

5 TRANSITIONS OF CARE

Revision Dates: August 15, 2014, March 1, 2017

Effective Date: January 1, 2014

In managed care, HSD will continue its commitment to providing the necessary supports to assist members to reintegrate into the community from institutional facilities. The State's activities will include:

1. Providing the necessary education and information on the front end for recipients in institutional facilities to understand the available opportunity;
2. Identifying eligible recipients;
3. Providing the necessary supports to facilitate transition;
4. Monitoring the success of the transition process.

The MCOs shall develop and implement methods for identifying Members who may have the ability and/or desire to transition from an institutional facility to the community. Such methods shall include, at a minimum:

1. The comprehensive needs assessment
2. PASRR
3. MDS
4. Identification of wrap-around services
5. Provider referral
6. Ombudsman referral
7. Family member referral
8. Change in medical status; ~~and/or~~
9. Member self-referral
10. Community Reintegration Allocation received; and/or
11. State Agency Referral

MCOs must identify and facilitate coordination of care for all members during changes or transitions between MCOs, as well as changes in service areas, sub-contractors, and/or health care providers.

TRANSITIONS FROM A NURSING FACILITY TO THE COMMUNITY

If a member is determined to no longer need long term care in a nursing facility, and the member is determined eligible for Community Benefits, the care coordinator shall facilitate the development of and implementation of a transition plan. The transition plan shall remain in place for a minimum of sixty (60) calendar days from the date of the decision to pursue transition or until the transition has occurred. The transition plan shall address the Member's transition needs including but not limited to:

1. Physical and behavioral health needs;
2. Selection of providers in the community;
3. Continuation of MAD eligibility;
4. Housing needs;¹
5. Financial needs;
6. Interpersonal skills; and
7. Safety
8. Agency-Based Community Benefit (ABCB) Community Transition Services

The member's care coordinator must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.

- The care coordinator must administer the Comprehensive Needs Assessment (CNA) in the nursing facility to determine the community benefits and services upon the member's discharge.
- The care coordinator will develop a new comprehensive care plan for the member within 14 business days of placement in the community.
- If the member has an existing Full Medicaid category of assistance, other than Institutional Care, an allocation is not needed to reintegrate into the community. The reintegration process can be completed and Community Benefits can be provided with the Full Medicaid category.
- If the member is Not Otherwise Medicaid Eligible (NOME), a Community Reintegration (CRI) allocation must be requested by contacting the Aging and Long Term Services

¹ Please see the CMS Standard Terms and Conditions for New Mexico's 1115 Waiver.

Department, Aging and Disability Resource Center (ALTSD/ADRC), prior to discharge (see Section 7: Community Benefits). The care coordinator must assist the member in gaining eligibility for a Community Benefits category of assistance, and ensure services are authorized and in place for a safe and seamless discharge.

The care coordinator shall conduct an additional visit within seventy-five (75) calendar days after transition to determine if the transition was successful and identify any remaining needs.

TRANSITIONS FOR MEMBERS WITH SPECIAL CIRCUMSTANCES

The following members may require additional or distinctive assistance during a period of transition. This includes members with:

1. Medical conditions or circumstances such as:
 - A. Pregnancy (especially women who are high risk and in third trimester, or are within 30 calendar days of their anticipated delivery date)
 - B. Major organ or tissue transplantation services which are in process
 - C. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing facilities, or other facilities,
 - D. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments; and/or
 - E. Significant behavioral health conditions (e.g., SMI, SED, SUD and COD) that require ongoing specialist care and appointments.
2. Members who are in treatment such as:
 - A. Chemotherapy and/or radiation therapy, or
 - B. Dialysis.
3. Members with ongoing needs such as:
 - A. Durable medical equipment including ventilators and other respiratory assistance equipment;
 - B. Home health services and/or Community Benefit services;
 - C. Medically necessary transportation on a scheduled basis;
 - D. Prescription medications, and/or

- E. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.
4. Members who at the time of their transition have received prior authorization or approval for:
- A. Scheduled elective surgery or surgeries;
 - B. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;
 - C. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period;
 - D. Appointments with a specialist located out of the MCO service area, and
 - E. Nursing facility admission.

For those Members whose [comprehensive needs](#) assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The transition plan shall address the Member's transition needs including but not limited to:

1. Physical and behavioral health needs
2. Selection of providers in the community
3. Housing needs²
4. Financial needs
5. Interpersonal skills; and safety

The [care coordinator](#) shall conduct an additional [visit](#) within seventy-five (75) calendar days after transition to determine if the transition was successful and identify any remaining needs.

TRANSITIONS OF CARE FOR MEMBERS MOVING FROM A HIGHER LEVELS OF CARE TO A LOWER LEVEL OF CARE

² Please see the [CMS Standard Terms and Conditions for New Mexico's 1115 Waiver](#).

The MCO shall develop and implement policies and procedures for ensuring that members transition successfully from higher levels of care (e.g. acute inpatient, residential treatment centers, social detoxification programs, treatment foster care, etc.) to the most appropriate lower level of care. Transitions from inpatient and behavioral health residential treatment facilities for both children and adults must be addressed. At a minimum, the following must be addressed:

1. Maintain on-going communication, enlist the involvement of and coordinate with state-run facilities to monitor and support their participation in the member's care.
2. Care coordinators must be knowledgeable of non-Medicaid behavioral and physical health programs/services, statewide, available to its members in order to facilitate referrals, coordinate care, and ensure transition to community based services.
3. Ensure that members receive follow-up care within 7 calendar days of discharge from a higher level of care to a lower level of care but receive follow up care no longer than 30 calendar days following other discharges.

~~NOTIFICATIONS REQUIRED OF MCOSs~~

~~Relinquishing MCOs must provide relevant information regarding members who transition to a receiving MCO.~~

~~Relinquishing MCOs who fail to notify the receiving MCO of transitioning members with special circumstances, or fail to send the transition notification, will be responsible for covering the member's care resulting from the lack of notification, for up to 30 calendar days.~~

~~MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, sub-contractors or other providers, as appropriate during times of transition.~~

~~Receiving MCOs must provide new members with their handbook and emergency numbers within ten calendar days of transition for acute care members and 12 calendar days of transition for members (allows for care coordination on-site visit).~~

~~If a member is referred to and approved for enrollment, the relinquishing MCO must coordinate the transition with the receiving MCO to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.~~

TRANSITIONS FROM A NURSING FACILITY TO THE COMMUNITY

~~If a member is determined to no longer need long term care in a nursing facility, and the member is determined eligible for Community Benefits, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of sixty (60) calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The member's care coordinator must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained. The care coordinator must administer the Comprehensive Needs Assessment (CNA) in the nursing facility to determine the community benefits and services upon the member's discharge.~~

TRANSITIONS OF MEMBERS TURNING TWENTY-ONE (21) YEARS OF AGE

All members, including those who are under the care of Early Periodic Screening and Diagnostic Treatment (EPSDT), must be transitioned to other services on their 21st birthday. The care coordinator must initiate a transition plan by the age of twenty (20) years which is ongoing until the member leaves the EPSDT program. The transition plan must:

- ~~1. 1. —~~ Establish a plan that is age appropriate and addresses the ~~current~~ transition needs of the member: ~~(i.e.,~~
 - ~~a. health condition management;~~
 - ~~b. developmental and functional independence;~~
 - ~~c. education;~~
 - ~~d. social and emotional health;~~
 - ~~e. guardianship; and;~~
 - ~~a.f. transportation);~~
2. Ensure families, members, guardians and their primary care providers are part of the development and implementation of the transition plan;

3. Document the transition plan in the medical record;
4. Provide family, guardian and member with a copy of the transition plan;
5. Establish a timeline for completing all services the member should receive through EPSDT prior to his or her twenty-first birthday;
6. Review and update the plan and timeline with member, guardian and family prior to official transition to adult provider;
7. Advise the member's primary care provider of the discharge and ensure coordination of the services with the adult primary care provider.

TRANSITION FOR MEMBERS CHANGING MCOs WHILE HOSPITALIZED DURING AN ENROLLMENT CHANGE

The MCO will make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include policies for the following:

1. Authorization of treatment by the receiving MCO on an individualized basis. The receiving MCO must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
2. Notification to the hospital and attending physician of the transition by the relinquishing MCO. The relinquishing MCO must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving MCO for authorization of continued services. If the relinquishing MCO fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing MCO will be responsible for coverage of services rendered to the hospitalized member for up to thirty (30) calendar days. This includes, but is not limited to, elective surgeries for which the relinquishing MCO issued prior authorization.
3. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving MCO, along with the mechanism for notification regarding pending discharge.
4. Transfer of care to a physician and/or hospital affiliated with the receiving MCO. Transfers from an out-of-network provider to one of the receiving MCO providers cannot

be made if harmful to the member's health and must be determined medically appropriate. The transfer may not be initiated without approval from the relinquishing MCO primary care provider, or the receiving MCO Medical Director.

NOTE: Members in Critical Care Units, Intensive Care Units and Neonatal Intensive Care Units require close consultation between the attending physician and the receiving MCO physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing MCO, and discharged after transition to the receiving MCO, both must work together to coordinate discharge activities.

The relinquishing MCO will be responsible for coordination with the receiving MCO regarding each specific prior authorized service. For members known to be transitioning, the relinquishing MCO will not authorize hospital services such as elective surgeries scheduled less than fifteen (15) calendar days prior to enrollment with the receiving MCO. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the MCO who authorized the service.

TRANSITION FOR MEMBERS CHANGING MCOs DURING MAJOR ORGAN AND TISSUE TRANSPLANTATION SERVICES

If there is a change in MCO enrollment, both the relinquishing and receiving MCOs will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a member changes MCO enrollment while undergoing transplantation at a contracted transplant center, the relinquishing MCO is responsible for contracted components or modules of the service up to and including completion of the service modules that the member is receiving at the time of the change. The receiving MCO is responsible for the remainder of the module components of the transplantation service.

If a member changes to a different MCO while undergoing transplantation at a transplant center that is not a contracted provider, each MCO is responsible for its respective dates of service. If the relinquishing MCO has negotiated a special rate, it is the responsibility of the receiving MCO to coordinate the continuation of the special rate with the respective transplant center.

TRANSITIONS ENROLLMENT CHANGES FOR MEMBERS CHANGING MCOs WHILE RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS

MCOs must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis, etc.) members and pregnant members during the transition period. The receiving MCO must have protocols to address the timely transition of the member from the relinquishing primary care provider (PCP) to the receiving PCP, in order to maintain continuity of care.

The receiving MCO must address methods to continue the member's care, such as contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving MCO.

Receiving MCOs are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new MCO within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

PROVIDER AND/OR SERVICE TERMINATIONS AND TRANSITIONS

Anticipated changes in the MCO provider network shall be reported to the MAD Contract Manager in writing within thirty (30) calendar days prior to the change, or as soon as the MCO knows of the anticipated change. Unexpected changes shall be reported within five (5) calendar days.

The MCO is required to submit a Notification, Narrative and Transition Plans A, and Transition Plan B as appropriate, to its Contract Manager on anticipated changes to the network. The Manager for either the Behavioral Health (BH) Unit or the Long-Term Support Services (LTSS) Unit shall be copied on any network change related to either BH or LTSS. Notification is expected whenever a provider informs the MCO of its intent to change or terminate a service(s), which may result in the need for members to transition from one service provider to another, or

when a service provider becomes incapable of performing a contracted service. In all instances, the MCO is expected to report how the changes will affect the service delivery system.

In both expected and unexpected changes in the network, the MCO shall assess the significance of the change or closure within ten (10) calendar days of a confirmation by the provider. If the MCO determines the change will not have a significant impact on the system, the Narrative template must be submitted within ten (10) calendar days from the date of notification of change or closure to the Contract Manager. The MCO must explain in the Narrative factors considered in making a determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable). If the MCO determines that the change or closure will significantly impact the delivery system, the MCO is required to submit Transition Plan A (Overall), Transition Plan B (Client Specific) and the Narrative to the Contract Manager within fifteen (15) calendar days of official notification to HSD. In the event that HSD determines a network change is significant, the MCO will be required to submit all transition information as requested.

Transition information will be submitted on the templates provided by HSD with all columns completed. The Narrative will be submitted in text format. Updates will be submitted every other week after the initial submission. A final update will be submitted when all consumers are transitioned. The Notification, Narrative and Transition Plan A will be submitted via email to the Contract Manager. Transition Plan B will be submitted by fax or via a secure website as determined by the MCO and HSD.

NOTIFICATION:

The Notification must include the following on the HSD approved forms:

1. Date
2. Name of Provider or Facility
3. Type of Service Region
4. Location (address)/City of the provider or facility closing
5. Total Number of members affected and number of Consumers ≤ 21 and > 21
6. Nature of the change

7. Anticipated Date of Closure
8. Transition Plans Required?
9. Narrative Due Date
10. If the MCO determines that transition plans will be required, the Notification will also include the following information:
 - a. Narrative, Transition Plan A and Transition Plan B due dates
 - b. Name of MCO staff responsible for the Transition and deliverables

NARRATIVE:

The Narrative will include the following:

1. How the change affects delivery of, or access to, covered services
2. The MCO's plan for maintaining access and the quality of consumer care
3. Factors considered in making the determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable)
4. Transition issues must be identified

Transition Plan A – Overall Transition Template

1. Preplanning
2. Network Operations
3. Transition Planning
4. Communication with the state
5. Care Coordination
6. Other requirements as needed depending on circumstances of closure
7. Transition Process Finalized

Transition Plan B – Client Specific Template

1. Client Name
2. Medicaid Number
3. Date of Birth
4. Parent or Legal Guardian (if applicable)

5. Services currently receiving
6. Current Provider
7. Date of Discharge (if applicable)
8. New Provider (or anticipated new provider)
9. Date or anticipated date of transition
10. First appointment date (for outpatient services)
11. Care Coordination and CSA (if applicable)
12. Special Conditions/Arrangements/Comments (e.g. barriers to transition)
13. CYFD – JJS or PS staff involvement (if applicable)

MCO NOTIFICATION REQUIREMENTS FOR MEMBERS TRANSITIONING BETWEEN MCOs

In instances of a provider and/or service termination, a member may request to be switched to another MCO for cause. The member must submit a written request to HSD. HSD will honor member switch requests under the following circumstances, not limited to:

- continuity of care
- The MCO does not cover the service the member seeks
- Please refer to NMAC 8.308.7 for further details.

The relinquishing MCO must provide relevant information regarding members who transition to a receiving MCO.

The relinquishing MCO that fails to notify the receiving MCO of transitioning members with special circumstances, or fails to send the transition notification, will be responsible for covering the member's care resulting from the lack of notification, for up to 30 calendar days.

The MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, sub-contractors or other providers, as appropriate during times of transition.

The receiving MCO must provide new members with their handbook and emergency numbers within ten calendar days of transition for acute care members and 12 calendar days of transition for all other members (allows for care coordination on-site visit).

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