TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 11 TRANSITION OF CARE

8.308.11.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.11.1 NMAC - Rp, 8.308.11.1 NMAC, 5/1/2018]

8.308.11.2 SCOPE: This rule applies to the general public.
[8.308.11.2 NMAC - Rp, 8.308.11.2 NMAC, 5/1/2018]

8.308.11.3 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 Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.11.3 NMAC - Rp, 8.308.11.3 NMAC, 5/1/2018]

8.308.11.4 DURATION: Permanent.
[8.308.11.4 NMAC - Rp, 8.308.11.4 NMAC, 5/1/2018]

8.308.11.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.11.5 NMAC - Rp, 8.308.11.5 NMAC, 5/1/2018]

8.308.11.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.11.6 NMAC - Rp, 8.308.11.6 NMAC, 5/1/2018]

8.308.11.7 DEFINITIONS: [**RESERVED**]

8.308.11.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.308.11.8 NMAC - Rp, 8.308.11.8 NMAC, 5/1/2018; A, 4/5/2022]

8.308.11.9 TRANSITION OF CARE: Transition of care refers to movement of an eligible recipient or a manage care organization (MCO) member from one health care practitioner or setting to another as their condition and health care needs change. The MCO shall have the resources, the policies and the procedures in place to actively assist the member with their transition of care.

A. Care coordination will be offered to members who are:
- **(1)** transitioning from a nursing facility or out-of-home placement to the community;
- **(2)** moving from a higher level of care to a lower level of care (LOC);
- **(3)** turning 21 years of age;
- **(4)** changing MCOs while hospitalized;
- **(5)** changing MCOs during major organ and tissue transplantation services; and
- **(6)** changing MCOs while receiving outpatient treatments for significant medical conditions.

A member shall continue to receive medically necessary services in an uninterrupted manner during transitions of care.

B. The following is a list of HSD's general MCO requirements for transition of care.

(1) The MCO shall establish policies and procedures to ensure that each member is contacted in a timely manner and is appropriately assessed by its MCO, using the HSD prescribed timeframes, processes and tools to identify their needs.

(2) The MCO shall have policies and procedures covering the transition of an eligible recipient into a MCO, which shall include:
- **(a)** member and provider educational information about the MCO;
- **(b)** self-care and the optimization of treatment; and
- **(c)** the review and update of existing courses of the member's treatment.

(3) The MCO shall not transition a member to another provider for continuing services, unless the current provider is not a contracted provider.

(4) The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption in the member's services.

(5) When a member of a MCO is transitioning to another MCO, the receiving MCO shall immediately contact the member's relinquishing MCO and request the transfer of "transition of care data" as specified by HSD. If a MCO is contacted by another MCO requesting the transfer of "transition of care data" for a transitioning member, then upon verification of such a transition, the relinquishing MCO shall provide such data in the timeframe and format specified by HSD to the receiving MCO, and both MCOs shall facilitate a seamless transition for the member.

(6) The receiving MCO will ensure that its newly transitioning member is held harmless by their provider for the costs of medically necessary covered services, except for applicable cost sharing.

(7) For a medical assistance division (MAD) medically necessary covered service provided by a contracted provider, the MCO shall provide continuation of such services from that provider, but may require prior authorization for the continuation of such services from that provider beyond 30 calendar days. The receiving MCO may initiate a provider change only as specified in the MCO agreement with HSD.

(8) The receiving MCO shall continue providing services previously authorized by HSD, its contractor or designee, in the member's approved community benefit care plan, behavioral health treatment plan or service plan without regard to whether such a service is provided by contracted or non-contracted provider. The receiving MCO shall not reduce approved services until the member's care coordinator conducts a comprehensive needs assessment (CNA).

C. Transplant services, durable medical equipment and prescription drugs:

(1) If an eligible recipient has received HSD approval, either through fee-for-service (FFS) or any other HSD contractor, the receiving MCO shall reimburse the HSD approved providers if a donor organ becomes available during the first 30 calendar days of the member's MCO enrollment.

(2) If a member was approved by a MCO for transplant services, HSD shall reimburse the MCO approved providers if a donor organ becomes available during the first 30 calendar days of the eligible recipient's FFS enrollment. The MCO provider who delivers these services will be eligible for FFS enrollment if the provider is willing.

(3) If a member received approval from their MCO for durable medical equipment (DME) costing $2,000 or more, and prior to the delivery of the DME item, was disenrolled from the MCO, the relinquishing MCO shall pay for the item.

(4) If an eligible recipient received FFS approval for a DME costing $2,000 or more, and prior to the delivery of the DME item, they are enrolled in a MCO, HSD shall pay for the item. The DME provider will be eligible for FFS provider enrollment if the provider is willing.

(5) If a FFS eligible recipient enrolls in a MCO, the receiving MCO shall pay for prescribed drug refills for the first 30 calendar days or until the MCO makes other arrangements.

(6) If a MCO member is later determined to be exempt from MCO enrollment, HSD will pay for prescription drug refills for the first 30 calendar days of their FFS enrollment. The pharmacy provider will be eligible for FFS enrollment if the provider is willing;

(7) If a FFS eligible recipient is later enrolled in a MCO, the receiving MCO will honor all prior authorizations granted by HSD or its contractors for the first 30 calendar days or until it makes other arrangements for the transition of services. A provider who delivered services approved by HSD or through its contractors shall be reimbursed by the receiving MCO.

(8) If a MCO member is later determined to be exempt from MCO enrollment, HSD will honor the relinquishing MCO's prior authorizations for the first 30 calendar days or until other arrangements for the transition of services have been made. The provider will be eligible for FFS enrollment if the provider is willing.

D. Transition of care requirements for pregnant individuals:

(1) When a member is in their second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prenatal care provider (whether a contracted or non-contracted provider) through the 12-month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in their first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment, the receiving MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery, without any form of prior approval from the receiving MCO and without regard to whether such services are being

provided by a contracted or non-contracted provider for up to 60 calendar days from her MCO enrollment or until they may be reasonably transferred to a MCO contracted provider without disruption in care, whichever is less.

(3) When a member is receiving services from a contracted provider, their 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 12-month postpartum period.

(4) When a member is receiving services from a non-contracted provider, their MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the 12-month postpartum period, without any form of prior approval, until such time when their MCO determines it can reasonably transfer them to a contracted provider without impeding service delivery that might be harmful to their health.

E. Transition from institutional facility to community:

(1) The MCO shall develop and implement methods for identifying members who may have the ability, the desire, or both, to transition from institutional care to their community, such methods include, at a minimum:

(a) the utilization of a CNA;

(b) the utilization of the preadmission screening and annual resident review (PASRR);

(c) minimum data set (MDS);

(d) a provider referral including hospitals, and residential treatment centers;

(e) an ombudsman referral;

(f) a family member referral;

(g) a change in medical status;

(h) the member's self-referral;

(i) community reintegration allocation received;

(j) state agency referral; and

(k) incarceration or detention facility referral.

(2) When a member's transition assessment indicates that they are a candidate for transition to the community, their MCO care coordinator shall facilitate the development and completion of 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:

(a) their physical and behavioral health needs;

(b) the selection of providers in their community;

(c) continuation of MAP eligibility;

(d) their housing needs;

(e) their financial needs;

(f) their interpersonal skills; and

(g) their safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to their community to determine if the transition was successful and identify any remaining needs of the member.

F. Transition from the New Mexico health insurance exchange:

(1) The receiving MCO must minimize the disruption of the newly enrolled member's care and ensure they have uninterrupted access to medically necessary services when transitioning between a MCO and their New Mexico health insurance exchange qualified health plan coverage.

(2) At a minimum, the receiving MCO shall establish transition guidelines for the following populations:

(a) pregnant members, including the 12-month postpartum period;

(b) members with complex medical conditions;

(c) members receiving ongoing services or who are hospitalized at the time of transition; and

(d) members who received prior authorization for services from their qualified health plan.

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

[8.308.11.9 NMAC - Rp, 8.308.11.9 NMAC, 5/1/2018; A, 4/5/2022]

HISTORY OF 8.308.11 NMAC: [**RESERVED**]

History of Repealed Material:
8.308.11 NMAC - Managed Care Program, Transition of Care, filed 12/17/2013 Repealed effective 5/1/2018.