INVOLUNTARY TERMINATION REQUEST

CENTENNIAL CARE Self-Directed Community Benefits (SDCB) TO Agency Based Community Benefits (ABCB)

This form is used when the Managed Care Organization (MCO) requests an involuntary termination of a SDCB member to transition to the ABCB model per **NMAC 8.308.12.21 TERMINATION FROM ABCB PCS/DIRECTED OR SDCB.**

MEMBER NAME:_____
SSN/MEMBER ID#:_____
MANAGED CARE ORGANIZATION:_____
SUBMITTED BY:_____
DATE:_____
SEND TO: Jeannette Gurule (Jeannette.c.gurule@state.nm.us)

Checklist:

In your request to HSD, you must include the following documentation with the completed Involuntary Termination Form:

- ✓ Care Coordination contact records for the past year
- ✓ Most recently completed Community Benefit Services Questionnaire (CBSQ) including the CB Member Agreement (CBMA)
- ✓ Most recent Employer of Record (EOR) self-assessment
- ✓ Date of last Comprehensive Needs Assessment (CNA)

Answer the following questions and provide as much detail as possible. Also, please include documentation to support your request.

1. Please cite and list sections in NMAC 8.308.12.21 and the Medical Assistance Division Managed Care Policy Manual that pertain to the reason(s) for the involuntary termination request.

2. Please explain the MCO's reason(s) for requesting the Involuntary Termination to ABCB.

3. What is the member's diagnosis?

4. Please list all approved services in the member's current plan. Indicate whether he/she is under or over-utilizing any of these services.

5. Who is the member's EOR and what is the relationship? Who is the Support Broker and Agency?

HUMAN SERVICES DEPARTMENT

INVOLUNTARY TERMINATION REQUEST

CENTENNIAL CARE Self-Directed Community Benefits (SDCB) TO Agency Based Community Benefits (ABCB)

6. What steps has the MCO taken to help the member be successful with self-direction?

7. How will switching to ABCB benefit the member?

8. What is the MCO's plan for ensuring the member's success in the ABCB model?