FISCAL IMPACT REPORT

SPONSOR Hickey **LAST UPDATED** **ORIGINAL DATE** 2/18/25

SHORT TITLE Medicaid Care Organization Recipients **BILL NUMBER** Senate Bill 336

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
HCA	No fiscal impact	$2,126.2	911.3	$3,037.5	Nonrecurring	Federal funds
HCA	No fiscal impact	$708.8	$303.7	$1,012.5	Nonrecurring	General Fund
Total	No fiscal impact	$2,835.0	$1,215.0	$4,050.0	Nonrecurring	

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)

SUMMARY

Synopsis of Senate Bill 336

Senate Bill 336 (SB336) requires the Health Care Authority (HCA) to ensure that a proportional number of Medicaid recipients are balanced among the managed care organizations (MCO) contracted with the state to provide medical assistance to Medicaid recipients, including managed care organization that are newly contracted with the state.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

HCA provides the following:

> Enactment of SB336 would require additional Medicaid system and Medicaid provider administrative costs.
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> Implementation of SB336 would require an eligibility system 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, 674.6 thousand 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.

SIGNIFICANT ISSUES

HCA provides the following:

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. The bill 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 and 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:

> ***Member Choice.*** Ensuring that at the time of initial enrollment and on an ongoing basis, **recipients have a choice** between a minimum of two 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.
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> ***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.

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.

ADMINISTRATIVE IMPLICATIONS

HCA notes:

The bill would require the HCA to initiate an amendment to the 1115 demonstration waiver in accordance with 42 Code of Federal Regulations 431.400 to modify special terms and conditions 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 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.

HCA further notes:

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

- Retroactive Newborns (enrolled to same MCO as mother): 999 individuals
- Client Choice: 10,295 individuals
- Reenrollment with Previous MCO: 1,134 individuals
- Family Continuity: 1,428 individuals
- 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.

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