise Care support that is available at no cost to you. We want to make sure that you know what Care Coordination does and how it helps you.
Your Comprehensive Needs Assessment (CNA) helps decide which level of Care Coordination would be best for you. A care coordinator can help you manage your health and learn how to work with your providers to reach your health goals. A care coordinator is assigned to help you if level 1 or level 2 care coordination would best fit your needs.
If you are identified for Care Coordination, a care coordinator comes to your home and does an in-depth assessment. This assessment helps us know what healthcare services and supports are best for your needs.

Community Benefit Services

You may be able to get Community Benefits if you have certain long-term care needs. For example, if you need help with bathing, dressing, or moving around, you may qualify for these benefits. You must have an assessment done in your home by a care coordinator to get long-term care services. The assessment will tell us what your needs are, and which services may help support you in your home and the community, while safely meeting your healthcare needs. These long-term care services and supports are provided in your home or community. Your care coordinator will talk with you about your options if you qualify for Community Benefit services.

Agency-Based Community Benefit (ABCB) long-term care services covered by Turquoise Care include:

- Adult day health
- Assisted living
- Behavior support consultation
- Community transition services
- Emergency response services
- Employment supports
- Environmental modifications
- Home health aide
- Nursing respite services
- Nutritional counseling
- Personal care services (21 and older)*
- Private duty nursing (21 and older)*
- Respite services
- Skilled maintenance therapies*
  - Occupational Therapy (21 and older)
  - Physical Therapy (21 and older)
  - Speech Therapy (21 and older)

Self-Directed Community Benefit (SDCB)

You can choose to self-direct your care if you qualify for long-term care services and if you have been getting Agency-Based Community Benefit services for 120 calendar days. This means that you can select, hire, fire, and train your long-term Community Benefit care providers. You must also manage a budget and care plan for your long-term care services. You can direct your own SDCB services. Your care coordinator can explain your options and give you more information to help you decide if this is the right option for you. SDCB services covered by Turquoise Care include:

- Behavior support consultation
- Customized community supports
- Emergency response services
- Employment supports
- Environmental modifications
- Home health aide
- Nutritional counseling
- Private duty nursing (21 and older)*
- Related goods
- Respite
- Self-Directed Personal Care (21 and older)*
- Skilled maintenance therapies (21 and older*)
- Specialized therapies
- Start-up good and services
- Transportation (non-medical)

*Members under age 21 may get these services, as medically necessary, through their general Medicaid benefit.

I would like to decline Care Coordination Supports.
Member Name
Signature
Member Representative Name
Signature
Date

More Information
If, at a later date, you are interested in Care Coordination or need these supports or services, please contact [MCO] Care Coordination at [MCO Care Coordination Unit phone], or toll-free at [MCO Care Coordination Unit phone] and a care coordination representative will be happy to assist you.

Please return a signed copy of this form to:
[MCO address]

4.17.4 MAD 866 HCA Standardized CCP

TURQUOISECARE

Health Care Authority (HCA)
Comprehensive Care Plan (CCP)

Demographic Information			
Member's Name (First, Middle, Last)		**Date of Birth**	**Medicaid ID**
Name of Emergency Contact	**Phone**	**Relation to Member**	
Most Recent CNA Completion Date	**CCP Start Date**		
Medicaid Eligibility Renewal Date	**Preferred Method of Contact**		
	☐Voice ☐Text ☐Mail ☐Email		

Interdisciplinary Care Team (ICT) Information (Power of Attorney, parent, spouse, partner, providers, natural supports etc. – if applicable)		
Care Coordinator	**Phone**	**Email**
Name/Title	**Phone**	**Email (if applicable)**
Name/Title	**Phone**	**Email (if applicable)**
Name/Title	**Phone**	**Email (if applicable)**
Add rows for additional ICT participants		

Services that will be authorized by the MCO Including amount, frequency, duration and scope (tasks and functions to be performed) of each service to be provided.

Physical Health (PH) and Behavioral Health (BH) Conditions/Diagnoses Conditions, needs and functional status (i.e., areas of functional deficit); relevant information regarding the Member's PH and BH condition(s), including treatment that is needed by a Provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care.

Medications Including names, dosages, frequency, and discontinued medications

Backup Plan I will talk with backup paid or unpaid caregivers about when they are available and my care needs before a situation comes up. I will call one of the people listed below if my scheduled paid or unpaid caregiver does not show up at his/her scheduled time (examples: provider, friends, family, former workers, church members, other volunteers).			
Name	**Phone**	**Address**	**Relationship**
Name	**Phone**	**Address**	**Relationship**

Name	Phone	Address	Relationship
Add rows for additional contacts			
This is my plan in case my caregiver(s) don't show up and I can't reach one of the people listed above:			

Disaster Preparedness Plan		
I will make and post a list of emergency contacts that my providers can easily find in the event of an unsafe or harmful situation. (Example: who to call for help in an emergency, or for help with decisions).		
Name	**Phone**	**Will be able to help with**
Name	**Phone**	**Will be able to help with**
Name	**Phone**	**Will be able to help with**
Add rows for additional contacts		
These are my plans for a natural disaster, emergency preparedness, and/or evacuation plan. This includes care of service animals or pets.		
I understand I may only get my critical needs met in an emergency. Below is an up to date list of the tasks that are essential to my health and welfare:		
☐Review needed items to take: (check all that apply) ☐Medication/drugs ☐Oxygen tank/concentrator ☐Nebulizer and attachments ☐Wound care supplies ☐Catheters/supplies ☐Feeding tube supplies ☐Identification (ID) cards and valuable papers ☐Special food ☐Clothing ☐Purse/wallet ☐Medical summary ☐Names/contact information of providers ☐Other:		
Fill out appropriately to coordinate services		
☐DME needs/provider: ☐Transportation needs/company: ☐I can get my medication drugs at: ☐Home health care agency: ☐Care of service animals or pets: ☐Have a list of emergency contacts (including my care coordinator) ☐Discussed with my care coordinator ways to stay safe in case of a fire, flood, or any other natural disaster. *If I believe I am at risk of harm from abuse, neglect, or being taken advantage of, I know that I should call **Adult Protective Services at 1-866-654-3219. Child Protective Services at 1-855-333-7233.** *If I believe I am experiencing an emotional crisis or having thoughts of hurting myself or others, I know that I should call the **New Mexico Crisis and Access Line at 1-855-NMCRISIS (662-7474).**		

Other Services that will be Provided to the Member Any non-covered services including services provided by other community resources, including social support services, and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive institutional placement, as reported by the Member.
☐N/A

Information About Services Provided by Medicare Payers, Medicare Advantage Plans and Medicare Providers To coordinate services for Members who are also Dual Eligible, as reported by the Member
Information/assistance needed/provided: ☐No needs identified ☐N/A

Frequency of Planned Care Coordinator Contacts Shall include consideration of the Member's individualized needs and circumstances and which shall meet minimum required contacts (additional care coordinator contacts shall be provided as needed).
☐**CCL1 Contact Guidelines:** 1 CNA per year, in-person and phone contacts as needed
☐**CCL2 Contact Guidelines:** 2 CNAs per year, in-person and phone contacts as needed
☐**Other** contact schedule requested by Member (list):

Member's Choice (if applicable)		
☐Home and Community Based Services (HCBS)	☐Agency Based	☐Self Directed Community Benefit (SDCB)
☐Institutional Care		

Opportunities, Goals, Interventions and Desired Health, Functional and Quality of Life Outcomes for the Member		
Opportunity: ☐**High Priority** ☐**Medium Priority** ☐**Low Priority**		
Strengths:		
Barriers:		
☐**Member deferred discussion** **Reason deferred (if stated):** ☐**Member declined discussion** **Reason declined (if stated):**		
Goal:		
Action I will take to achieve this goal:		
Begin Date:	Target End Date:	Date Goal Accomplished:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:

Opportunity: ☐**High Priority** ☐**Medium Priority** ☐**Low Priority**			
Strengths:			
Barriers:			
☐**Member deferred discussion** **Reason deferred (if stated):** ☐**Member declined discussion** **Reason declined (if stated):**			
Goal:			
Action I will take to achieve this goal:			
Begin Date:	Target End Date:	Date Goal Accomplished:	
Progress Update:			Date:
Progress Update:			Date:
Progress Update:			Date:
Progress Update:			Date:
Progress Update:			Date:
Progress Update:			Date:
Add rows for additional opportunities/goals			

4.17.5 MAD 902 CARA DUR Member Notification Form

Member Notification Form

(DUR: Difficult to Engage, Unable to be Reached, Refused Care Coordination)

MCOs: Please email this document to CARA Staff: CARA.CYFD@cyfd.nm.gov

Date: _____

Care Coordination Level:
☐Difficult To Engage (DTE)
☐Unable to be Reached (UTR)
☐Refused Care Coordination (RCC)

SCI Report:
Was an SCI Report completed? ☐Yes ☐No

MCO Reporter
Name
MCO
Phone Number
Email

CARA Member Information
Name
Medicaid ID
Member Date of Birth

Parent/Guardian Contact Information:	
Name	
Address:	
Phone	Email

Please provide requested information in the appropriate section below:

Unable To Be Reached (UTR) Outreach Attempts
Please include the dates and times of telephonic attempts and any additional methods used to contact member. Date UTR letter sent:

Difficult To Engage (DTE) Outreach Attempts
Please include the most recent successful contact date and subsequent unsuccessful telephonic contact attempts. Date UTR letter sent:

Refused Care Coordination (RCC) Documentation
Please document the date that the member's parent/guardian refused Care Coordination. Did parent/guardian sign Care Coordination Declination form? ☐Yes ☐No

Additional Information
Please include the New Mexico Healthy Families (NMHF) portal Plan of Care (POC) ID. *Example: ZAL-T56-8427*
For CYFD Use: enter additional information as appropriate.
Example: Alternate member contact information, member request to re-engage

4.17.6 MAD 867 HCA Comprehensive Needs Assessment

Health Care Authority (HCA)
Comprehensive Needs Assessment (CNA)

Demographic Information			
Member's Name (First, Middle, Last)	**Date of Birth**	**Medicaid ID**	**Assessment Date(s)**

Race/Ethnicity

☐Asian or Pacific Islander ☐Black or African American ☐Hispanic or Latino
☐White or Caucasian non-Hispanic ☐Multiracial or biracial ☐A race/ethnicity not listed
☐Native American or Alaskan Native, —Tribal Affiliation if applicable:

What sex was the Member assigned at birth?

☐Male ☐Female ☐X or intersex ☐ Decline/prefer not to answer

What is the Member's current gender?

☐Male ☐Female ☐Transgender Man ☐Transgender Woman ☐Non-binary ☐Other
☐ Decline/prefer not to answer

What is the Member's sexual identity?

☐Gay or lesbian ☐Straight, that is not gay or lesbian ☐Bisexual ☐Other
☐ Decline/prefer not to answer

Member's Address	**Member's Telephone**
Street: **City:** **State/Zip:**	**Cell:** **Home:** **Other:**
Email Address	**Preferred Method of Contact**
	☐Voice ☐Text ☐Mail ☐Email

Name of Emergency Contact	**Phone**	**Relation to Member**

MCO Enrollment Date	**Category of Eligibility (COE)**
Medicaid Eligibility Begin date	**Medicaid Eligibility Renewal Date**

Is the Member Justice-Involved?	**Is the Member a Comprehensive Addiction and Recovery Act (CARA) individual?**
☐Yes ☐No If yes, specify	☐Yes ☐No

Is the Member Children Youth and Families Department (CYFD)

☐Yes ☐No
If yes, specify

Is the Member a Child In State Custody (CISC)?

☐Yes ☐No

If yes, specify	
Does the Member have any other insurance in addition to New Mexico Medicaid? ☐Yes ☐No If yes, specify	**Is the Member on a Waiver?** ☐Yes ☐No If yes, clarify type of Waiver
Assessment Method ☐In-person in-home ☐In-person (alternate location exception approved) ☐Telephonic (exception approved) ☐Video (exception approved)	
Assessment Type (check all that apply) ☐Initial ☐Annual ☐Semi-Annual ☐Change in Condition ☐Treat First	
Name/Relation of Person(s) Completing CNA if Other than Identified Member	

Name/Relation of Person(s) Participating in the CNA in addition to the Member, if applicable

Authorized Representative Information **(Power of Attorney, Parent, Spouse, Partner, etc. – if applicable)**		
Name/Title	**Phone**	**Email**
Who is the decision maker?	**Was documentation submitted?**	**Type of documentation submitted**
	☐Yes ☐No	
Do we have permission to contact the representative without the Member present?		
☐Yes ☐No		

Introduction		
Number	**Question**	**Response**
1.	Before beginning, is the Member experiencing an emergency right now? For example, chest pain, stroke symptoms, or thoughts of hurting themselves or someone else?	☐Yes ☐No STOP AND CALL 911 IF THERE IS IMMINENT RISK.
2.	Does the Member meet requirements for a Community Benefits Service Questionnaire (CBSQ)/Community Benefits Member Agreement (CBMA)?	☐Yes ☐No If yes, complete CBSQ/CBMA
3.	What are the Member's most significant needs today?	
4.	Does the Member have a language need other than English? Does the Member need translation services?	☐Yes ☐No ☐Yes ☐No If yes, describe

5.	Does the Member have any special preferences we should be aware of?	☐Cultural preference If yes, describe ☐Literacy If yes, describe ☐Religion/spiritual needs or preferences If yes, describe ☐None ☐Other If yes, describe
6.	How many times has the Member been seen in the Emergency Department in the last 12 months?	☐0 ☐1 ☐2 ☐3 ☐4 or more ☐ unknown Describe, if appropriate
7.	Does the Member need information on alternatives to the Emergency Department?	☐Yes ☐No
8.	How many times has the Member been in the hospital in the last 6 months?	☐0 ☐1 ☐2 ☐3 or more Describe, if appropriate
9.	Has the Member been approved for or are they waiting for any type of transplant?	☐Yes ☐No If yes, specify

Vision/Hearing/Dental		
Number	**Question**	**Response**
10.	Does the Member currently have any vision issues?	☐Yes ☐No If yes, describe
11.	When was the last time the Member had their vision tested by an eye care professional?	

12.	Does the Member need any assistance obtaining an eye care professional appointment?	☐Yes ☐No
13.	Does the Member have any hearing issues?	☐Yes ☐No If yes, describe
14.	When was the last time the Member had their hearing tested by a hearing professional?	
15.	Does the Member need any assistance obtaining an appointment with a hearing specialist?	☐Yes ☐No If yes, describe
16.	When was the last time the Member had a dental visit?	
17.	Does the Member need any assistance obtaining a dental appointment?	☐Yes ☐No If yes, describe

Pregnancy (if applicable)		
Number	**Question**	**Response**
18.	Is the Member currently pregnant?	☐Yes ☐No If yes, have they had prenatal care? ☐Yes ☐No If yes, what is their due date? If yes, have they been told their pregnancy is high risk? ☐Yes ☐No If yes, do they need assistance finding a Maternal Health Care Provider or scheduling an appointment? ☐Yes ☐No If no, have they been pregnant within the last 12 months? ☐Yes ☐No If yes, have they experienced postpartum depression? ☐Yes ☐No
19.	How many times has the Member been pregnant (including current pregnancy if pregnant)? How many viable births has the Member had?	
20.	Does the Member have a history of mutiple births?	☐ Yes ☐No ☐ Unknown
21.	Has the Member ever had a C-section?	☐ Yes ☐No ☐ Unknown
22.	Did the Member ever experience complications during a previous pregnancy or delivery?	☐Yes ☐No ☐N/A If yes, specify
23.	Is the Member interested in being referred to a Maternal Home Visiting program?	☐Yes ☐No ☐N/A if yes, enter Home Visiting Provider Member was referred to:

Physical Health (PH) Needs		
Number	**Question**	**Response**
24.	How would the Member describe their overall health compared to a year ago?	☐Excellent ☐Good ☐Fair ☐Poor

25.	What physical health conditions/diagnoses does the Member have?	☐Diagnosis ☐Self-Reported
26.	What is the Member's height? What is the Member's weight?	
27.	Does the Member have any known allergies not related to medications?	☐Yes ☐No If yes, specify to what and the type of reaction
28.	Has the Member seen a healthcare provider in the last 12 months (to include any preventative health screenings, vaccinations)?	☐Yes ☐No If yes, specify
29.	Does the Member need assistance obtaining an appointment with a Primary Care Provider (PCP) or a healthcare provider?	☐Yes ☐No
30.	In the last 12 months, has the Member (child) had a well-child visit?	☐Yes ☐No If yes, enter date
31.	When was the Member's last mamogram (if applicable)?	
32.	When was the Member's last pap smear (if applicable)?	
33.	Has the Member had a colorectal screening (if applicable)?	☐Yes ☐No If yes, specify If no, specify
34.	What surgeries, procedures, treatments has the Member had in the past?	
35.	Does the Member have any medical appointments, medical tests, surgeries, or other health services planned for the next 3-6 months?	☐Yes ☐No If yes, specify
36.	Does the Member need assistance in scheduling appointments or procedures?	☐Yes ☐No
37.	Does the Member use or need Durable Medical Equipment (DME)?	☐Yes ☐No If yes, specify
38.	Does the Member need assitance obtaining needed DME?	☐Yes ☐No If yes, specify
39.	Does the Member have any neurological diagnoses such as dementia, epilepsy, or a Traumatic Brain Injury (TBI) or Aquired Brain Injury (ABI)?	☐Yes ☐No If yes, specify diagnoses and onset date
40.	Does the Member smoke, vape, or chew tobacco?	☐Yes ☐No If yes, are they interested in receiving information on or participating in a tobacco cessation program? ☐Yes ☐No

Medication		
41.	Does the Member take any prescribed or over the counter medications?	☐Yes ☐No If yes, specify: ☐1☐2☐3☐4☐5 ☐6 or more
42.	Is the Member able to obtain all their needed medications?	☐Yes ☐No If no, specify
43.	Does the Member have any prescribed or over the counter medications that they are no longer taking?	☐Yes ☐No If yes, specify
44.	Does the Member have any known allergies to medications?	☐Yes ☐No If yes, specify to which medication and the type of reaction

45.	Does the Member take medications that cannot be stopped or would risk their life if not taken?	☐Yes ☐No If yes, specify

Behavioral Health (BH) Needs		
46.	What behavioral health conditions/diagnoses does the Member have?	☐Diagnosis ☐Self-Reported
47.	In the past 12 months has the Member had any BH inpatient/residential admisssions?	☐Yes ☐No If yes, specify
48.	When was the Member's most recent visit to a BH provider?	
49.	Does the Member need any asssitance obtaining a BH provider or appointment?	☐Yes ☐No If yes, specify
50.	Does the Member have a good overall understanding of their BH condition(s)?	☐Yes ☐No ☐Unsure
51.	Does the Member have any current or past alcohol or substance use issues?	☐Yes ☐No If yes, specify

PHQ-2/PHQ-9					
In the past two weeks, how often have you been bothered by any of the following problems?					
		Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
52.	Little interest of pleasure in doing things	0	1	2	3
53.	Feeling down, depressed, or hopeless	0	1	2	3
	Column Totals (questions 52-53)				
	Total PHQ-2 Score (add column totals)				

If applicable, continue with questions 54-61:					
54.	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
55.	Feeling tired or having little energy	0	1	2	3
56.	Poor appetite or overeating	0	1	2	3
57.	Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
58.	Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
59.	Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around alot more than usual	0	1	2	3
60.	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
	Column Totals (questions 52-60)				
	Total PHQ-9 Score (add column totals)				
61.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult			
CAGE					
62.	Have you ever felt you should cut down on your drinking?	☐Yes (1) ☐No (0) If yes, specify			

63.	Have people annoyed you by criticizing your drinking?	☐Yes (1) ☐No (0) If yes, specify
64.	Have you ever felt bad or guilty about your drinking?	☐Yes (1) ☐No (0) If yes, specify
65.	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐Yes (1) ☐No (0) If yes, specify
	Total Score	

Health Related Social Needs (HRSN)		
66.	Does the Member have any indicators of housing insecurity?	☐Yes ☐No If yes, specify

67.	Does the Member live alone or with others?	☐Alone ☐With others If with others, specify
68.	Does the Member feel physically and emotionally safe where they are living?	☐Yes ☐No If no, specify
69.	Does the Member have urgent needs (example: Member does not have a place to sleep tonight, no food, or has fear of harm in the home)?	☐Yes ☐No If yes, specify
70.	Would the Member like a referral to our Housing Specialist?	☐Yes ☐No
71.	Does anyone in the Member's household receive Community Benefit (CB) services?	☐Yes ☐No If yes, specify Type of services received MCO services are received from
72.	Does the Member have any natural supports such as an unpaid family/friend caregiver?	☐Yes ☐No If yes, list name(s) and contact information If yes, does the Member feel the time spent with the natural support meets their needs? ☐Yes ☐No If no, explain
73.	Does the Member have a paid caregiver?	☐Yes ☐No If yes, list name(s) and contact information If yes, specify hours/days per week
74.	Does the Member have sufficient child care?	☐Yes ☐No ☐N/A
75.	Within the past 12 months, has the Member worried that they would run out of food or has the food the Member bought run out and the Member did not have money to get more?	☐Yes ☐No
76.	How does the Member describe their current work situation/employment status?	
77.	What is the Member's primary source of income?	
78.	Is the Member able to manage financial matters independently?	☐Yes ☐No If no, specify
79.	Does the Member have any legal issues?	☐Yes ☐No If yes, specify
80.	Does the Member have reliable transportation?	☐Yes ☐No If no, specify

81.	Does the Member need any assistance in obtaining or referrals for:	

	• Housing • Caregiver support • Childcare support • Food • Employment • Transportation • Financial/Legal • Utilities	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)		
82.	Does the Member need assistance with any of the following ADLs?	Bathing ☐Yes ☐No If yes, describe Dressing ☐Yes ☐No If yes, describe Grooming ☐Yes ☐No If yes, describe Bowel/bladder ☐Yes ☐No If yes, describe Toileting ☐Yes ☐No If yes, describe Eating ☐Yes ☐No If yes, describe Mobility Assistance ☐Yes ☐No If yes, describe Transfer ☐Yes ☐No If yes, describe Meal preparation and assistance ☐Yes ☐No If yes, describe Daily medication ☐Yes ☐No If yes, describe
83.	Does the Member need assistance with any of the following IADLs?	Support Services ☐Yes ☐No If yes, describe Minor Maintenance of DME ☐Yes ☐No If yes, describe Light Housekeeping ☐Yes ☐No If yes, describe Finances ☐Yes ☐No If yes, describe
84.	Does the Member have any indications of fall risk?	☐Yes ☐No If yes, specify

85.	Does the Member need to be evaluated for a Nursing Facilty Level of Care (NF LOC) or do they intend to access Long Term Services and Supports (LTSS)?	☐Yes ☐No
Summary		
86.	What is the Member's main health goal or outcome they want to achieve?	

87.	Provide a summary of the Member's Physical Health (PH), including objective observations related to the Member's physical health.	
88.	Provide a summary of the Member's Behavioral Health (BH), including objective observations related to the Member's behavior.	
89.	Provide overall, objective observations of: • Safety of the Member's home environment • Member's vision, hearing, language • Member's caregiver resources or needs, including a summary of objective observations related to the Member's functional needs (example: no mobility limitations observed, unsteady gait observed, if Member was able to operate assistive devices/DME, indicate Member's range of motion, were they able to sign paperwork/eat/drink, any observations that may impact the Member's ability and inability to perform ADLs/IADLs) • Member's HRSN needs • Any additional observations	
90.	What community/provider referrals were needed and/or provided to the Member?	
91.	What assistance was needed and/or provided to the Member in scheduling appointments?	
92.	Does the Member have an advance directive?	☐Yes ☐No If no, would they like more information? ☐Yes ☐No

Care Coordination Engagement

93.	Per Comprehensive Needs Assessment, Member meets criteria for (may check more than one box):	☐CCL1 (at a minimum) ☐Member has current NF LOC and/or requires assistance with two (2) or more ADLs or IADLs living in the community* ☐Perinatal or maternal health Member or Member engaged in Maternal Home Visiting (MHV) ☐Waiver Member ☐Member with three or more complaints, grievances, or appeals related to the Member's experience with the service delivery system ☐Behavioral Health diagnosis (non-SUD/SMI/SED) ☐Is a dependent child in an out-of-home placement ☐Frequent emergency room use with four or more annual individual patient visits* ☐Readmitted to the hospital within thirty (30) Calendar Days of discharge ☐Dementia, mild or more significant cognitive deficits requiring prompting or cueing ☐Has poly-pharmaceutical use, defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class ☐Other (specify) ☐CCL2 ☐High-Cost High Needs (HCHN) Member* ☐Member with Substance Use Disorder (SUD) ☐Member with Serious Emotional disturbance (SED) ☐Member with Serious Mental Illness (SMI) ☐Justice-Involved Member* ☐Member has a TBI

		☐Member has housing insecurity ☐Children In State Custody (CISC) Member* ☐CARA Member* ☐Member is in an out-of-state placement* ☐Medically Fragile Member ☐Is a transplant recipient ☐Is residing in an ICF/IID ☐Multi-comorbidity ☐Has an acute disease, as defined by the MCO ☐Terminal disease ☐Medically Frail ☐Other (specify) *Members with the below indicators may not be leveled down: • 095 and 096 Members; • CISC Members; • CARA Members; • Members with four or more annual individual emergency department or inpatient visits; • Members defined as high-cost high-need; • Members with a Nursing Facility Level of Care; • Members in Out of State Placement; • Members who have been incarcerated in the last year; or • Members who are homeless.

At this time, the care coordinator will explain Care Coordination to the Member, including the number of touch points for the two levels and what a care coordinator can assist with.		
94.	Is the Member interested in Care Coordination?	☐Yes ☐No
95.	What is the Member's assigned Care Coordination Level?	☐CCL0 ☐CCL1 ☐CCL2 ☐Initial Not Otherwise Medicaid Eligible (NOME) If the Member's assigned Care Coordination Level does not match criteria noted in Q.93, please specify the reason:

96.	If the Member refused Care Coordination: Was the HCA approved Care Coordination Declination Form explained and signed? What was the reason for refusal?	☐Yes ☐No ☐N/A If no, explain Specify
97.	Summarize the care coordinator's conclusions about the Member's eligiblity and access to community resources and the next steps that will be taken by the care coordinator and the Member.	
At this time, the care coordinator will discuss the Comphensive Care Plan (CCP) and process for the CCP with the Member.		
98.	Were the CBSQ and CBMA completed?	☐Yes ☐No ☐N/A If no, explain
At this time, the care coordinator will explain Alternative Benefit Program (ABP) Exempt to the Member.		
99.	Does Member have a COE 100 ABP? Does Member want to be evaluated for ABP Exempt?	☐Yes ☐No ☐Yes ☐No ☐ABP ☐ABP Exempt ☐N/A
100.	Does the Member qualify for ABP Exempt?	☐Yes ☐No If yes, specify PH or BH exempt reason
101.	Has the care coordinator assessed the Member's living arrangement to ensure compliance with the HCBS settings rule?	☐Yes ☐No ☐N/A If no, explain
102.	Member was provided with information on all available services and benefits.	☐Yes ☐No If no, explain
103.	Describe the member's satisfaction with services and care.	
104.	Is the Member being assessed for Complex Case Management or considered for initial NFLOC?	☐Initial NFLOC ☐Complex Case Management ☐N/A

4.17.7 MAD 868 HCA Standardized TOC Assessment

Health Care Authority (HCA)
Transition of Care (TOC) Assessment/Plan

1. Demographic Information			
Member's Name (First, Middle, Last)		**Date of Birth**	**Medicaid ID**
Date of MCO Notification of Transition	**TOC Plan Start Date**	**Transition Date**	**TOC Plan Completion Date**
Member's Address Prior to Transition **Street:** **City:** **State/Zip:**		**Member's Telephone** **Cell:** **Home:** **Other:**	
Email Address		**Preferred Method of Contact** ☐Voice ☐Text ☐Mail ☐Email	
Name of Emergency Contact	**Phone**	**Relation to Member**	
Medicaid Eligibility Begin date		**Medicaid Eligibility Renewal Date**	

The CISC PC contact information will only be completed/populated into the TOC plan provided for CISC Members.

For Children in State Custody (CISC) Members (if applicable):	
Permanency Coordinator (PC) Name	**PC Phone**

Transition Type:

☐ Nursing Facility (NF)
Higher to lower Level of Care (LOC):
- ☐Acute inpatient (IP)
- ☐Residential Treatment Center (RTC)
- ☐Social detoxification program
- ☐Treatment Foster Care (TFC)
- ☐Other (specify)

☐ Turning 21 (complete sections 1, 5, and 6 only)
☐ Substance exposed infants: 60 days prior to graduation from Comprehensive Addiction and Recovery Act (CARA) program (complete sections 1, 2, 5, and 7 only)
☐ CISC 066/086 Members (sections 1, 2, 5, and 8 only)

☐ Other (specify)

This section will only be completed/populated into the TOC plan provided for Members discharging from a facility.

2. Coordination with Discharge (D/C) Planning Team

If no needs are identified for a requirement, enter "none" in Needs column

Summary of contact attempts
(if d/c planning team was not reached, enter "None" in "Needs Identified by D/C Planning Team column)

	Requirement	Needs Identified by D/C Planning Team	Actions
1.	Need for Home and Community Based Services	☐None ☐Yes (if yes, describe)	

2.	Follow-up appointments	☐None ☐Yes (if yes, describe)	
3.	Therapies and treatments	☐None ☐Yes (if yes, describe)	
4.	Medications	☐None ☐Yes (if yes, describe)	
5.	Durable Medical Equipment (DME)	☐None ☐Yes (if yes, describe)	

This section will not be completed for Members Turning 21 and will only populate into the TOC plan provided to the Member if it is completed.

3. Transition of Care (TOC) Assessment/Plan

If no needs are identified for a requirement, enter "none" in Needs column

	Requirement	Needs	Actions
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Community Benefits	☐None ☐Yes (if yes, describe)	
4.	Continuation of Medicaid eligibility	☐None ☐Yes (if yes, describe)	

5.	PH/BH providers	☐None ☐Yes (if yes, describe)	
6.	Community resource providers	☐None ☐Yes (if yes, describe)	
7.	Housing	☐None ☐Yes (if yes, describe)	
8.	Financial	☐None ☐Yes (if yes, describe)	
9.	Interpersonal skills	☐None ☐Yes (if yes, describe)	
10.	Safety	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided to the Member if they require a 3-Day Post-Discharge In-Home Assessment (Members transitioning from inpatient hospital or NF stay who may be in need of Community Benefits).

4. 3-Day Post-Discharge In-Home Assessment

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Safety in the home environment	☐None ☐Yes (if yes, describe)	
2.	Physical Health Needs	☐None ☐Yes (if yes, describe)	
3.	Behavioral Health Needs	☐None ☐Yes (if yes, describe)	

4.	Housing Needs	☐None ☐Yes (if yes, describe)	
5.	Continuation of Medicaid Eligibility	☐None ☐Yes (if yes, describe)	
6.	Financial Needs	☐None ☐Yes (if yes, describe)	
7.	CNA **if one is not in place**	☐None ☐Yes (if yes, describe)	
8.	Community Benefit needs and services in place	☐None ☐Yes (if yes, describe)	

5. Monthly Follow-Up (for 3 months)

The Transition of Care Plan shall remain in place for a minimum of 60 calendar days from the date of the decision to pursue transition or until the transition has occurred and a new CCP is in place. If the

CCP is in place prior to the 3rd monthly follow-up, that assessment is not required to be conducted. If no needs are identified for a requirement, enter "none" in Additional Needs/Notes column. Additional rows may be added to accommodate further follow-up.		
Date		**Additional Needs/Notes**
1.		☐None ☐Yes (if yes, describe)
2.		☐None ☐Yes (if yes, describe)
3.		☐None ☐Yes (if yes, describe)

This section will only be completed/populated into the TOC plan provided for Members turning 21.

6. Transition for Members Turning 21

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Health condition management	☐None ☐Yes (if yes, describe)	
2.	Developmental and functional independence	☐None ☐Yes (if yes, describe)	
3.	Education	☐None ☐Yes (if yes, describe)	
4.	Social and emotional health	☐None ☐Yes (if yes, describe)	
5.	Continuity of BH services (if requested)	☐None ☐Yes (if yes, describe)	
6.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
7.	Transportation	☐None ☐Yes (if yes, describe)	
8.	EPSDT services and provider needs	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CARA Members.

7. Transition for Members Graduating from CARA

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	

2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	
8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CISC Members.

8. Transition for CISC 066/086 Members

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement and permanency plan	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	

8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
12.	Transitioning to a new MCO (if applicable)	☐None ☐Yes (if yes, describe)	