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LFC Requester:	

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *2/11/25*
Bill Number: *SB336*

Check all that apply:
Original _x_ Correction __
Amendment __ Substitute __

Sponsor: Sen Hickey
Short Title: MEDICAID MANAGED CARE ORGANIZATIONS

Agency Name and Code Number: HCA-630
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
$0	$0	N/A	N/A

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0	$0	$0	N/A	N/A

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
IT System changes: Fed. Funds	$0.0	$2,126.2	$911.3	$3,037.5	Nonrecurring	Federal Funds
IT System changes: State Funds	$0.0	$708.8	$303.7	$1,012.5	Nonrecurring	State General Fund
	$0.0	$2,835.0	$1,215.0	$4,050.0	Nonrecurring	TOTAL

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: Not known
Duplicates/Relates to Appropriation in the General Appropriation Act: Not known

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:
SB 336 revises the Public Assistance Act to require that a proportional number of Medicaid members are in each Managed Care Organization (MCO), including new MCOs that join the market.

FISCAL IMPLICATIONS

Enactment of SB336 would require additional Medicaid system and Medicaid provider administrative costs.

Implementation of SB336 would require an eligibility system (ASPEN) coding change to balance enrollment among contracted Medicaid managed care organizations (MCOs) with the new methodology needed to achieve balancing. It is estimated that the total cost of system and ancillary changes is $4,050,000 (federal share $3,037,500, general fund $1,012,500), and with a 1.5-year timeframe to complete.

The system and ancillary changes include:

1) ASPEN system changes to new MCO member enrollment assignment reasons: client choice, family continuity, and previous enrollment with the same MCO.
2) Updating MCO enrollment notices that limit new MCO choices and MCO switches at annual enrollment.
3) Changes to both paper and online applications to limit choice and switches at annual enrollment.

Currently, 674,619 Medicaid members are enrolled in MCO plans. Balancing these members across MCO contractors would have unknown impacts on their costs of doing business, and is likely to impact the MCOs' capitation payments. A clearer definition of 'balancing' is needed to review these cost and revenue impacts to the MCOs, and the fiscal implications to the Medicaid program.

Implementation of SB336 could have systemwide Medicaid provider administrative costs. A large

reassignment of membership will require providers to update their systems with new membership information for service provision and billing.

SIGNIFICANT ISSUES

New Mexicans currently have the right to choose their Medicaid MCO, and member choice is the primary driver of MCO enrollment. Member choice promotes personal agency and drives individual engagement. SB336 would change the MCO assignment algorithm to prioritize rebalancing over the choices of Medicaid enrollees. This would conflict with federal regulations, which prioritize member choice for MCO assignment.

This bill risks upending the basic principle of member choice by requiring rebalancing of Medicaid membership without the specific input of Medicaid recipients. This bill also risks Medicaid member care continuity and compliance with federal funding requirements by requiring that members switch MCOs, possibly interrupting current services and provider relationships.

The Centers for Medicare & Medicaid Services (CMS) authorize Medicaid managed care through a federal 1115 demonstration waiver, which requires the following as supported by the federal Code of Federal Regulations (CFR):

Member Choice

Ensuring that at the time of initial enrollment and on an ongoing basis, **recipients have a choice** between a minimum of two (2) MCOs that meet all federal regulatory requirements, including readiness and network requirements to ensure sufficient access, quality of care, and care coordination for members as required by 42 CFR 438.66(d). Requirements must be approved by CMS before the state begins mandatorily enrolling recipients with MCOs.

Auto Assignment

Any member who does not make **an active selection** will be assigned, by default, to a participating MCO in accordance with 42 CFR 438.54(d)(5), which only permits the state to assign beneficiaries to qualified MCOs who have the capacity to enroll beneficiaries.

Mandatory Enrollment

Not mandatorily enroll individuals into any MCO that does not meet network adequacy requirements as defined in 42 CFR 438.206. Not require American Indian/Alaska Native (AI/AN) individuals to enroll with a MCO, unless they are dually eligible and/or meeting a Nursing Facility Level of Care (NF LOC). AI/AN individuals who are not required to enroll, may elect to enroll at their option.

Current Turquoise Member Choice and Auto Assignment Details

Member Choice

Turquoise Care beneficiaries select an MCO at the time of their enrollment or during other permitted selection periods such as open enrollment and recertification. New Mexico State regulations allow a member to change MCO selection outside of the annual recertification period for cause, such as but not limited to: 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. 8.308.7.9 H NMAC.

Auto Assignment

If the eligible recipient makes no selection, then the recipient currently is auto assigned to an MCO based on the following criteria:

1. If the recipient was previously enrolled with an MCO and lost eligibility for a period of 3 months or less, then they will be re-enrolled with that MCO.
2. If the recipient has a family member enrolled in a specific MCO, then they will be enrolled with that MCO.
3. If the recipient has family members who are enrolled with different MCOs, then 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.
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 an MCO.

Native Americans may opt into or out of managed care or choose Fee for Service as required. Native Americans who are dually eligible or in need of long-term care services are required to enroll in an MCO following the above enrollment criteria. SB366 does not consider these requirements.

Quality Driven Auto Assignment

Starting on January 1, 2026, auto assignments will be made to MCOs based on their quality performance through a quality-driven auto-assignment algorithm using an auto-assignment default logic that considers nationally recognized quality standards to reward MCOs that demonstrate superior performance on one or more key dimensions of performance.

Turquoise Care Managed Care Contracts

The current Turquoise Care MCOs bid on the Turquoise Care contract and executed a contract with the state with explicit knowledge that there would *not* be a redistribution of members, and that the member assignment would be a product of member choice and auto assignment.

The quality-driven auto-assignment algorithm set to commence on January 1, 2026, is in alignment with the Turquoise Care contract section 4.2.5.3.4 of the HCA Medicaid Managed Care agreement. Written notice of this intent was provided to the MCOs in 2024.

PERFORMANCE IMPLICATIONS

As directed in this bill, rebalancing member enrollment across MCOs removes the incentive to provide quality-driven services or fulfill the requirements of the managed care contract, diminishes the importance of member choice in the MCO selection process, and would ultimately result in thousands of New Mexicans being switched to an MCO that they did not select, which could directly impact their ability to continue seeing their chosen health care provider.

ADMINISTRATIVE IMPLICATIONS

The bill would require the HCA to initiate an amendment to the 1115 demonstration waiver in accordance with 42 CFR 431.400 to modify STC provisions in conflict with the proposed bill. The waiver process requires public input at the state and federal levels and tribal consultation. Waiver negotiations with CMS can take twelve (12) months or longer from amendment submission date for a determination to be rendered.

Amending the state's 1115 waiver would reopen the entire waiver for renegotiation with the federal government. It is possible that, given changes at the federal level, this could result in major changes to the waiver program and/or revocations of current approvals.

Extensive Medicaid member education across the state would be required to provide member education about the transfer of their health care to another MCO.

Revisions to 8.308.7.9 H NMAC would also be required.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
The proposed bill is in conflict with the waiver STCs and Code of Federal Regulations (CFR) referenced above.

TECHNICAL ISSUES
The are two technical issues in Section C of the bill: 1) AI/AN individuals should be included as an exclusion; and 2) the quotes at the end of the section should be removed.

OTHER SUBSTANTIVE ISSUES
SB336 requires balancing existing MCO enrollment with newly contracted MCOs. Current balancing methodology randomly assigns Medicaid recipients based on 30% of total managed care enrollment. Applying the 30% threshold percentage results in only the two newly contracted MCOs getting random assigned enrollment, with some minor exceptions. Member choice and family continuity take precedence over random assignment to ensure that recipients are enrolled into their MCO of choice and that households get assigned to the same MCO as others in the household for continuity.

During the month of Dec. 2024, newly enrolled members included:

1. Retroactive Newborns (enrolled to same MCO as mother): 999 individuals
2. Client Choice: 10,295 individuals
3. Reenrollment with Previous MCO: 1,134 individuals
4. Family Continuity: 1,428 individuals
5. Random Assignment: 818 individuals, of which 774 (95%) were assigned to the two newly contracted MCOs. Other assignment would have been due to other rules such as only assigning children in state custody to the single state plan, PHP.

The fact that 10,295 Medicaid recipients chose their MCO in a single month illustrates how member choice drives assignments. Implementing this bill could revise the enrollment methodology to remove client choice and result in mixed MCO enrollment within a single household and disrupting family continuity for family members enrolled into different MCOs.

SB 336 implementation would affect the risk-adjustment of MCO rates, requiring a review of the health status of clients upon balancing their enrollment in MCO plans. HCA's actuary assigns risk scores to each MCO reflecting their membership, and notes that the balancing methodology under consideration (unspecified in the bill) would impact how each MCO plan is compensated by other MCO plans depending on the health risks of their members. The bill would result in a redistribution of risk-scored populations across MCO plans and impact MCO reimbursements.

ALTERNATIVES
None suggested.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Status quo. Members will continue to be able to choose their preferred MCO.

AMENDMENTS
None