TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 7 ENROLLMENT AND DISENROLLMENT

8.308.7.1 ISSUING AGENCY: New Mexico health care authority (HCA).
[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018; A, 7/1/2024; A, 8/1/2026]

8.308.7.2 SCOPE: This rule applies to the general public.
[8.308.7.1 NMAC - Rp, 8.308.7.2 NMAC, 5/1/2018]

8.308.7.3 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.7.4 DURATION: Permanent.
[8.308.7.4 NMAC - Rp, 8.308.7.4 NMAC, 5/1/2018]

8.308.7.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.7.5 NMAC - Rp, 8.308.7.5 NMAC, 5/1/2018]

8.308.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.7.6 NMAC - Rp, 8.308.7.6 NMAC, 5/1/2018]

8.308.7.7 DEFINITIONS: [**RESERVED**].

8.308.7.8 MISSION STATEMENT: We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.308.7.8 NMAC - Rp, 8.308.7.8 NMAC, 5/1/2018; A, 8/10/2021; A, 8/1/2026]

8.308.7.9 MANAGED CARE ENROLLMENT:

A. General: A medical assistance division (MAD) eligible recipient is required to enroll in a HCA managed care organization (MCO) unless they are:

(1) a Native American who opts into managed care. If a Native American is dually eligible or in need of long-term care services, they are required to enroll in a MCO; or

(2) is in an excluded population. See 8.200.400 NMAC and 8.308.6 NMAC. Enrollment in a MCO may be the result of the eligible recipient's selection of a particular MCO or assignment by HCA. The MCO shall accept as a member an eligible recipient in accordance with 42 CFR. 434.25 and shall not discriminate against, or use any policy or practice that has the effect of discrimination against the potential or enrolled member on the basis of health status, the need for health care services, or race, color, national origin, ancestry, spousal affiliation, sexual orientation or gender identity. HCA reserves the right to limit enrollment in a specific MCO.

B. Newly eligible recipients: An individual who applies for a MAP category of eligibility (COE) and has an approved COE effective date of January 1, 2019, or later, and who is required to enroll in a MCO, must select a MCO at the time of their application for a MAP COE. An eligible recipient who fails to select a MCO at such time will be auto assigned to a MCO. See Subsection C of this Section. Members may choose a different MCO one time during the first three months of their enrollment.

C. Auto assignment: HCA will auto-assign an eligible recipient to a MCO in specific circumstances, including but not limited to: a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of their application for MAD eligibility; b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HCA may modify the auto-assignment algorithm, at its discretion, when it determines it is in the best interest of the

program, including but not limited to, sanctions imposed on the MCO, consideration of quality measures, cost or utilization management performance criteria. The HCA auto-assignment process will consider the following:

(1) if the eligible recipient was previously enrolled with a MCO and lost their eligibility for a period of six months or less, they will be re-enrolled with that MCO, provided they are eligible for reenrollment in that MCO at the time of auto assignment;

(2) if the eligible recipient has a family member enrolled in a specific MCO, they will be enrolled with that MCO;

(3) if the eligible recipient has family members who are enrolled with different MCOs, they will be enrolled with the MCO that the majority of other family members are enrolled with;

(4) if the eligible recipient is a newborn, they will be assigned to the mother's MCO for the month of birth, at a minimum; see Subsection A of 8.308.6.10 NMAC; or

(5) if none of the above applies, the eligible recipient will be assigned to an MCO using the default logic that auto assigns an eligible recipient to a MCO.

D. Effective date for a newly eligible recipient's enrollment in managed care: In most instances, the effective date of enrollment with a MCO will be the same as the effective date of eligibility approval.

E. A recipient is limited to no more than three months of retroactive MCO enrollment prior to the current month for the following reasons:

(1) retroactive medicare enrollment; or

(2) retroactive changes in eligibility; or

(3) retroactive nursing facility coverage; or

(4) changes in race code from Native American to non-Native American.

F. Eligible recipient member lock-in: A member's enrollment with a MCO is for a 12-month lock-in period. During the first three months of their initial MCO enrollment, either by the member's choice or by auto-assignment, they shall have one option to change MCOs for any reason, except as described below.

(1) If the member does not choose a different MCO during their first three months of enrollment, the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

(2) If during the member's first three months of enrollment in the initially or annually-selected or a HCA assigned MCO, and they choose a different MCO, they are subject to a new 12-month lock-in period and will remain with the newly selected MCO until the lock-in period ends. After that time, the member may switch to another MCO.

(3) At the conclusion of the 12-month lock-in period, the member shall have the option to select a new MCO, if desired. The member shall be notified of the option to switch MCOs two months prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If an inmate, as defined at 8.200.410.17 NMAC, becomes a newly eligible recipient during incarceration and remains eligible at the time of their release, they will be enrolled with the MCO of their choice or auto-assigned to a MCO, unless they are Native American. Their initial 12-month lock-in period will begin on the first of the month of their release from incarceration.

(5) If a member misses what would have been their annual switch enrollment period due to incarceration, hospitalization or incapacitation, the member will have two months to choose a new MCO.

G. Eligible recipient MCO open enrollment period: The open enrollment period is the last two months of an eligible recipient's 12-month lock-in period, and is the time period during which a member can change their MCO without having to provide a specific reason to HCA. The open enrollment period may be initiated at HCA's discretion in order to support program needs.

H. Mass transfers from another MCO: A MCO shall accept any member transferring from another MCO as authorized by HCA. The transfer of membership may occur at any time during the year.

I. Change of enrollment initiated by a member during a MCO lock-in period:

(1) A member may select another MCO during their annual renewal of eligibility, or re-certification period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. The member may submit the request to HCA's consolidated customer service center or the medical assistance division. Examples of "cause" include, but are not limited to:

(a) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(b) the member requires related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all of the related services are available within the network, and their

PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(c) poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.

(d) continuity of care (for example, a member's physician or specialist is no longer in the MCO's provider network or a member lives in a rural area and the closest physician that accepts their current MCO is too far away);

(e) family continuity (for example, a switch that is requested so that all family members are enrolled with the same MCO);

(f) administrative error (for example, a member chooses an MCO at initial enrollment or requests to change MCOs during an allowable switch period but the request was not honored).

(3) No later than the first calendar day of the second month following the month in which the request is filed by the member, HCA must respond in writing. If HCA does not respond timely, the request of the member is deemed approved. If the member is dissatisfied with HCA's determination, they may request a HCA administrative hearing; see 8.352.2 NMAC for detailed description.

(4) Native American opt-in and opt-out:

(a) Native American members in fee-for-service (FFS) may opt-in to managed care at any time during the year. MCO enrollment begins on the first calendar day of the month following HCA's receipt of the member's MCO opt-in request.

(b) Native American members may opt-out of managed care at any time during the year. MCO enrollment ends on the last calendar day of the enrollment month in which HCA receives the opt-out request.

(c) Native Americans who opt-in to managed care are not retroactively enrolled into managed care for prior months.

(d) A Native American who is approved for a category of eligibility that is required to be enrolled with a MCO must follow Subsection E, F and H of 8.308.7.9 NMAC regarding MCO enrollment.

[8.308.7.9 NMAC - Rp, 8.308.7.9 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021; A, 8/1/2026]

8.308.7.10 DISENROLLMENT

A. Member disenrollment initiated by a MCO: The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of their utilization of medical or behavioral health services, the member's diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. Other HCA member disenrollment: A member may be disenrolled from a MCO or may lose their MAD eligibility if:

(1) the member moves out of the state of New Mexico;

(2) the member no longer qualifies for a MAP category of eligibility or has a change to a MAP category of eligibility that is not eligible for managed care enrollment;

(3) the member requests disenrollment for cause, including but not limited to the unavailability of a specific care requirement that none of the contracted MCOs are able to deliver and disenrollment is approved by HCA;

(4) a member makes a request for disenrollment which is denied by HCA, but the denial is overturned in the member's HCA administrative hearing final decision; or

(5) HCA imposes a sanction on the MCO that warranted disenrollment.

C. Effective date of disenrollment: All HCA-approved disenrollment requests are effective on the first calendar day of the month following the month of the request for disenrollment, unless otherwise indicated by HCA. In all instances, the effective date shall be indicated on the termination record sent by HCA to the MCO.

[8.308.7.10 NMAC - Rp, 8.308.7.10 NMAC, 5/1/2018; A, 1/1/2019; A, 8/1/2026]

8.308.7.11 MASS TRANSFER PROCESS: The mass transfer process is initiated when HCA determines that the transfer of MCO members from one MCO to another is in the best interests of the program.

A. Triggering a mass transfer: The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in the MCO identification number or the MCO changes its name or other changes that is not relevant to the member and services will continue with that MCO; and

(2) a significant change in a MCO's contracting status, including but not limited to, the loss of licensure, substandard care, fiscal insolvency or significant loss in network providers; in such instances, a notice is sent to the member informing them of the transfer and the opportunity to select a different MCO.

B. Effective date of mass transfer: The change in enrollment initiated by the mass transfer begins with the first day of the month following HCA's identification of the need to transfer MCO members.

[8.308.7.11 NMAC - Rp, 8.308.7.11 NMAC, 5/1/2018; A, 8/1/2026]

8.308.7.12 MEMBER IDENTIFICATION CARD

A. Each member shall receive an identification card (ID) that provides their MCO membership information within 20 calendar days of notification of enrollment with the MCO.

B. The MCO shall re-issue a member ID card within 10 calendar days of notice if the member reports a lost card or if information on the card needs to be changed.

C. The MCO shall ensure a member understands that the ID card:

(1) is intended to be used only by the member;

(2) the sharing the member's ID card constitutes fraud; and

(3) the process of how to report sharing of a member's ID card.

[8.308.7.12 NMAC - Rp, 8.308.7.12 NMAC, 5/1/2018; A, 8/1/2026]

8.308.7.13 MEDICAID MARKETING GUIDELINES: HCA shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at a member before use by a MCO. The MCO shall comply with all federal regulations regarding medicare-advantage and medicaid marketing. See 42 CFR. Parts 422, 438.

[8.308.7.13 NMAC - Repealed, 8.308.7.13 NMAC, 5/1/2018; A, 8/1/2026]

HISTORY OF 8.308.7 NMAC:

History of Repealed Material:

8.308.7 NMAC - Managed Care Program, Enrollment and Disenrollment, filed 12/17/2013 Repealed effective 5/1/2018.