INDEX

8.305.16 CLIENT TRANSITION OF CARE

8.305.16.1 ISSUING AGENCY 1
8.305.16.2 SCOPE 1
8.305.16.3 STATUTORY AUTHORITY 1
8.305.16.4 DURATION 1
8.305.16.5 EFFECTIVE DATE 1
8.305.16.6 OBJECTIVE 1
8.305.16.7 DEFINITIONS 1
8.305.16.8 MISSION STATEMENT 1
8.305.16.9 MEMBER TRANSITION OF CARE 1

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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 16 CLIENT TRANSITION OF CARE

8.305.16.1 ISSUING AGENCY: Human Services Department (HSD).
[8.305.16.1 NMAC - N, 7-1-01; A, 8-1-12]

8.305.16.2 SCOPE: This rule applies to the general public.
[8.305.16.2 NMAC - N, 7-1-01]

8.305.16.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.305.16.3 NMAC - N, 7-1-01; A, 8-1-12]

8.305.16.4 DURATION: Permanent
[8.305.16.4 NMAC - N, 7-1-01]

8.305.16.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.305.16.5 NMAC - N, 7-1-01]

8.305.16.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.16.6 NMAC - N, 7-1-01; A, 8-1-12]

8.305.16.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.16.7 NMAC - N, 7-1-01]

8.305.16.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.305.16.8 NMAC - N, 7-1-01; A, 7-1-09; A, 8-1-12]

8.305.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of members from one health care practitioner or setting to another as their condition and care needs change. The MCO and SE shall have the resources and policies and procedures in place to actively assist members with transition of care. Members transitioning from institutional levels of care such as hospitals, nursing homes, residential treatment facilities or ICFs/MR back to community services with transition of care needs shall be provided with care coordination services. Medicaid-eligible clients may initially receive physical and behavioral health services under fee-for-service medicaid prior to enrollment in managed care. During the member's medicaid eligibility period, enrollment status with a particular MCO may change and the member may switch enrollment to a different MCO. Certain members covered under managed care may become exempt and other members may lose their medicaid eligibility while enrolled in an MCO and SE. A member changing from MCO to MCO, fee-for-service to managed care coverage and vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The MCO and SE shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO, including the CoLTS MCO members and state coverage insurance (SCI) MCO members.

(1) The MCO and SE shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(a) When the medical assistance division notifies the MCO and SE of a mass transfer of members, the MCO and SE shall participate in a work group to decide on processes to be followed for the transition.

(b) For a mass transfer of members, the prior authorizations granted by HSD contractors, the COLTS MCOs, the SE and the SCI MCOs shall be honored for the following timeframes:

(i) all practitioner authorizations shall be honored for 60 days or until the receiving MCO has made other arrangements for care; providers who delivered these approved services shall be reimbursed by the receiving MCO;

(ii) for members with approved transplant services, the receiving MCO shall reimburse the approved providers if a donor organ becomes available during the first 60 days of enrollment;

(iii) all prescription drug refills shall be paid for by the receiving MCO for the first 90 days or until the MCO has made other arrangements; and

(iv) all durable medical equipment (DME) delivered after the mass transfer shall be paid for by the receiving MCO.

(c) Encounter data requirement. The MCO and SE shall provide pharmacy, dental, practitioner, facility, vision, DME and transportation encounter data for the one year prior to transition for their members identified as individuals with special health care needs, home and community-based waiver recipients, members receiving long-term services, members eligible for disease management and members receiving care coordination. The medical assistance division reserves the right to include other encounter data and other populations as it deems necessary.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member and provider education about the MCO, about self-care and the optimization of treatment, and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment. The MCO shall have written policies and procedures to facilitate a smooth transition of a member to another MCO when a member chooses and is approved to switch to another MCO.

(4) The MCO and SE shall have policies and procedures regarding provider responsibility for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the [~~MCO/SE~~] MCO and SE shall help coordinate for a seamless transition of post-discharge care. The MCO and SE shall have a mechanism for monitoring the transition of care from an inpatient or residential treatment facility.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the MCO and SE shall honor all prior authorizations granted by HSD through its contractors or the CoLTS MCO for the first 30 days of enrollment or until the [~~MCO/SE~~] MCO and SE has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the MCO and SE.

(2) For members who recently became exempt from managed care or enrolled in CoLTS, HSD or the CoLTS MCO shall honor prior authorization of fee-for-service covered benefits or CoLTS covered benefits granted by the MCO and SE for the first 30 days under fee-for-service medicaid or CoLTS or until other arrangements for the transition of services have been made. Providers who deliver these services and are eligible and willing to enroll as medicaid fee-for-service providers shall be reimbursed by HSD or the CoLTS MCO.

(3) For members who had transplant services approved by HSD under fee-for-service or under CoLTS, the MCO shall reimburse the providers approved by HSD or the CoLTS MCO if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the MCO, HSD or the CoLTS MCO shall reimburse the providers approved by the MCO if a donor organ becomes available for the member during the first 30 days under fee-for-service medicaid. Providers who deliver these services shall be eligible and willing to enroll as medicaid fee-for-service providers.

(5) For newly enrolled members, the MCO and SE shall pay for prescriptions for drug refills for the first 30 days or until the MCO and SE has made other arrangements. All drugs prescribed by a licensed behavioral health provider shall be paid for by the SE.

(6) For members who recently became exempt from managed care, HSD shall pay for prescriptions for drug refills for the first 30 days under the fee-for-service formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid fee-for-service provider.

(7) The MCO shall pay for DME costing $2,000 or more, approved by the MCO but delivered to the member after disenrollment from managed care or enrollment into CoLTS.

(8) HSD or the CoLTS MCO shall pay for DME costing $2,000 or more, approved by HSD or the CoLTS MCO but delivered to the member after enrollment in the MCO. The DME provider shall be eligible for and willing to enroll as a medicaid fee-for-service provider. DME is not covered by the SE unless it has been prescribed by a behavioral health provider.

C. **Special payment requirement.** The MCO shall be responsible for payment of covered physical health services, provided to the member for any month the MCO receives a capitation payment. The SE shall be

responsible for payment of covered behavioral health services provided to the member for any month the SE receives a capitation payment.

D. **Claims processing and payment** In the event that an MCO's and SE's contract with HSD has ended, is not renewed or is terminated, the MCO and SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's and SE's contract has ended.

(1) The MCO and SE shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO and SE shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO and SE shall continue to meet timeframes established for processing all claims.

[8.305.16.9 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09; A, 8-1-12]

HISTORY OF 8.305.16 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]