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Volume: XXXII **Issue:** 15 **Publication date:** 8/10/2021 **Number of pages:** 3 **(ALD Use Only) Sequence No.** 542.4

Issuing agency name and address: HSD - Medical Assistance Division

Agency DFA code: 630

Contact person's name: Tabitha Mondragon

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Type of rule action:

New ☐ **Amendment** ■ **Repeal** ☐ **Emergency** ☐ **Renumber** ☐

(ALD Use Only)
Most recent filing date: 11/14/2018

Title number: 8 **Title name:** Social Services

Chapter number: 308 **Chapter name:** Managed Care Program

Part number: 7 **Part name:** Enrollment and Disenrollment

Amendment description (If filing an amendment): Amending (2) Sections.

Amendment's NMAC citation (If filing an amendment): Sections 8 and 9 of 8.308.7 NMAC.

Are there any materials incorporated by reference?

Yes ☐ **No** X

Please list attachments or Internet sites if applicable.

If materials are attached, has copyright permission been received? **Yes** ☐ **No** ☐ **Public domain** ☐

Specific statutory or other authority authorizing rulemaking:

Centennial Care 2.0 1115 Waiver

Notice date(s): 3/9/2021

Hearing date(s): 4/8/2021

Rule adoption date: 7/4/2021

Rule effective date: 8/10/2021

Concise Explanatory Statement For Rulemaking Adoption:

Findings required for rulemaking adoption:

Findings MUST include:

- Reasons for adopting rule, including any findings otherwise required by law of the agency, and a summary of any independent analysis done by the agency;

- Reasons for any change between the published proposed rule and the final rule; and

- Reasons for not accepting substantive arguments made through public comment.

Language has been added to clarify Continuity of Care, Family Continuity and Administrative Error switch request criteria. There were no public oral or written comments received regarding 8.308.7 revisions so the rule is being adopted as proposed.

Issuing authority (If delegated, authority letter must be on file with ALD):

Name: David R. Scrase

Check if authority has been delegated ☐

Title: Secretary

Signature: **(BLACK ink only)** DocuSigned by: David R. Scrase, M.D. 9DBE7D7D1353422...

Date signed: 7/4/2021

This is an amendment to 8.308.7 NMAC, Sections 8 and 9, effective 8/10/2021.

8.308.7.8 **[~~RESERVED~~] 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 and elects enrollment in MAD's fee-for-service (FFS)~~] a Native American who opts into managed care. If a Native American is dually eligible or in need of long-term care services, he or she is 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 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.

(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 [~~or annual~~] 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 [~~60 days~~] 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 a member loses his or her MAD eligibility for a period of six months or less, he or she will be automatically re-enrolled with the former MCO.~~

~~(5)~~] 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.

[~~(6)~~] **(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 re-certification period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. [~~The member must submit a written request to HSD or may submit an oral request by calling the New Mexico medicaid call center~~] 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 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]