MEDICAID MANAGED CARE
ENROLLMENT IN MANAGED CARE
Tribal Consultation Version 10.15.2013

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 5 ENROLLMENT IN MANAGED CARE

8.305.5.1 ISSUING AGENCY: Human Services Department
[8.305.5.1 NMAC - Rp 8.305.5.1 NMAC, 7-1-04]

8.305.5.2 SCOPE: This rule applies to the general public.
[8.305.5.2 NMAC - Rp 8.305.5.2 NMAC, 7-1-04]

8.305.5.3 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.
[8.305.5.3 NMAC - Rp 8.305.5.3 NMAC, 7-1-04]

8.305.5.4 DURATION: Permanent
[8.305.5.4 NMAC - Rp 8.305.5.4 NMAC, 7-1-04]

8.305.5.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.5.5 NMAC - Rp 8.305.5.5 NMAC, 7-1-04]

8.305.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.5.6 NMAC - Rp 8.305.5.6 NMAC, 7-1-04]

8.305.5.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.5.7 NMAC - Rp 8.305.5.7 NMAC, 7-1-04]

8.305.5.8 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.
[8.305.5.8 NMAC - Rp 8.305.5.8 NMAC, 7-1-04; A, 7-1-09]

8.305.5.9 ENROLLMENT PROCESS.

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, or sexual orientation and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, or sexual orientation. All enrollments in a specific MCO shall be member choice. Enrollment in the SE is mandatory for all members enrolled in managed care or medicaid fee-for-service.

B. **Selection period:** The member shall have at least 16 calendar days to select an MCO. If a selection is not made, the member shall be assigned to an MCO by HSD. Members mandated into managed care shall be automatically assigned to the SE.

C. **Enrollment methods when no selection made:**

(1) **Enrollment with previous MCO:** The member is automatically enrolled with the previous MCO unless the MCO is no longer in good standing, is no longer contracting with HSD or has had enrollment suspended.

(2) **Enrollment based on case continuity:** Enrollment based on case continuity is applied in the following manner:

(a) **Processing case continuity:** The member is enrolled with the MCO to which the majority of the case (family) members are assigned. If an equal number of case (family) members are assigned to different MCOs and a majority cannot be identified, the member is assigned to an MCO to which other case (family) members are assigned.

(b) **Newborn enrollment:** When a child is born to a mother enrolled with a Salud! MCO, hospitals or other providers shall complete a notification of birth, MAD Form 313. The newborn remains enrolled with the mother's MCO until the mother selects a new MCO for the child.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, members who are not enrolled using the previous methods may be enrolled in an MCO using a percentage-based assignment process. The percentage-based assignments for each MCO may be determined based upon consideration of the MCO's performance in such areas as the quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of service, grievance resolution, claims payment, price and consumer input.

D. **Begin date of enrollment:** Enrollment begins the first day of the first full month following selection or assignment except in the following circumstances:

(1) newborn enrollment (Subsection A of 8.305.4.10 NMAC, *newborn enrollment*); and

(2) members receiving hospice care (Subsection E of 8.305.4.10 NMAC, *members receiving hospice services*)

E. **Member lock-in:** Member enrollment in an MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to an MCO, the member shall have the option to choose a different MCO to provide care during the member's remaining period of managed care enrollment.

(1) If the member does not choose a different MCO, the member will continue to receive care from the MCO that provided the member's care in the first 90 days.

(2) If, during the member's first 90 days with an MCO, he chooses a different MCO, the member will have a 90-day open enrollment period with this new MCO.

(3) After exercising his switching rights, and returning to a previously selected MCO, the member shall remain with this MCO until his 12-month lock-in period expires before being permitted to switch MCOs.

(4) At the conclusion of the 12-month cycle, the member shall have the same choices offered at the time of initial enrollment. The member shall be notified 60 days prior to the expiration date of the member's lock-in period of the expiration of the lock-in and the deadline by when to choose a new MCO.

(5) If a member loses medicaid eligibility for a period of two months or less, he will be automatically reenrolled with the former MCO. If the member misses the annual disenrollment opportunity during this two-month time, he may request to be assigned to another MCO.

F. **Member switch enrollment:** A member who is required to enroll in managed care may request to be disenrolled from an MCO and switch to another MCO "for cause" at any time. The member or his representative shall make the request in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO no later than the first day of the second month following the month in which the member or his representative files the request. If HSD fails to make a disenrollment determination so that the member may be disenrolled during this timeframe, the disenrollment is considered approved. A member who is denied disenrollment shall have access to HSD's fair hearing process. The following criteria shall be cause for disenrollment:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in assigning a member to an MCO;

(4) assignment of a member where travel for primary care exceeds community standards (90 percent of urban residents shall travel no further than 30 miles to see a PCP; 90 percent of rural residents shall travel no further than 45 miles to see a PCP; and 90 percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

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

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

G. **Exemption:** HSD shall grant exemptions to mandatory enrollment on a case-by-case basis. HSD shall grant exemptions to mandatory enrollment for medicaid managed care physical health and behavioral health services for cause on a case-by-case basis. If the exemption is granted, the member shall receive the member's behavioral health services through the SE under the medicaid fee-for-service (FFS) program and the member's physical health services under the medicaid FFS program. A member or the member's representative, parent or legal guardian shall request exemption in writing to HSD, describing the special circumstances that warrant an exemption. Alternatively, HSD may initiate an exemption on a case-by-case basis. Requests for exemption shall be evaluated by HSD clinical staff and forwarded to the medical assistance division medical director or designee for final determination. Members shall be notified of the disposition of exemption requests. A member requesting an exemption, who is not enrolled in managed care at the time of the exemption request, shall remain exempt until a final determination is made. A member already in managed care at the time of the exemption request shall remain in managed care until a final determination is made. HSD shall review the request and furnish a written response to the member no later than the first day of the second month following the month in which the member files the request. If HSD fails to make a determination so that the member may become exempt within this timeframe, the exemption is considered approved. A member who is denied exemption shall have access to HSD's fair hearing process.

H. **Disenrollment, MCO/SE initiated:** The MCO/SE may request that a particular member be disenrolled from managed care. Member disenrollment from an MCO/SE shall be considered in rare circumstances. Disenrollment requests shall be made in writing to HSD. The request and supporting documentation shall meet HSD conditions stated below in Subsection I of 8.305.5.9 NMAC, *conditions under which an MCO/SE may request member disenrollment*. The MCO/SE shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs (except when his continued enrollment with the MCO/SE seriously impairs the MCO's or SE's ability to furnish services to either this particular member or other members). The MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO/SE retains responsibility for the member's care until the member is enrolled with another MCO or exempted from managed care. In the case of the SE, the member would be exempted from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The MCO/SE shall assist with transition of care.

I. **Conditions under which an MCO/SE may request member disenrollment:** Conditions under which an MCO/SE may request disenrollment are:

(1) the MCO/SE demonstrates a good faith effort has been made to accommodate the member and address the member's problems, but those efforts have been unsuccessful;

(2) the conduct of the member does not allow the MCO/SE to safely or prudently provide medical or behavioral health care subject to the terms of the contract;

(3) the MCO/SE has offered to the member in writing the opportunity to use the grievance procedures; and

(4) the MCO/SE has received threats or attempts of intimidation from the member to the MCO's or SE's providers or MCO/SE staff.

J. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all contracted MCOs, HSD shall evaluate the member for medical management. In the case of the SE, the member would be exempted from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program.

K. **Date of disenrollment:** MCO/SE enrollment, upon approval, shall terminate at the end of a calendar month.

[8.305.5.9 NMAC - Rp 8.305.5.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.5.10 ENROLLMENT ROSTERS: The MCO/SE shall receive a monthly roster with the aggregate number of members, member names, member addresses, member social security numbers, member rate cells and member capitation amounts.
[8.305.5.10 NMAC - Rp 8.305.5.10 NMAC, 7-1-04; A, 7-1-05]

8.305.5.11 MEMBER IDENTIFICATION CARD: The MCO shall issue a member identification card with SE contact information within 30 days of enrollment to each member. HSD shall review and approve the identification card. The card shall be substantially the same as the card issued to commercial enrollees. The card shall not contain information that identifies the member as a medicaid recipient, other than designations commonly used by MCOs to identify for providers the members' benefits, such as group or plan numbers.
[8.305.5.11 NMAC - Rp 8.305.5.14 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is appropriate.

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

(1) a maintenance change, such as changes in MCO identification number or MCO name; and

(2) a significant change in MCO contracting status, including but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

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

C. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when the medicaid or managed care status change of the MCO is transparent to the member. For instance, a change in the MCO's medicaid identification number is a system change that requires a mass transfer but is not relevant to the member and service continues with the MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the prior MCO experiencing the maintenance change.

D. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, a notice is sent to members informing them of the transfer and their opportunity to select a different MCO.
[8.305.5.12 NMAC - Rp 8.305.5.15 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.5.13 MEDICAID MANAGED CARE AND SINGLE STATEWIDE ENTITY MARKETING GUIDELINES: When marketing to medicaid members, the MCOs/SE shall follow the medicaid managed care marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity**.** The marketing and outreach material must meet the following minimum requirements:

(1) marketing and outreach materials must meet requirements for all communication with medicaid members, as delineated in the quality standards (8.305.8.15 NMAC, *member bill of rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO/SE under the medicaid managed care contract shall state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a prevalent population of five percent in the MCO/SE membership that has limited English proficiency, as identified by the MCO/SE or HSD, marketing materials must be available in the language of the prevalent population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets, newspaper, magazine, radio, television, billboard, MCO/SE yellow page advertisements, web site, press releases, telephone scripts and presentation materials used by an MCO/SE, an MCO/SE representative or an MCO/SE sub-

contractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid member. HSD may request, review and approve or disapprove any communication to any medicaid member regarding behavioral health. The MCO/SE is not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at medicaid members and marketing material that mentions medicaid, medical assistance, Title XIX or makes reference to medicaid behavioral health services. The MCO/SE shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to medicaid populations, such as billboards or bus posters disproportionately located in low-income neighborhoods;

(2) mention the MCO/SE's medicaid product name; or

(3) contain language or information designed to attract medicaid enrollment.

C. **Advertising and marketing material:** The dissemination of medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the internet requires the approval of HSD or its designee. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material must be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references to MCO/SE strengths:** Misleading information shall not be allowed even if it is accurate. For example, an MCO/SE may seek to advertise that its health care services, including behavioral health, are free to medicaid members. HSD would not allow the language because it could be construed by members as being a particular advantage of the MCO/SE. In other words, they might believe they would have to pay for medicaid health services if they chose another MCO or remained in fee-for-service medicaid.

(3) **Threatening messages:** An MCO/SE shall not imply that another managed care or other behavioral health program is endangering members' health status, personal dignity or the opportunity to succeed in various aspects of their lives. An MCO/SE may differentiate itself by promoting its legitimate strengths and positive attributes, but not by creating threatening implications about the mandatory assignment process or other aspects of the program.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO/SE directly, its network providers, its subcontractors or any other party affiliated with the MCO/SE. HSD shall prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose medicaid benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan that discourages or encourages MCO selection based on health status or risk;

(3) initiating an enrollment request on behalf of a medicaid member except under circumstances in which the MCO, its representative, network provider or subcontractor may perform presumptive eligibility screening or medicaid onsite application assistance as an agent of the state;

(4) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(5) asserting or implying that the MCO offers unique covered services where another MCO provides the same or similar services;

(6) the use of more than nominal gifts such as diapers, toasters, infant formula or other incentives to entice medicaid members to join a specific health plan;

(7) telemarketing or door-to-door marketing with potential members;

(8) conducting any other marketing activity prohibited by HSD or its designee;

(9) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(10) distributing any marketing materials without first obtaining the approval of HSD or its designee;

(11) seeking to influence enrollment in conjunction with the sale or offering of any private insurance;

(12) engaging in telephone or other cold call marketing activities, directly or indirectly; and

(13) other requirements specified by HSD.

E. **Marketing in current care sites:** Promotional materials may be made available to members and

potential MCO/SE enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings at care delivery sites for the purpose of marketing to potential MCO/SE enrollees by MCO/SE staff shall not be permitted.

F. **Provider communications with medicaid members about MCO/SE options:** HSD marketing restrictions shall apply to MCO/SE subcontractors and providers as well as to the MCO/SE. The MCO/SE is required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Member-initiated meetings with MCO/SE staff prior to enrollment:** Face-to-face meetings requested by a member are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with the member must be in compliance with the guidelines identified in these regulations.

H. **Mailings by the MCO/SE:** MCO/SE mailings shall be permitted in response to a member's oral or written request for information. The content of marketing or promotional mailings shall be prior approved by HSD or its designee. MCO/SE may, with HSD approval, provide potential members with information regarding the MCO/SE medicaid benefit package. MCO/SE shall not send gifts however nominal in value, in these mailings. MCO/SE may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO/SE preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be prior approved by HSD or its designee.

I. **Group meetings:** The MCO/SE may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve any marketing material to be presented at the meeting. HSD, or its designee shall approve the methodology used by the MCO/SE to solicit attendance for the public meetings. HSD or its designee may attend the meeting.

J. **Light refreshments for members at meetings:** The MCO/SE may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to members:** The MCO/SE and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs/SE to include reward items in information sent to new MCO/SE members.

M. **Marketing time frames:** The MCO/SE may initiate marketing and outreach activities at any time.

[8.305.5.13 NMAC - Rp 8.305.5.16 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

HISTORY OF 8.305.5 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.606.4, Managed Care Policies, Enrollment In Managed Care, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.4, Managed Care Policies, Enrollment In Managed Care - Repealed, 7-1-01.
8.305.5 NMAC, Medicaid Managed Care, Enrollment in Managed Care - Repealed, 7-1-04.