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 ~~c~~Care ~~c~~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 C~~c~~are C~~c~~oordination functions are requirements for C~~c~~are C~~c~~oordination that must be performed by staff employed by the MCO or entities designated as Care Coordination delegates.~~:~~

- Conducting Health Risk Assessments (HRAs) for M~~m~~embers newly enrolled in ~~Centennial Care~~Turquoise Care or M~~m~~embers who have had a change in circumstance or change of health ~~condition that~~condition that requires an assessment for a higher level of care and who are not currently identified for Care Coordination Level ~~2~~1 or ~~3~~2 services, including those with retroactive eligibility;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semiannually, ~~or~~ 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 ~~or quarterly~~ in-person visits with the M~~m~~ember;
- Quarterly ~~or monthly~~ telephone contact with the ~~m~~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 ~~m~~Member's individual diagnosis. ~~(as determined by the CNA).~~

MCOs may delegate care coordination functions, per 4.4.10 of the Agreement. ~~in the following instances:~~

- ~~MCOs that own and operate patientcentered medical homes (PCMHs) as part of their provider network may delegate to such PCMHs, provided the PCMH Care Coordinator is employed by the MCO;~~
- ~~MCOs may delegate all primary care coordination functions to a designated Section 2703 Health Home, provided the Health Home is determined ready by the Health Home Steering Committee to perform such functions;~~
- ~~MCOs may fully delegate care coordination to providers/health systems in a valuebased purchasing (VBP) arrangement that outlines a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes; and/or~~
- ~~MCOs may delegate the HRA, CNA, care coordination touch points with high need members, coordination of referrals, linking Members to community services, and locating and engaging with Unreachable and Difficult to Engage Members as part of the Shared Function Model with entities or individuals for a mutuallyagreed upon reimbursement rate.~~

The MCOs may not delegate the NF level of care (LOC) assessment and may not delegate Cc~~c~~are Cc~~c~~oordination for M~~m~~embers who are in the SDCB model.

The MCO, through its Cc~~c~~are Cc~~c~~oordination monitoring of MCO staff and Cc~~c~~are Cc~~c~~oordination delegates, will ensure, at a minimum:

- The Cc~~c~~are ~~F~~Cc~~c~~oordination 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 P~~p~~lans (CCPs) are developed and updated on schedule in compliance with the Agreement;
  - ~~Care plans~~CCPs reflect needs identified in the CNA and reassessment process;

- ~~Care plan~~CCP goals are M~~m~~ember centric, and agreed upon by the M~~m~~ember;
- ~~Care plans~~CCPs are appropriate and adequate to address the M~~m~~ember'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 ~~care plan~~CCP and authorized by the MCO;
- Services are appropriate to address the M~~m~~ember's needs; including culturally responsive treatments and supports ~~to~~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 M~~m~~ember 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 ~~m~~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 ~~care plan~~CCP, date of authorization of the ~~care plan~~CCP, date of initial service delivery for each service in the ~~care plan~~CCP, date of each NF LOC and needs reassessment, date of each update to the ~~care plan~~CCP, and dates regarding transition from an institutional facility to the community;
  - Capture C~~c~~are C~~c~~oordination level assignments and track compliance with minimum C~~c~~are C~~c~~oordination contacts as specified in the Agreement;
  - Notify the c~~C~~are c~~C~~oordinator of eligibility end date, date for ~~annual NF~~annual NF LOC reassessment, date of comprehensive needs reassessment, and date to update the ~~care plan~~CCP;
  - Capture and track eligibility/enrollment information, NF LOC assessments and reassessments, and needs assessments and reassessments;

- Capture and monitor the ~~care plan;~~CCP
- Track requested and approved service authorizations, including Covered Services and VAS, as applicable;
- Document all referrals received by ~~the C~~care~~r~~the care ~~C~~coordinator on behalf of the M~~m~~ember for Covered Services and VAS, as applicable, needed ~~in order~~ to ensure the M~~m~~ember'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 ~~C~~care c~~C~~oordinator, including any additional follow up;
- Establish a schedule of services for each M~~m~~ember 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 c~~C~~are c~~C~~oordinator to immediately address service gaps;
- Document case notes relevant to the provision of C~~c~~are C~~c~~oordination; and
- Allow the ~~HSD~~ HCA or its designee to have remote access to case files.

4.3. Health Risk Assessment

The MCO or its delegate shall conduct ~~HSD~~ HCA's standardized HRA~~s~~ (see Appendix 4.15.1) on all ~~m~~Members who are newly enrolled in ~~Centennial~~ Turquoise Care for the purpose of: introducing the MCO to the ~~m~~Member, obtaining basic health and demographic information about the ~~m~~Member, and confirming the need for a CNA to determine if the ~~m~~Member should be assigned to ~~c~~Care ~~c~~Coordination ~~l~~Level ~~2~~1 or ~~l~~Level ~~3~~2. ~~The MCO may assign a mMember for to cCare cCoordination without completion of a CNA, provided they obtain HSDHCA approval in advance of the level assignment.~~

The standardized HRA (Section 4.15.1.) will be completed for each new ~~Centennial~~ Turquoise Care ~~m~~Member within 30 calendar days of notification to the MCO of the ~~m~~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 ~~State~~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 ~~m~~Member's health condition if the ~~m~~Member is not in ~~c~~Care ~~c~~Coordination ~~l~~Level ~~2~~1 or ~~l~~Level ~~3~~2. The HRA may be conducted by telephone

or~~,~~ in person~~, or as otherwise approved by HSD~~HCA; HRA information must be obtained from the ~~m~~Member or the Authorized Representative (AR) and must be documented in the ~~m~~Member's file. The MCO shall ensure its staff, subcontractors, or vendor(s) conducting the HRA are adequately trained to effectively conduct the ~~HSD~~HCA standardized HRA.

The MCO or its delegate will make reasonable efforts to contact ~~m~~Members to conduct an HRA and provide information about ~~c~~Care ~~c~~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 ~~p~~Protective ~~s~~Services (PS) and/or ~~j~~Juvenile ~~j~~Justice ~~s~~Services (JJS) involved children/youth, the MCO or its delegate will collaborate with the assigned CYFD ~~p~~Permanency ~~placement~~ Planning ~~w~~Worker (PPW), ~~j~~Juvenile ~~p~~Probation ~~o~~Officer (JPO), and ~~c~~Community ~~b~~Behavioral ~~h~~Health ~~c~~Clinician (CBHC) for physical and behavioral health services. The MCO or its delegate shall document at least three attempts to contact a ~~m~~Member which includes at least one attempt to contact the ~~m~~Member at the most recently reported phone number. The three attempts shall be followed by a letter sent to the ~~m~~Member's most recently reported address that provides information about ~~c~~Care ~~c~~Coordination and how to obtain an HRA. Documentation of the three attempts shall be included in the ~~m~~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 M~~m~~ember has not been engaged, the M~~m~~ember is categorized as "~~Unreachable~~Unable to Reach" (UTR) and is ~~not~~ assigned to ~~care coordination level 2 or level 3~~CCL0U. The MCO will conduct quarterly claims mining for these M~~m~~embers and will renew attempts to reach the M~~m~~ember if claims indicate a possible need for ~~c~~Care ~~c~~Coordination.

If the MCO has made three documented attempts to contact and has reached the M~~m~~ember at least once, but the M~~m~~ember fails to engage with the completion of the HRA or CNA, the M~~m~~ember is categorized as "Difficult to Engage" (DTE) and is ~~not~~ assigned to CCL0~~D~~a care coordination level 2 or ~~level 3~~. If the M~~m~~ember is categorized as a ~~care coordination level~~CCL1 ~~2~~ or ~~level 3~~CCL2 based on the most recent CNA but fails to engage in two consecutive contract required touch points (telephonic or in

person), the M~~m~~ember is then categorized as DTE (CCL0~~D~~), with appropriate documentation in the M~~m~~ember'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.

~~The HSD standardized HRA includes the following information:~~

- ~~Member demographics~~
  - ~~Member name, address, telephone number, date of birth;~~
  - ~~Member Medicaid number;~~
  - ~~Names and relationship of person(s) completing form (other than member);~~
  - ~~Emergency contact and telephone number;~~
  - ~~HRA date; and~~
  - ~~Assessment Method and Type.~~
- ~~Member Health Information~~
  - ~~Language preference, translation needs, and special preferences (cultural, religious, physical);~~
  - ~~Main health concern;~~
  - ~~Current or past PH and BH conditions or diagnoses, including brain injury;~~
  - ~~Pending PH or BH procedures;~~
  - ~~Most recent physical examination and/or recent medical appointment;~~
  - ~~Emergency room visits, including reason, number of visits and dates of visit(s);~~
  - ~~Number of hospital stays in past 6 months, and any readmissions;~~
  - ~~Indication of a 1915(c) waiver LOC assessment;~~
  - ~~Number of medications;~~

- ~~Living situation;~~
- ~~Assistance with two or more activities of daily living (ADL) and type of need;~~
- ~~Interest in and need for LTC services;~~
- ~~Advance directives preference and interest in receiving information; and~~
- ~~Interest in receiving care coordination.~~

~~The MCO or its delegate shall provide the following information to every member during his or her HRA:~~

- ~~The purpose of care coordination;~~
- ~~The care coordination levels (CCLs);~~
- ~~Notification of the member's right to request a higher CCL;~~
- ~~For Native American members, the right to have a Native American Care Coordinator;~~
- ~~Requirement for an in-person CNA for the purpose of providing services associated with CCL2 or CCL3; and~~
- ~~Specific next steps for the member.~~

Within ~~seven~~ ten calendar days of completion of the HRA, all ~~m~~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 ~~Stateapproved~~State-approved guidelines.

~~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 State approval. Requests must be sent for approval to HSDHCA/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.~~

4.4. Comprehensive Needs Assessment

~~A~~ HCA's standardized CNA is conducted for Medicaid ~~m~~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~~2~~ or CCL2~~3~~. ~~The MCO shall schedule a CNA within 14 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 care coordination functions with other StateapprovedState-approved guidelines.~~

Members who are identified as not needing a CNA shall be monitored by the MCO ~~c~~Care ~~c~~Coordination unit quarterly through predictive modeling software and available utilization and claims data to determine if the ~~m~~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 ~~m~~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 ~~m~~Member's interest in receiving CB services.

~~For members who have indicators that may warrant a NF LOC, the MCO Care Coordinator shall conduct an in person, in home CNA at the member's primary residence.~~ The MCO shall use the New Mexico Medicaid NF LOC Criteria and Instructions to determine NF LOC for ~~m~~Members.

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

CNAs must be performed through the utilization of ~~an assessment tool that has been approved by~~the ~~HSD~~HCA standardized CNA for assessing the ~~m~~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 assessment tool may include the identification of targeted needs related to improving health, functional outcomes, or quality of life outcomes (e.g., related to targeted health education, pharmacy management, or increasing and/or maintaining functional abilities, including provision of covered services). Any changes to the assessment tool must be approved by HSD 30 calendar days prior to use by the MCO or its delegate.~~

The CNA must be conducted in the ~~m~~Member's primary place of residence or facility for ~~m~~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 ~~m~~Member. For CYFD PS and/or JJS involved children/youth, the MCO or its delegate, will collaborate with the assigned CYFD ~~p~~Permanency ~~placement~~ Planning ~~w~~Worker (PPW), ~~j~~Juvenile ~~p~~Probation ~~o~~Officer (JPO), and ~~c~~Community ~~b~~Behavioral ~~h~~Health ~~c~~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 ~~m~~Member and collateral parties in the home~~,~~ unless an exception has been granted by ~~HSD~~HCA. Home setting is defined as the primary residence for the ~~m~~Member in the community where there is an identifiable address, and the ~~m~~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 ~~m~~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 ~~m~~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 ~~m~~Member is currently part of the prison or jail involved population preparing for release; or
-
- If the Member is in a Health Home. ~~or being served by a provider approved for a Full Care Coordination Delegation Model.~~

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

- Complete the ~~Centennial~~ Turquoise Care CNA Exception Request form (MAD 601) (see Appendix 4.17.2) ;
- Alternate locations must be submitted to ~~HSD~~HCA for review and should be assessed for privacy to ensure the ~~m~~Member's Protected Health Information (PHI) is not jeopardized;
- Send the completed MAD 601 by secure email to: ~~HSD~~HCA~~SD~~-QB-CCU-CNA@~~state.nm.ushsd.nnm.gov;~~hsd.nm.gov;
- ~~HSD~~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 HSD-QB-CCU-CNA@hsd.nm.gov~~state.nm.us~~; and
  - Via any format other than the MAD 601 Form.

All efforts must be made to negotiate with and educate the ~~m~~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 ~~m~~Member and/or legal representatives when refusal by the ~~m~~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 ~~m~~Member. The CNA, when conducted with the ~~m~~Member in his/her home, includes determination of: any structural problems for ~~m~~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~~s~~ 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 ~~m~~Member.

When a ~~m~~Member, currently categorized as a CCL1~~2~~ or a CCL2~~3~~, refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the ~~needs assessment~~CNA with the ~~m~~Member, emphasizing this assessment makes the determination of useful resources to meet the ~~m~~Member's needs, such as the CB for personal care assistance, special home environment modifications and adaptive equipment. The MCO will ensure the ~~m~~Member signs the ~~HSD~~HCA-approved ~~c~~Care ~~c~~Coordination D~~d~~eclination F~~f~~orm and maintain the signed form in the ~~m~~Member's file (See Appendix ~~.~~4.17.3). If the ~~m~~Member refuses to sign the ~~c~~Care ~~c~~Coordination D~~d~~eclination F~~f~~orm, the MCO shall document such refusal in the ~~m~~Member's record. The MCO will perform quarterly claims mining for these ~~m~~Members and will renew attempts to reach the ~~m~~Member if claims mining indicates a possible need for ~~c~~Care ~~c~~Coordination. The ~~m~~Member who has refused ~~c~~Care ~~c~~Coordination will not be assigned to ~~c~~Care ~~c~~Coordination ~~l~~Level ~~2~~1 or ~~l~~Level ~~3~~2. In documented refusal circumstances, the MCO will submit a proposal to the ~~m~~Member outlining a basic ~~care plan~~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.

~~At a minimum, the CNA shall:~~

- ~~Assess PH and BH needs, including but not limited to: current diagnoses; history of significant PH and BH events, including hospitalizations and emergency room visits; complete placement history for children and youth in CYFD PS custody; medications; allergies; providers involved in member's care; DME; brief substance abuse screening questionnaire, as approved by HSD/BHSD and history; family medical and BH (MH and substance use/abuse) history; cognitive capacities, (including evaluation of alertness, orientation, history of head/brain injury); healthrelated lifestyle (smoking, food intake/nutrition, sleep patterns, exercise, continence); and functional abilities, including ADLs (mobility, grooming, bathing, eating, dressing, and medications) and instrumental activities of daily living (IADLs)(i.e., money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, and grocery shopping).~~

- ~~Assess LTC needs including but not limited to: environmental safety including items such as smoke detectors; pests/infestation; trip and fall dangers; and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the CB, the MCO shall assess for all CB services.~~
- ~~Include a risk assessment, using a tool and protocol approved by HSD, as applicable. A risk agreement that shall be signed by the member or his/her representative that shall include: identified risks to the member; the consequences of such risks; strategies to mitigate the identified risks; and the member's decision regarding his/her acceptance of risk.~~
- ~~Assess disease management needs, including: identification of disease state; need for targeted intervention and education; and development of appropriate intervention strategies.~~
- ~~Determine a social profile including, but not limited to: living arrangements; natural and social support systems which are available to assist the member; Individualized Planning Meeting Plans for children and youth in CYFD PS custody; demographics; transportation; employment; financial resources and challenges (other insurance, food, utilities, housing expenses); Medicare services; other community services being accessed, such as senior companion services, mealsonwheels, etc.; living environment (related to health and safety); Individualized Education Plan; and Individualized Service Plans for Developmental Disabilities, Medically Fragile (MF), or Mi Via Waiver Program recipients, (if applicable). A copy of the HCBS Waiver Prior Authorization or budget is not required to be obtained by the Care Coordinator.~~
- ~~Identify possible suicidal and/or homicidal thinking, planning/intent and lethality risk, history of aggressive and/or violent behaviors, history of running away and wandering for both adults and children.~~
- ~~Identify cultural information, including language and translation needs and utilization of ceremonial or natural healing techniques.~~
- ~~Ask the member for a selfassessmentself-assessment regarding their viewpoint of their condition(s) and service needs.~~
- ~~In the event the member is a minor under the age of 18, or is a youth in CYFD PS custody, identify the parent or legal guardian participating in and/or responding for the minor during assessment.~~
- ~~For members on the DD, Mi Via, or MF Waivers (categories of eligibility [COEs] 095 and 096) and as applicable to the member's living arrangement, identify the parent, family member or legal guardian participating in and/or responding for the member during the assessment.~~

- ~~In the event the member is receiving the Alternative Benefit Plan (ABP) and meets the definition and criteria of Medically Frail or is otherwise ABP Exempt, notify the member that he/she may be exempt, explain the difference in benefits and facilitate his/her transition to the ABP Exempt benefit package at the member's choice.~~

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 M~~m~~ember, and the Community Benefit Member Agreement (CBMA) elicits the ~~member~~Member's participation in identifying risks. The CBMA is not used to document the ~~member~~Member's refusal to complete a CBSQ.

The completed CBSQ and the CBMA are considered part of the ~~member~~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 ~~member~~Members:

- Allocated M~~m~~embers receiving their first CNA, including M~~m~~embers who are in the process of community reintegration from a NF and M~~m~~embers who lost their full Medicaid Category of Eligibility (COE) and are being allocated for continuity of care.
- Annually for M~~m~~embers with a current NF LOC (see note about CCL3 M~~m~~embers below).
- Full Medicaid M~~m~~embers without a NF LOC who request CB services.
- Full Medicaid M~~m~~embers 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 M~~m~~ember's CNA including the functional needs identified in the HRA.

The CBSQ/CBMA will not be administered for the following M~~m~~embers:

- 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~~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~~Member's record.
- Members who decline Cc~~c~~are Cc~~c~~oordination. The Dd~~d~~eclination Ff~~f~~orm must be on file with the MCO. If a ~~member~~Member refuses to sign the Cc~~c~~are Cc~~c~~oordination Dd~~d~~eclination Ff~~f~~orm, the contractor shall document such refusal in the ~~member~~Member's record.

CCL2~~3~~ ~~member~~Members:

- For all M~~m~~embers with CCL2~~3~~ and a NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the Care Coordinator.
- For M~~m~~embers with CCL2~~3~~ 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 M~~m~~ember and/or the M~~m~~ember's representative to inform them of the availability of CB services.

~~HSD~~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 discuss with their PCS provider and Care Coordinator. The M~~m~~ember and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the ~~member~~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 M~~m~~ember can collaboratively revise the M~~m~~ember's Individual Plan of Care (IPoC) to reflect this reduced hour commitment.

The request for a reduction in hours must be ~~member~~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 M~~m~~ember's request for a reduction in hours should not be made for temporary or otherwise short-term periods. A M~~m~~ember must understand the request for reduced hours will be for the remainder of their budget/care plan year. However, if the M~~m~~ember 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.

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 ~~2~~1 ~~c~~Care ~~c~~Coordination and at least semi-annually for level ~~3~~2 ~~c~~Care ~~c~~Coordination, to determine if the ~~care plan~~CCP is appropriate for the ~~m~~Member and if a higher or lower ~~LOC~~ Care ~~c~~Coordination Level may be needed.

Additional CNAs may also be conducted, as the ~~C~~care ~~C~~coordinator deems necessary, as requested by the ~~m~~Member, provider, family ~~member~~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 ~~m~~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 ~~m~~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 ~~m~~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 ~~m~~Member's record should clearly establish why the triggering event did not result in the MCO conducting a new CNA. The decision can be made via telephone contact or face to face visit with the ~~m~~Member.

4.7. Comprehensive Care Plan Requirements

The MCO or its delegate shall ~~conduct~~complete the HCA's standardized CCP (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 ~~care plan~~CCP for all ~~m~~Members in levels ~~2~~1 and ~~3~~2 of ~~c~~Care ~~c~~Coordination. The MCO- or ~~HSD~~HCA-approved designee is responsible for ensuring a CCP is initiated upon enrollment and must oversee the ~~C~~care ~~C~~coordinator who is responsible for coordinating all services in the CCP.

- CCP Scope and Process. The MCO or ~~HSD~~HCA approved designee must establish a process to ensure coordination of care for ~~m~~Members that includes:
  - Coordination of the ~~m~~Member's PH, BH, and long-term health care needs through the development of the CCP;
  - Collaboration with the ~~m~~Member, ~~m~~Member's friends and family (at ~~m~~Member's request), ~~m~~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 ~~care plan~~CCP, including documentation of all attempts to engage providers and other individuals identified in the development of the ~~care plan~~CCP;
  - With the ~~m~~Member's consent to share information, the ~~care plan~~CCP should be shared and utilized by those involved in providing care to the ~~m~~Member (e.g., BH providers should be aware and take into consideration the ~~m~~Member's PH care issues when working with the ~~m~~Member); ~~and~~
  - Verification of all decisions made regarding the ~~m~~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~~Member may designate his/her representative to have a participatory role, as needed, and as defined by the ~~member~~Member, unless the representative has decision making authority, under law.~~; and~~

- ~~CCP Development and Management:~~
  - ~~The CCP is in a language the member and/or family member can understand. The member shall lead the person-centered planning process to ensure the CCP is member-centric and agreed upon by the member;~~
  - ~~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; and~~
  - ~~The MCO or HSD approved designee shall develop the CCP within 14 business days of completion of the CNA unless the member is in a health home and/or using the Treat First model of care.~~
  - The ~~C~~care ~~C~~coordinator shall:
    - Ensure the ~~m~~Member or ~~m~~Member's legal representative understands, reviews, signs and dates the CCP.
    - Provide a copy of the completed CCP to the ~~m~~Member, ~~m~~Member's legal representative as applicable or other providers authorized to deliver care to the ~~m~~Member in a format that is easily readable (e.g., 12 font).
    - With the ~~m~~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 ~~m~~Member's CCP.
    - Ensure timelines for the development, ~~and~~ implementation, and/or updating~~e~~ the CCP are met.
    - Facilitate treatment and coordinate with providers to assist the ~~m~~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 ~~m~~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 ~~m~~Member's needs.
- With ~~m~~Member's consent, maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the ~~m~~Member's care.
- 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 ~~m~~Member's risk, address those changes and update the ~~m~~Member's risk agreement and CCP as necessary to include measures to minimize the identified risks.

- Inform each ~~m~~Member of his or her Medicaid eligibility status and end date and assist the ~~m~~Member with the process for eligibility redetermination.
- For children and youth in CYFD PS custody, inform Native American children and youth and their ~~p~~Permanency ~~placement~~ Planning ~~w~~Worker (PPW) of opportunities to receive culturally responsive treatments, interventions and supports, including those that are non-medicalized.
- Educate ~~m~~Members with identified disease management needs by providing specific disease management interventions and strategies.
- Educate the ~~m~~Member about his or her ability to have an Advance Directive and ensure the ~~m~~Member's decision is well documented in the ~~m~~Member's file.
- Educate ~~m~~Member about non-Medicaid services available as appropriate (e.g., Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant MH).

- Reflect cultural considerations of the ~~m~~Member and conduct the CCP process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

~~- Required Elements of a CCP include the following:~~

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

~~- Ensure implementation of interventions and the dates by which the interventions must occur and identify specific agencies or organizations with which treatment must be coordinated, including non-Medicaid providers.~~

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

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

~~- Member or family, foster family or extended kinship barriers to receiving treatment, such as a member or family member's inability to travel to an appointment or for children and youth in CYFD PS custody who lack access to services in the child's home community.~~

- ~~Identify the member or family's, foster family's, and/or extended kinship/guardian's strengths, resources, priorities, and concerns related to achieving mutual recommendations made in caring for the member.~~

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

~~- Identify services provided by natural supports that are scheduled to be enhancers and back-up (including emergency purposes) to services that are authorized by the MCO.~~

~~- An interdisciplinary team, with member's consent, including but not limited to: the Care Coordinator; social worker; registered nurse (RN); medical director; PCP; and others must be identified to develop, implement and update the CCP as needed and coordinate with the Individualized Planning Team for each child or youth in CYFD PS custody.~~

~~- Reflect the setting in which the individual resides is chosen by the member, and is integrated in and supports full access of members receiving HCBS, to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive~~

~~services in the community to the same degree of access as individuals not receiving Medicaid HCBS.~~

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

- CCP Revisions
  - The CCP will be revised when the ~~m~~Member experiences one of the following circumstances:
    - Risk of significant harm: within one business day of the MCO receiving notification, the ~~c~~Care ~~c~~Coordination team will convene, in person or by teleconference; and if necessary the ~~care plan~~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 ~~m~~Member is a victim of abuse, neglect, or exploitation;
    - Any team ~~m~~Member requests a meeting to propose changes to the CCP;
    - Criminal justice involvement on the part of the ~~m~~Member (e.g., arrest, incarceration, release, probation, parole); or

- As requested by ~~HSD~~HCA.

▪ Within five business days of completing a reassessment of a ~~m~~Member's needs, ~~the Care Coordinator shall update the member's CCP as appropriate, and~~ the MCO or ~~HSD~~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 ~~HSD~~HCA approved designee shall perform real time and ongoing ~~c~~Care ~~c~~Coordination to ensure all ~~m~~Members receive the appropriate care.

▪ CCL1 and CCL2 Members shall receive quarterly telephonic touchpoints and bi-annual in-person visits. The in-person visits may not coincide with the Member's CNA.

▪ Ongoing ~~c~~Care ~~c~~Coordination functions shall include all elements defined in the Agreement including the following:

- Identify gaps and address the needs of the ~~m~~Member, including develop and/or update the ~~care plan~~CCP as needed.
- Ensure when a ~~m~~Member's ~~LOC~~ Care ~~c~~Coordination Level increases or decreases that continuity of care is always maintained.
- Maintain a single point of contact for the ~~m~~Member to ensure coordination of all services and monitoring of treatment.
- Maintain face-to-face and telephonic meetings with the ~~m~~Member to ensure appropriate support of the ~~m~~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 ~~m~~Member's PCP, specialists, and other individuals involved in the ~~m~~Member's care. The MCO shall maintain consistent communication and contact with the assigned CYFD ~~p~~Permanency ~~placement~~ Planning

~~w~~Worker (PPW) for protective services involved children and youth, ~~j~~Juvenile ~~p~~Probation ~~o~~Officer (JPO) for juvenile justice involved youth, and ~~c~~Community ~~b~~Behavioral ~~h~~Health ~~c~~Clinician (CBHC) for CYFD involved children and youth.

- Maintain and monitor the ~~m~~Member's CB and provide assistance with complex services.
- Consider ~~m~~Member and provider input to identify opportunities for improvement.
- Collaborate and/or cooperate with representatives of the Independent Consumer Support System.

4.8. Staffing Requirements and Delegations

The MCO may utilize a ~~c~~Care ~~c~~Coordination team approach to perform ~~c~~Care ~~c~~Coordination activities, with the MCO's ~~c~~Care ~~c~~Coordination team consisting of the ~~m~~Member's primary ~~C~~care ~~C~~coordinator and other individuals with relevant expertise and experience appropriate to address the needs of ~~m~~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 ~~HSD~~HCA standardized HRA. CNAs must be performed by primary ~~C~~care ~~C~~coordinators employed by the MCO or its delegate. The MCO may delegate some ~~c~~Care ~~c~~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~~Member of the MCO ~~c~~Care ~~c~~Coordination team and its delegated ~~C~~care ~~C~~coordinators to ensure specific functions are performed by a qualified ~~C~~care ~~C~~coordinator. Maximum caseloads per ~~C~~care ~~C~~coordinator~~,~~ are established by ~~HSD~~HCA and shall not be exceeded by the MCO. As the MCO transitions more ~~c~~Care ~~c~~Coordination functions to the provider level, it will collaborate with ~~HSD~~HCA to adjust ~~c~~Care ~~c~~Coordination caseload requirements. Caseload to ~~C~~care ~~C~~coordinator ratios are as follows:

- CCL1~~2~~ – 1:75~~:~~

~~• Members not residing in a NF 1:75; and~~

~~• Members residing in a NF 1:125.~~

- CCL2~~3~~ – 1:50~~:~~

~~a. Members not residing in a NF 1:50; and~~
~~b. Members residing in a NF 1:125.~~

~~**2.** Care coordination for members who participate in the selfdirectedself-directedself-directed CB:~~

~~a. CCL2 is 1:75; and~~

~~b.~~a. ~~CCL3 is 1:50.~~

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

- The number of ~~C~~care ~~C~~coordinators, ~~c~~Care ~~c~~Coordination supervisors, other ~~c~~Care ~~c~~Coordination team ~~member~~Members the MCO plans to employ;
- The ratio of ~~C~~care ~~C~~coordinators to ~~m~~Members;
- The MCO's plans to maintain ratios as outlined by ~~c~~Care ~~c~~Coordination ~~l~~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~~Member of the ~~c~~Care ~~c~~Coordination team;
- A strategy that encourages the use of Native American ~~C~~care ~~C~~coordinators and limits duplication of services between ~~Indian Health Services~~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 ~~C~~care ~~C~~coordinators serving ~~m~~Members in rural/frontier areas of the State and/or for those ~~m~~Members that require extraordinary efforts from the assigned ~~C~~care ~~C~~coordinator; and
- How the MCO will use ~~C~~care ~~C~~coordinators to meet the needs of New Mexico's unique population.

The MCO or its delegate shall ensure ~~m~~Members have a telephone number for direct contact with their ~~C~~care ~~C~~coordinator and/or a ~~m~~Member of their ~~c~~Care ~~c~~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 ~~m~~Member's ~~C~~care ~~C~~coordinator or a ~~m~~Member of the ~~m~~Member's ~~c~~Care ~~c~~Coordination team is not available, the call shall be answered/facilitated by another qualified staff person in the MCO's or its delegate's ~~c~~Care ~~c~~Coordination ~~u~~Unit. Calls requiring immediate attention shall be "warm" transferred directly to another ~~C~~care ~~C~~coordinator, not letting the call go to voice mail. After normal business hours, calls requiring immediate attention by ~~C~~care ~~C~~coordinator shall be handled by the ~~member~~Member services line, as stipulated by Section 4.15.3~~1~~ of the Agreement.

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

The MCO or its delegate must accommodate the ~~m~~Member's requests to change to a different ~~C~~care ~~C~~coordinator if desired and if there is an alternative ~~C~~care ~~C~~coordinator available. Such availability may take into consideration the MCO's or its delegate's need to efficiently deliver ~~c~~Care ~~c~~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 ~~m~~Member's ~~C~~care ~~C~~coordinator. The MCO or its delegate may need to initiate change in the following circumstances:

- Assigned ~~C~~care ~~C~~coordinator is no longer employed by the MCO or its delegate;
- There is a conflict of interest preventing neutral support for the ~~m~~Member;
- Care ~~C~~coordinator is on temporary leave from employment; or
- Caseload of the assigned ~~C~~care ~~C~~coordinator must be adjusted due to its size or intensity.

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

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

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

4.9. Engagement of Members

~~HSD~~HCA recognizes there may be a select few managed care ~~m~~Members who present challenges to the service delivery system due to the complexity of their needs. This policy is designed for ~~m~~Members who demonstrate inappropriate behaviors and/or frequent contact of State and MCO staff, and/or have been unresponsive to traditional ~~c~~Care ~~c~~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 ~~care plan~~CCPs. Responding to the challenges presented by this category of ~~m~~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 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 ~~m~~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 and appropriate 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 ~~C~~care ~~C~~coordinator, a management level staff of the MCO and a high-level clinical staff ~~member~~Member of the MCO. The ~~m~~Member may request one or two people to be in attendance. The intention of the meeting with the 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~~Member of the team;
- Clarify rules of engagement (who can call whom and when, etc.) and program regulations;
- Assign tasks to each team ~~member~~Member with timeline;
- Sign agreement that documents the discussion and assignment of tasks and holds each ~~m~~Member accountable;

- Schedule 2nd meeting within two weeks. Second meeting is a final meeting. Review tasks. Discuss/establish consequences of any failure to deliver on tasks. Sign contract/~~care plan~~CCP. (Includes updates weekly and addressing ongoing/emergent issues at a bimonthly meeting.)
- Schedule updates between participants, MCO staff on a regular basis; and
- Ensure maintenance of documentation is with MCO, participant, and natural supports.

When HHR/HRU recipients are identified, the MCOs will designate one point of contact and communicate that point of contact to ~~HSD~~HCA/MAD and other involved individuals. If the identified recipient calls ~~HSD~~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~~a~~ Via, Supports ~~Waiver and~~Waiver and Medically Fragile (MF) Waivers

The MCOs provide acute and ancillary medical and BH services to the 1915 (c) HCBS recipients/MCO ~~member~~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~~Member's medical, BH, and ancillary needs; explaining to the ~~member~~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~~Member's current care coordination level. Exceptions to care coordination functions are specifically described below for ~~member~~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 (ICF-IID) 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 ~~member~~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 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; e~~E~~mployment Supports services; environmental modification services; h~~H~~ome h~~H~~ealth a~~A~~ide; 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~~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~~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 non-waiver (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~~Member and ~~member~~Member's 1915 (c) case manager/consultant to coordinate the transition dates for the ~~member~~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~~Member's DDW ISP and Budget.
- The MCO will not complete a NF LOC on ~~member~~Members enrolled in the DD 1915 (c) waiver, unless the ~~member~~Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the ~~member~~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~~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~~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 ~~member~~Members who are receiving HCBS through the DD waiver.

- MCO ~~member~~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~~Member's Mi Via SSP and Budget.
  - The MCO will not complete a NF LOC on ~~member~~Members enrolled in the Mi Via 1915 (c) Waiver, unless the ~~member~~Member is transitioning from the community to a nursing

facility for long-term care permanent placement. The MCO shall inform the ~~member~~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~~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~~Member and the participant's family.
- The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for ~~member~~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~~Member's Supports Waiver ISP and Budget.
  - The MCO will not complete a NF LOC on ~~member~~Members enrolled in the Supports Waiver 1915 (c) waiver, unless the ~~member~~Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the ~~member~~Member's Supports Waiver CSC in the event of a NF long-term permanent placement.
  - The MCO will utilize the Supports Waiver ~~LOC obtained~~LOC obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the ~~member~~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~~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 ~~member~~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~~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 ~~member~~Members enrolled in the MF 1915(c) Waiver, unless the ~~member~~Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the ~~member~~Member's MFW case manager in the event of a NF long-term permanent placement.
  - Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF ~~member~~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 ~~member~~Members.
  - 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 (non-waiver) who meet the MF criteria. The same MF parameters are utilized for non-waiver ~~member~~Members.

For MF EPSDT (non-waiver) 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 ~~member~~Members.
- Ensure the MF ISP serves as the CCP for the MF ~~member~~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 ~~member~~Members and families.
- Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF ~~member~~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 ~~member~~Members.

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

The ~~HSD~~ 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 ~~member~~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 ~~HSD~~HCA BISF service coordination contractor to verify the status of a ~~member~~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~~Member's care from the BISF to the MCO.
  - The HRA shall include questions about specific health diagnoses, including brain injury.
  - For ~~member~~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~~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~~Member to affect the participation of the BISF service coordinator and/or other identified advocates in the ~~member~~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~~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 ~~HSD~~ 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 ~~member~~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~~two-year schedule.

4.15 MCO Care Coordination for CARA infants and mothers

4.15.1 Care Coordination Teams

The Contractor is directed to have a Care Coordination team dedicated solely to CARA ~~member~~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~~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~~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 D~~d~~eclination F~~f~~orm from the individual refusing Care Coordination in accordance with 4.4.1.5 of the New Mexico Human Services Department 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 (See Appendix 4.17.5).

4.15.2. Care Coordination Presence in Hospitals

The Contractor is directed to assign ~~member~~Members of their Care Coordination team to each of the 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

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, ~~HSD~~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 ton 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 ~~member~~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~~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 ~~member~~Members engaged in Care Coordination with the MCO, by assigning the same care coordinator to all ~~member~~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
- 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
- CCL level (if applicable)
- Describe how member will be receiving 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.*	

Health Risk Assessment (HRA)

Member's Name (First, Middle, Last)		Member's Medicaid ID	Date
Has Member Given Permission for Another Person to Complete this form? ☐ Yes ☐ No		**Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member**	
Member's Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Other Phone**	
Emergency Contact Name/Phone		**Date of Birth**	
Assessment Method ☐ Telephonic ☐ In-person ☐ Other		**Demographics Verified?** ☐ Yes ☐ No	
Assessment Type ☐ Initial assessment ☐ Reassessment ☐ Change in health status			

	Question	Response
1.	Do you have a language need other than English? Do you need translation services? Please describe:	☐ Yes ☐ No ☐ Yes ☐ No _____
		☐ Cultural preference ☐ Hearing Impairment
2.	Do you have any special preferences we should be aware of?	☐ Religion/Spiritual needs or preferences ☐ Visual Impairment ☐ Literacy ☐ None ☐ Other (describe):_____
3.	What is your main health concern right now?	_____
4.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐ Behavioral health diagnosis ☐ Comorbid conditions ☐ ICF/MR/DD ☐ High risk pregnancy ☐ Transplant patient ☐ Medically Fragile Waiver Program ☐ Medically frail ☐ Traumatic brain injury ☐ Other acute or terminal disease: _____
5.	(*Adult only question*) Compared to others your age, would you say your health is…..?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐ Yes ☐ No _____
7.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for visit(s):	☐ Yes ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more _____ _____

	Question	Response
8.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more ☐Yes ☐No
9.	How many medicines are you currently taking?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐6+
10.	What is your current living situation?	☐ Homeless ☐ Living alone ☐ Living in group home ☐ Living in shelter ☐ Living with other family ☐ Living with others unrelated ☐ Living with spouse ☐ Living in assisted living facility ☐ Lives in out of state facility ☐ Lives in out of home placement ☐ Dependent child in out of home placement ☐ Living in a nursing facility ☐ Other (describe): _____
11.	Do you need assistance with 2 or more of the following?	☐ Yes ☐ No ☐ Dressing ☐ Bathing/grooming ☐ Eating ☐ Meal acquisition/preparation ☐ Transfer ☐ Mobility ☐ Toileting ☐ Bowel/bladder
	Is your need for assistance being met today?	☐ Daily medication ☐ Other: _____ ☐ Yes ☐ No
12.	Do you need or are you interested in Long-Term Care services?	☐ Yes ☐ No
13.	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. Do you have a living will or an advance directive in place? Could I send you 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
14.	Are you interested in receiving Care Coordination Services?	☐ Yes ☐ No

The MCO shall provide the following information to every Member during his or her HRA:

1. Information about the services available through Care Coordination
2. Information about the Care Coordination Levels (CCLS)
3. Notification of the Member's right to request a higher Care Coordination Level
4. Requirement for an in-person Comprehensive Needs Assessment for the purpose of providing services associated with Care Coordination level 2 or level 3
5. Information about specific next steps for the Member

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

TURQUOISECARE

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

CARA DUR

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