MEDICAID MANAGED CARE
MANAGED CARE ELIGIBILITY
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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 4 MANAGED CARE ELIGIBILITY

8.305.4.1 ISSUING AGENCY: Human Services Department
[8.305.4.1 NMAC - N, 7-1-01]

8.305.4.2 SCOPE: This rule applies to the general public.
[8.305.4.2 NMAC - N, 7-1-01]

8.305.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.4.3 NMAC - N, 7-1-01]

8.305.4.4 DURATION: Permanent
[8.305.4.4 NMAC - N, 7-1-01]

8.305.4.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.305.4.5 NMAC - N, 7-1-01]

8.305.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.4.6 NMAC - N, 7-1-01]

8.305.4.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.4.7 NMAC - N, 7-1-01]

8.305.4.8 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 their communities.
[8.305.4.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.4.9 MANAGED CARE ELIGIBILITY: HSD determines eligibility for enrollment in the managed care program. All medicaid eligible clients are required to participate in the medicaid managed care program except for the following:

A. clients eligible for both medicaid and medicare (dual eligibles);
B. institutionalized clients, defined as those expected to reside in a nursing facility for long term care or permanent placement; this does not include clients placed in a nursing facility to receive subacute or skilled nursing care in lieu of continued acute care;
C. clients residing in intermediate care facilities for the mentally retarded;
D. clients participating in the health insurance premium payment (HIPP) program;
E. children and adolescents in out-of-state foster care or adoption placements;
F. Native Americans;
G. clients eligible for medicaid category 029, family planning services only;
H. women eligible for medicaid category 052, breast and cervical cancer program;
I. adults ages 19-64 eligible for category 062, state coverage insurance;
J. members with brain injury COE 092;
K members approved for adult personal care options (PCO) services; and
L. members approved for the disabled and elderly home and community-based waiver categories 091, 093 and 094.

[8.305.4.9 NMAC - Rp 8 NMAC 4.MAD.606.3.1, 7-1-01; A, 7-1-02; A, 7-1-04; A, 7-1-05; A, 7-1-08; A, 7-1-09]

8.305.4.10 SPECIAL SITUATIONS:

A. **Newborn enrollment:** The following provisions apply to newborns:

(1) Medicaid eligible and enrolled newborns of medicaid eligible enrolled mothers are eligible for a period of 12 months starting with the month of birth. These newborns are enrolled retroactive to the date of birth with the same MCO the mother had during the birth month, as soon as the newborn's eligibility is approved, regardless of where the child is born (that is, in the hospital or at home). The MCO is responsible for care of a newborn to a Salud! enrolled mother, whose eligibility is determined through daily rosters provided by HSD or by the MCO's required follow-up of the MAD 313 form.

(2) If the newborn's mother is not a member of the MCO at the time of the birth in a hospital or at home, the newborn must be medicaid enrolled and shall be MCO enrolled during the next applicable enrollment cycle.

B. **Hospitalized members:** Regarding Salud! MCO and medicaid fee-for-service (FFS) members: If an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO or FFS shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud! Regarding Salud!MCO and CoLTS MCO members: For members transitioning to or from CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE. This does not apply to newborns born to a member mother; see Subsection A of 8.305.4.10 NMAC above. The originating and receiving organization are both required to ensure continuity and coordination of care during the transition.

C. **Native Americans:** A self-identified Native American shall be afforded the option of participating in managed care or being covered by medicaid fee-for-service for medical or behavioral health services. Upon determination of medicaid eligibility, a Native American may choose to participate in managed care, or opt in, by enrolling in an MCO for medical services or by choosing the managed care SE for behavioral health services. By not enrolling in an MCO or not choosing the managed care SE, the Native American chooses not to participate in managed care and shall be covered through medicaid fee-for-service. A medicaid eligible Native American may opt-in at any time by enrolling with an MCO or by choosing the managed care SE. If an opt-in request is made prior to the 20th of the month, the opt-in shall become effective the following month. If the opt-in request is made after the 20th of the month and before the first day of the next month, the opt-in shall be effective on the first day of the second full month following the request. After enrolling in an MCO or the managed care SE, a Native American may opt out during the first 90 days of any 12-month enrollment lock-in period (disenrollment). Disenrollment is effective the following month. At the end of the lock-in period, a Native American may choose to either continue enrollment in managed care or opt-out of managed care.

D. **Members receiving hospice services:** Members who have elected to receive hospice services and are receiving hospice services at the time they are determined eligible for medicaid will be exempt from enrolling in managed care unless they revoke their hospice election.

E. **Members placed in nursing facilities:** If a member is placed in a nursing facility for what is expected to be a long term or permanent placement, the MCO or the SE, remains responsible for the member until the member is disenrolled from Salud! and enrolled into the CoLTS program at the time that the nursing facility determination (the approved abstract) is entered into the MMIS system. Failure of a nursing facility to maintain abstract authorization for an institutionalized member that causes the system to enroll the member into managed care is considered an error in enrollment. The MCO/SE is not responsible for payment of any medical or behavioral services delivered and all capitations shall be recouped.

F. **Members in third trimester of pregnancy:** A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider may continue that relationship. Refer to Paragraph (4) of Subsection H of 8.305.11.9 NMAC for special payment requirements.

G. **Members placed in institutional care facilities for the mentally retarded (ICF/MR):** If a member is placed in an ICF/MR for what is expected to be a long-term or permanent placement, the MCO/SE remains responsible for the member until the member is disenrolled by HSD.
[8.305.4.10 NMAC - Rp 8 NMAC 4.MAD.606.3.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.4.11 MANAGED CARE STATUS CHANGE: A change of medicaid eligibility for a member enrolled in an MCO/SE may result in managed care disenrollment or change of enrollment status within the MCO/SE.

A. **Effect of exclusion and exempt status on managed care status:** If the member's medicaid eligibility status changes so that he is no longer a mandatory MCO/SE enrollee, the member shall be disenrolled from the MCO/SE.

(1) **Enrollment process immediately initiated:** If a member's eligibility status changes requiring mandatory enrollment in managed care, the enrollment process shall be initiated.

(2) **Delay in automatic assignment to MCO/SE process:**

(a) A member who has been exempt by residing in a nursing facility or intermediate care facility for the mentally retarded and is discharged to live at home, shall be eligible for enrollment in managed care upon discharge.

(b) A Native American member may choose to opt in to managed care at any time.

B. **Change in eligibility without change in managed care status:** If a member's eligibility category changes and enrollment in an MCO/SE is mandatory for the new eligibility category, the member's managed care status shall not change. Members remain enrolled in the current MCO/SE unless another change occurs which invalidates enrollment with the current MCO/SE.
[8.305.4.11 NMAC - Rp 8 NMAC 4.MAD.606.3.3, 7-1-01; A, 7-1-04; A, 7-1-05]

HISTORY OF 8.305.4 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.3, Managed Care Policies, Managed Care Eligibility - 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.3, Managed Care Policies, Managed Care Eligibility - Repealed, 7-1-01.