CENTENNIAL CARE AND CARE COORDINATION

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Introduction to Centennial Care

New Mexico Centennial Care was implemented on January 1, 2014 as a replacement to the outdated New Mexico Medicaid system

There are 4 Managed Care Organizations (MCOs) Offering Centennial Care Coverage

- Blue Cross Blue Shield of New Mexico
- Molina Health Care of New Mexico
- Presbyterian Health Plan Inc.
- United Health Care Community Plan of New Mexico

Centennial Care was created to Simplify New Mexico Medicaid

- All MCOs provide all Services
- Salud, CoLTS, and Optum are being combined into one program
- MCOs are Responsible for Physical Health Care Coordination, Behavioral Health Care Coordination, and Long Term Services and Supports
- One Stop Shopping

DD Waiver and Medically Fragile Waiver Members

- Receive Long Term Care Services through Mi Via
- Receive Acute Care Services through the MCO

Native American Members

- Can choose to opt out and have Fee For Service Medicaid unless they were in CoLTS

Centennial Care Assessments

- Health Risk Assessment
- Comprehensive Needs Assessment
- Nursing Facility Level Of Care Assessment
- Personal Care Services Allocation Tool

Health Risk Assessment

- Basic Assessment may be performed by telephone or in person
- Provides basic Health and Demographic information
- Helps MCO to determine Level of Care Coordination needed
- Helps to determine if member needs Nursing Facility Level of Care (NFLOC) assessment

Comprehensive Needs Assessment

The CNA is an in depth assessment tool used by the MCOs to determine a member's

- Medical Needs
- Behavioral Health Needs
- Long Term Care Needs
- Social Needs
- Risk Level

The CNA is completed

- By the Care Coordinator
- At the Member's Home
- Annually for Level 2 Members
- Every 6 Months for Level 3 Members
- Whenever there is a Level of Care Change

Nursing Facility Level Of Care (NFLOC) Assessment

Annual Assessment to Determine if Member meets Criteria to receive Long Term Services and Supports

It is completed:

- If member was previously receiving Long Term Services and Supports
- If member is found to have 2 or more deficits in Activities of Daily Living
- If member, family, provider, or other representative think member needs and would qualify for Long Term Services and Supports

Specifics of:

- HSD prescribes criteria necessary to meet NFLOC
- Care Coordinator completes Assessment
- Utilization Management at MCO completes review
- If member meets Criteria they qualify for additional benefits based upon need. These are called Long Term Services and Supports.

Long Term Services and Supports

Agency Based Community Benefit

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Personal Care Services
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services

Self Directed Community Benefit

- Behavior Support Consultation
- Customized Community Support
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker/Personal Care
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapy Services
- Specialized Therapies
- Transportation (non-medical)

For a Description of these Services See the Managed Care Policy Manual Chapter 7. http://www.hsd.state.nm.us/providers/managed-care-policy-manual.aspx

Care Coordination

- Care Coordination is similar to Case Management
- Disease Management is included
- Every Member will receive a telephonic Health Risk Assessment (HRA)upon enrollment with a MCO.
- Based on answers to the HRA members will be stratified as:

  Low Risk – Level 1

  Moderate Risk – Level 2

  High Risk – Level 3
- Every Member who Stratifies as Level 2 or 3 will receive a Comprehensive Needs Assessment (CNA)
- Every Member who is Level 2 or 3 has a Comprehensive Care Plan Developed

Care Coordination By Level

Level 1

- Annual HRA
- Quarterly Claims Review
- Are not assigned an Individual Care Coordinator

Level 2

- Annual CNA
- Semi-annual in person visits
- Quarterly Telephonic contact
- Development of Comprehensive Care Plan
- Assigned an Individual Care Coordinator

Level 3

- Semi-annual CNA
- Quarterly in-person visits
- Monthly Telephone contact
- Development of Comprehensive Care Plan
- Assigned an Individual Care Coordinator

Care Coordination Stratification

Level 1

- Low risk
- Minimal needs

Level 2

- Moderate Risk
- Co-morbid health conditions
- Frequent emergency room use
- Mental Health or Substance Abuse Condition causing Moderate functional impairment
- Requires assistance with 2 or more ADL's or IADL's and living in community with low risk
- Mild Cognitive deficits
- Poly-pharmaceutical use

Level 3

- High Risk
- Medically Complex or Fragile
- Excessive emergency room use
- Mental Health or Substance Abuse Condition causing High functional impairment
- Untreated substance dependency based on DSM or other State determined functional scale
- Requiring assistance with 2 ADL's or IADL's and living in the community at medium to high risk
- Significant cognitive deficits
- Contraindicated pharmaceutical use

Care Coordination Functions

- Care Coordination helps ensure the member's complex needs are identified and addressed:
- Provides the member with a single point of contact at the MCO
  - Communication is the key to success
  - Allows for early intervention
- Ensures that care is member-centered, family-focused, and culturally competent.
- Assists members' in locating services and utilizing natural supports to meet their health and social needs.
- Includes the Interdisciplinary Care Team to Develop Goals and Interventions which are member specific

Interdisciplinary Care Team

Members of the ICT are:

- Natural supports (Supports not paid for with Medicaid funds)
  - Unpaid Family Members
  - Churches
  - Community Members
- Medical Health Providers
- Behavioral Health Providers
- Support Brokers

Co-Management

Members with both Behavioral Health and Medical Needs will be Co-Managed

- They may be assigned 2 Care Coordinators
- The primary Care Coordinator will be based on the member's greatest needs and will be the Primary Contact for the member
- Care Coordinators will work together to make sure all of the member's needs are met
- Closer collaboration since both Behavioral Health and Medical Care Coordinators are employed by the same entity

Questions?