INDEX

8.306.16 MEMBER TRANSITION OF CARE

This page intentionally left blank.

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 16 MEMBER TRANSITION OF CARE

8.306.16.1 ISSUING AGENCY: Human Services Department
[8.306.16.1 NMAC - N, 7-1-05]

8.306.16.2 SCOPE: This rule applies to the general public.
[8.306.16.2 NMAC - N, 7-1-05]

8.306.16.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.16.3 NMAC - N, 7-1-05; A, 6-1-10]

8.306.16.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.16.4 NMAC - N, 7-1-05; A, 6-1-10]

8.306.16.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.16.5 NMAC - N, 7-1-05]

8.306.16.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.16.6 NMAC - N, 7-1-05]

8.306.16.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.16.7 NMAC - N, 7-1-05]

8.306.16.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of the communities.
[8.306.16.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of a member from one health care practitioner or setting to another as his/her condition and care requires change. The MCO shall have the resources, policies and procedures in place to ensure continuity of care without disruption in service to members and assure the service provider of payment. The MCO shall actively assist with transition of care issues. During the individual member's SCI recertification of eligibility period and re-enrollment, the member may switch enrollment to a different MCO. Employer groups may also switch MCOs during the group re-enrollment process. Certain members may lose their SCI eligibility while enrolled in an MCO. A member changing from one MCO to another SCI MCO shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The MCO 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.

(1) The MCO 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.

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

(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.

B. **Special payment requirement:** The MCO shall be responsible for payment of covered medical services, provided to the member for any month the MCO receives a capitation payment, even if the member has lost SCI eligibility.

C. Tracking of members who are nearing the annual claims benefit maximum or annual bed-day maximum:

(1) MCOs will track dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify individuals who are at 50 percent of claims benefits paid out in a benefit year and those who have utilized 80 percent of their available hospital inpatient resources.

(2) Identified members who are at the 50 percent level of claims payments or at 80 percent of hospital inpatient days available will have all care coordinated by the MCO to identify methods to manage care so as to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims or hospital day maximum thresholds.

(3) MCO will provide information on these individuals to HSD who will work in conjunction with the MCO to find alternative health care options for these individuals.

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

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

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

[8.306.16.9 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

HISTORY OF 8.306.16 NMAC: [RESERVED]