

LFC Requester:

Eric Chenier

**AGENCY BILL ANALYSIS - 2025 REGULAR SESSION****WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO****[AgencyAnalysis.nmlegis.gov](https://www.nmlegis.gov/AgencyAnalysis) and email to [billanalysis@dfa.nm.gov](mailto:billanalysis@dfa.nm.gov)*****(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:** 3/18/25*Check all that apply:***Bill Number:** HB589HCS 231776.2Original ☐ Correction ☐Amendment ☐ Substitute ☒**Agency Name****and Code**

HCA 630

**Number:****Sponsor:** Rep. Hochman-Vigil**Short** MCOs Proportional Medicaid**Person Writing** Jennifer Jones**Title:** Recipients**Phone:** (505) 709-**Email** Jenniferr.jones@hca.n**SECTION II: FISCAL IMPACT****APPROPRIATION (dollars in thousands)**

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	FY26		
\$0.0	\$0.0	\$0.0	\$0.0

(Parenthesis ( ) indicate expenditure decreases)

**REVENUE (dollars in thousands)**

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	FY26	FY27		
\$0.0	\$0.0	\$0.0	-	-

(Parenthesis ( ) indicate revenue decreases)

**ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)**

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected

<b>IT System changes: Fed. Funds</b>	\$0.0	\$2,126.2	\$911.3	\$3,037.5	Nonrecurring	Federal Funds
<b>IT System changes: State Funds</b>	\$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: Duplicates SB 336  
 Duplicates/Relates to Appropriation in the General Appropriation Act

### **SECTION III: NARRATIVE**

#### **BILL SUMMARY**

##### Synopsis:

HHHC Substitute for HB 589 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 HHHC Substitute for HB 589 would require additional Medicaid system and Medicaid provider administrative costs.

Implementation of HHHC Substitute for HB 589 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 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 HHHC Substitute for HB 589 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**

The requirement of HHHC Substitute for HB 589 that a proportional number of Medicaid recipients are balanced among the managed care organizations contracted with the state to provide medical assistance to Medicaid recipients provides a mandate to HCA that is vague and open to interpretation potentially resulting in mandatory member reassignments creating risk for Turquoise members. The addition of language instructing the HCA to preserve member choice does not eliminate a potential need to reassign currently assigned individuals for reasons outside of member choice to comply with the stated mandate. This could have large impacts to continuity of care and result in the need for widespread reenrollments to ensure current member choice.

Enactment of HHHC Substitute for HB 589 will have negative impacts on Turquoise Care because it will remove an important driver of quality care by requiring the HCA to not implement Quality Driven Auto Assignment planned for January 1, 2026. Quality Driven Auto Assignment will consider how the four MCOs have scored in improving health outcomes specifically identified as poor performing or lagging among NM Medicaid beneficiaries. Measures are based on national quality standards. The auto assignment rewards MCOs for improving health outcomes for New Mexicans.

Enactment of HHHC Substitute for HB 589 is duplicative because the current auto assignment standard generates an equal share of members between all MCOs who are below the maximum upper limit for auto assignment of 30% of the total New Mexico Managed Care Membership applicable to auto-assignment enrollment.

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.

### **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.

### **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. This may include, but is 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 recently 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. HHHC Substitute for HB 589 does not consider these requirements.

### **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 Special Terms and Conditions (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 state's 1115 waiver STCs and Code of Federal Regulations (CFR) referenced above.

### **TECHNICAL ISSUES**

There is one technical issue in Section C of the bill: 1) AI/AN individuals should be included as an exclusion.

### **OTHER SUBSTANTIVE ISSUES**

HHHC Substitute for HB 589 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.

HHHC Substitute for HB 589 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 on 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**