

**MANAGED CARE PROGRAM
ENROLLMENT AND DISENROLLMENT**

EFF: 8/10/2021

INDEX

8.308.7	ENROLLMENT AND DISENROLLMENT	
8.308.7.1	ISSUING AGENCY	1
8.308.7.2	SCOPE	1
8.308.7.3	STATUTORY AUTHORITY	1
8.308.7.4	DURATION	1
8.308.7.5	EFFECTIVE DATE	1
8.308.7.6	OBJECTIVE	1
8.308.7.7	DEFINITIONS	1
8.308.7.8	MISSION STATEMENT	1
8.308.7.9	MANAGED CARE ENROLLMENT	1
8.308.7.10	DISENROLLMENT	3
8.308.7.11	MASS TRANSFER PROCESS	3
8.308.7.12	MEMBER IDENTIFICATION CARD	4
8.308.7.13	MEDICAID MARKETING GUIDELINES	4

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EFF: 8/10/2021

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

8.308.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018]

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.
[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018]

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: 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.
[8.308.7.8 NMAC - Rp, 8.308.7.8 NMAC, 5/1/2018; A, 8/10/2021]

8.308.7.9 MANAGED CARE ENROLLMENT

A. General: A medical assistance division (MAD) eligible recipient is required to enroll in a HSD managed care organization (MCO) unless he or she is:

(1) a Native American unless he or she is dually-eligible or in need of long-term care services which requires enrollment 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 HSD. 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. HSD 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 his or her 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: HSD 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 his or her 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). HSD 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.

**MANAGED CARE PROGRAM
ENROLLMENT AND DISENROLLMENT**

EFF: 8/10/2021

(1) The HSD auto-assignment process will consider the following:

- (a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of six months or less, he or she will be re-enrolled with that MCO, provided he or she is eligible for reenrollment in that MCO at the time of auto assignment;
- (b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;
- (c) if the eligible recipient has family members who are enrolled with different MCOs, he or she will be enrolled with the MCO that the majority of other family members are enrolled with;
- (d) if the eligible recipient is a newborn, he or she 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
- (e) 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. Retroactive MCO enrollment is limited to up to six months 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 his or her initial MCO enrollment, either by the member's choice or by auto-assignment, he or she 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 his or her 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 HSD assigned MCO, and he or she chooses a different MCO, he or she is 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, he or she 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 his or her 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 his or her MCO without having to provide a specific reason to HSD. The open enrollment period may be initiated at HSD'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 HSD. 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 his or her annual renewal of eligibility, or recertification 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 HSD'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 his or

**MANAGED CARE PROGRAM
ENROLLMENT AND DISENROLLMENT**

EFF: 8/10/2021

her 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, HSD must respond in writing. If HSD does not respond timely, the request of the member is deemed approved. If the member is dissatisfied with HSD's determination, he or she may request a HSD 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 HSD'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 HSD 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]

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 his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

B. Other HSD member disenrollment: A member may be disenrolled from a MCO or may lose his or her MAD eligibility if:

- (1) he or she moves out of the state of New Mexico;
- (2) he or she 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) he or she 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 HSD;
- (4) a member makes a request for disenrollment which is denied by HSD, but the denial is overturned in the member's HSD administrative hearing final decision; or
- (5) HSD imposes a sanction on the MCO that warranted disenrollment.

C. Effective date of disenrollment: All HSD-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 HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the MCO. [8.308.7.10 NMAC - Rp, 8.308.7.10 NMAC, 5/1/2018; A, 1/1/2019]

8.308.7.11 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD 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

**MANAGED CARE PROGRAM
ENROLLMENT AND DISENROLLMENT**

EFF: 8/10/2021

(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 him or her 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 HSD's identification of the need to transfer MCO members.
[8.308.7.11 NMAC - Rp, 8.308.7.11 NMAC, 5/1/2018]

8.308.7.12 MEMBER IDENTIFICATION CARD

A. Each member shall receive an identification card (ID) that provides his or her 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]

8.308.7.13 MEDICAID MARKETING GUIDELINES: HSD 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]

HISTORY OF 8.308.7 NMAC: [RESERVED]

History of Repealed Material:

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