5 TRANSITIONS OF CARE

Revision dates: August 15, 2014, March 1, 2017, January 1, 2019

Effective date: January 1, 2014

In managed care, HSD will continue its commitment to providing the necessary supports to assist members as they transition under various circumstances.

The MCOs must identify and facilitate coordination of care for all members during various transitions including but not limited to:

- Transition from a nursing facility to the community;
- Transition for Member(s) with special circumstances;
- Transition for Member(s) moving from a higher level of care to a lower level of care;
- Transition for Member(s) turning twenty-one (21) years of age;
- Transition for Member(s) changing MCOs while hospitalized;
- Transition for Member(s) changing MCOs during major organ and tissue transplantation services;
- Transition for Member(s) changing MCOs while receiving outpatient treatment for significant medical conditions;
- Transition for Member(s) changing MCOs;
- Transition for Member(s) previously in Fee For Service (FFS);
- Transition for Member(s) moving from a residential placement or institutional facility to a community placement;
- Transition for children returning home from a foster care placement;
- Transition for Member(s) released from incarceration or detention facilities;
- Transition for Member(s) discharging from a hospital;
- Transition for Member(s) discharging from out-of-home placements (ARTC, RTC, GH, TFC) and crisis centers related to Behavioral Health treatment; and/or
- Transition for Member(s) who are preparing to receive out-of-state treatment~~From an institutional facility into the community;~~
- ~~Between MCOs;~~
- ~~From the hospital to their home; and~~
- ~~From higher levels of care to lower levels of care~~

TRANSITIONS OF CARE~~FROM A NURSING FACILITY TO THE COMMUNITY~~

The MCOs shall develop and implement methods for identifying ~~Members~~ and facilitingate care coordination for all Members ~~during~~ involved in various transition scenarios.~~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. Preadmission Screen and Resident Review (PASRR)
3. Minimum Data Set (MDS)
~~4. Identification of wrap-around services~~
~~5.~~4.Provider referrals ~~including~~to or from hospitals and RTCs
~~6.~~5.Ombudsman ~~referral~~
~~7.~~6.Family member ~~referral~~
~~8.~~7.Change in medical status;
~~9.~~8.Member self-referral
~~10.~~9. Community Reintegration Allocation received; ~~and/or~~
10.State Agency Referral; and/or
11.Incarceration or detention facility referral.

If a ~~member is determined to no longer need long term care in a nursing facility~~Member is a candidate for transitioning to the community, the care coordinator shall, ~~and the member is determined eligible for Community Benefits, the care coordinator shall: F~~facilitate the development of and implementation of a transition plan which must be labeled "Transition of Care Plan" and may be a stand-alone document or included in the Comprehensive Care Plan (CCP). If included as a part of the CCP, the "Transition of Care Plan" must be clearly labeled for MCO tracking and HSD auditing ~~prior to the member's discharge~~. The transition of care 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 and a new CCP is in place. The transition of care plan shall address the Member's transitional needs including but not limited to:

a. Physical and behavioral health needs;
b. ~~Selection of providers of community services (i.e. meals on wheels)~~Community Benefit needs;
c. Continuation of ~~MAD~~ Medicaid eligibility
~~c.~~d.Selection of Providers in the community;
~~d.~~e.Housing needs;
~~e.~~f. Financial needs;
~~f.~~g. Interpersonal skills (the social skills people use to interact effectively with other people, including the ability to convey one's needs); and
~~g.~~ Safety. ~~in the home environment; and~~
h. ~~Community Transition Services through the Agency-Based Community Benefit (ABCB)~~

~~2. 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 shall ~~C~~conduct an additional assessment ~~in the home~~ within seventy-five (75) calendar days after the transition to determine if the transition was

successful and to identify any remaining needs resulting in a new CCP or ~~any~~ modifications to ~~the~~ an existing CCP.

1. 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.

2. If the member is Not Otherwise Medicaid Eligible (NOME), ~~in order move from a nursing facility and~~ and in a sursing facility and wishes to receive services in the community, a Community Reintegration (CRI) allocation must be requested by contacting the Aging and Long Term Services 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.

TRANSITIONS OF CARE REQUIREMENTS~~FOR MEMBERS WITH SPECIAL CIRCUMSTANCES~~

~~General Requirements~~

1. The MCO shall establish policies and procedures to ensure that all Members are contacted in a timely manner and are appropriately assessed;~~,~~ using HSD prescribed time frames, ~~and~~ processes and tools, to identify needs.

2. The MCO shall coordinate with the discharge planning teams at hospitals and institutions (e.g. Nursing Facilities, Jails/Prisons, Juvenile Detention Centers, RTCs) to address at a minimum:
    - Need for Home and Community Based Services;
    - Follow up appointments;
    - Therapies and treatments;
    - Medications; and/or
    - Durable Medical Equipment

3. The MCO shall notify the assigned CYFD lead worker (Permanency Placement Worker (PPW)) for Protective Services involved children and youth and Juvenile Probation Worker (JPO) for Juvenile Justice involved youth~~)~~ within thirty (30) business days prior to transition in care for CYFD involved children/youth.

4. The MCO shall perform an in-home assessment for Members who are transitioning from an inpatient hospital or Nursing Facility stay ~~to home and/or community and may be in need of Community Benefits~~ within three (3) Calendar Days after the transition. The assessment will address at a minimum:
    - Safety in Home Environment;
    - Physical Health Needs;
    - Behavioral Health Needs;
    - Housing Needs;
    - Continuation of Medicaid Eligibility;
    - Financial Needs;
    - CNA if one is not in place; and
    - Community Benefit needs and services in place.

The MCO shall contact the Member monthly for three (3) months to ensure continuity of care has occurred and the Member's needs are met.

5. The MCO shall not transition Members to another Provider for continuing services unless the current provider is not a Contract Provider.
6. The MCO shall facilitate a seamless transition to new services and/or Providers, without any disruption in services as ~~applicable~~ outlined~~,~~ in the CCP. ~~developed by the MCO without any disruption in services.~~
7. For Members who are preparing to receive out-of-state treatment, the MCO shall ensure daily updates are provided to the Member and/or authorized representative about the status of the out-of-state provider agreement and authorized treatment plan until treatment begins.

The MCO shall maintain active communication with the Member and/or authorized representative once out-of- state treatment begins, including weekends and holidays, for the duration of the treatment.

The MCO shall resume Care Coordination activities pursuant to 4.4 of the Agreement following treatment completion and Member's return to New Mexico.

TRANSITION OF CARE REQUIREMENTS FOR PREGNANT WOMEN

In the event a Member ~~entering the~~enrolling with an MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the MCO, the MCO shall be responsible for providing continued access to the prenatal care Provider (whether Contract or Non-Contract Provider) through the postpartum period, without any form of prior approval.

In the event a Member ~~entering the~~enrolled with an MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the MCO shall be responsible for the costs related to the ~~of~~ continuation of such medically necessary prenatal care services~~,~~ this -includes~~ing~~ the ~~prenatal care and~~ delivery, without any form of prior approval and without regard to whether such services are being provided by a Contract or Non-Contract Provider. This coverage is required -for up to sixty (60) Calendar Days from the Member's enrollment or until the Member may be reasonably transferred to a Contract Provider without disruption in care, whichever is less.

If the Member is receiving services from a Contract Provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

If the Member is receiving services from a Non-Contract Provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the MCO can reasonably transfer the Member to a Contract Provider without impeding service delivery that might be harmful to the Member's health in accordance with this Section 4.4.16.3.

TRANSFER FROM THE HEALTH INSURANCE EXCHANGE

The MCO must minimize disruption of care and ensure uninterrupted access to Medically Necessary Services for individuals transitioning between Medicaid and Qualified Health Plan coverage on the Health Insurance Exchange.

At a minimum, the MCO shall establish transition guidelines for the following individuals:

- Pregnant women;
- Individuals with significant health care needs or complex medical conditions;
- Individuals receiving ongoing services or who are hospitalized at the time of transition; and

- Individuals who received prior authorization for services from its Qualified Health Plan.

The MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these individuals, and to maintain written policies, procedures and documentation to address coverage transitions.

~~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)~~
   - A. ~~Major organ or tissue transplantation services which are in process~~
   - A. ~~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,~~
   - A. ~~Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments; and/or~~
   - A. ~~Significant behavioral health conditions (e.g., SMI, SED, SUD and COD) that require ongoing specialist care and appointments.~~
1. ~~Members who are in treatment such as:~~
   - A. ~~Chemotherapy and/or radiation therapy, or~~
   - A. ~~Dialysis.~~
1. ~~Members with ongoing needs such as:~~
   - A. ~~Durable medical equipment including ventilators and other respiratory assistance equipment;~~
   - A. ~~Home health services and/or Community Benefit services;~~
   - A. ~~Medically necessary transportation on a scheduled basis;~~
   - A. ~~Prescription medications, and/or~~
   - A. ~~Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.~~
1. ~~Members who at the time of their transition have received prior authorization or approval for:~~
   - A. ~~Scheduled elective surgery or surgeries;~~
   - A. ~~Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;~~
   - A. ~~Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period;~~
   - A. ~~Appointments with a specialist located out of the MCO service area, and~~

~~A. 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 must be labeled "Transition of Care Plan" and may be a stand-alone document or included in the Comprehensive Care Plan (CCP). If included as part of the CCP, the "Transition of Care Plan" must be clearly labeled for MCO tracking and HSD auditing. The transition plan 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:~~

~~0. Physical and behavioral health needs~~
~~0. Selection of providers in the community~~
~~0. Housing needs[1]~~
~~0. Financial needs~~
~~0. Interpersonal skills; and safety~~

~~The care coordinator shall conduct an additional assessment in the home within seventy-five (75) calendar days after transition to determine if the transition was successful and identify any remaining needs resulting in a new CCP or any modifications to the CCP.~~

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

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.

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

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

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 be labeled "Transition of Care Plan" and may be a stand-alone document or included in the CCP. If included as part of the CCP, the "Transition of Care Plan" must be clearly labeled for MCO tracking and HSD auditing. The transition plan must:

1. Establish a plan that is age appropriate and addresses the transition needs of the member:
    A. health condition management;
    B. developmental and functional independence;
    C. education;
    D. social and emotional health;
    E. guardianship; and
    F. transportation
2. Ensure members and when authorized - family members, guardians and 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 the member, and when authorized – family members and guardian - 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 the member, and when authorized – the 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

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.

TRANSITION 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.

MCO REQUIREMENTS FOR MEMBERS TRANSITIONING BETWEEN MCOs

For any member transitioning from one MCO to another the following must occur:

1. The relinquishing MCO must provide relevant information regarding members who transition to a receiving MCO.
2. 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.
3. The receiving MCO must provide new members with their handbook and emergency numbers within ten calendar days of transition for acute care members and within 12 calendar days of transition for all other members (allows for care coordination on-site visit).
4. 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.
5. 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.

~~5.~~6. The MCO shall ensure that any Member entering the MCO has access to services consistent with the access they previously had and ~~it~~is permitted to retain their current provider for a period of time, if that provider is not ~~in~~contracted with the MCO.