Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: January 15, 2018

Behavioral Health Services for Medicaid Expansion Adults

AT A GLANCE

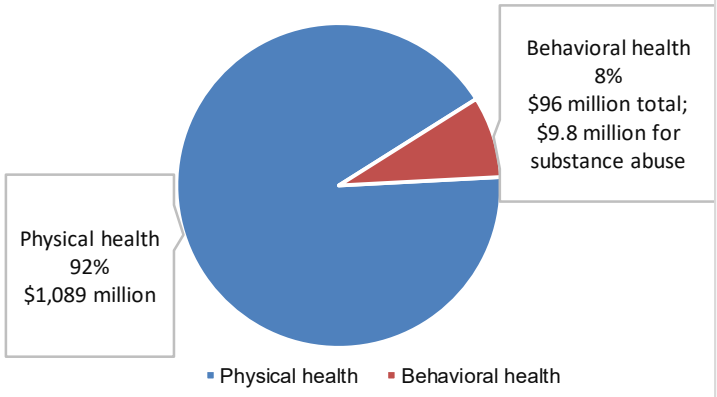
In 2014, New Mexico implemented the Affordable Care Act's option to expand Medicaid coverage to all individuals with incomes less than 138 percent of the federal poverty level (FPL). Medicaid expansion has provided access to behavioral health services for over 254,000 New Mexicans, about a third of whom have made use of those services on a yearly basis since 2014. By comparison, about 18 percent of the base Medicaid population uses behavioral health services. However, despite relatively high rates of utilization and substantial expenditures, the outcomes for the program are unclear and appear mixed at best.

This Health Note first discusses key characteristics of the expansion population, and looks at the improvements expansion has brought for two particularly vulnerable groups of New Mexicans, homeless individuals and individuals involved with the justice system.

The brief then offers analysis of which behavioral health services, at what cost, were most used by the cohort between 2014 and 2016. The brief finds that overall spending on behavioral health services for the expansion population has risen faster than the number of people using those services. One key driver: a 167 percent increase in spending for services that treat substance abuse disorder. Evidence-based treatment protocols appear to be used relatively frequently for substance abuse disorders, but less so for mental health therapy.

The brief considers access to care issues, which show some positive signs but also some persistent gaps in the provider networks of the Centennial Care managed care organizations.

Chart 1: MCO Spending on Medicaid Expansion, CY16



Source: MCO financial reports

Lastly, the brief reviews available behavioral health outcome measures for Medicaid recipients as well as the program itself. Behavioral health outcomes are notoriously difficult to quantify. The Medicaid behavioral health program lacks sufficient meaningful outcome measures to reflect spending and utilization levels, and there are mixed outcomes on the measures that are available. The number of reported behavioral health critical incidents increased significantly between 2014 and 2016. On the other hand, the state's rate of drug overdose deaths declined slightly between 2014 and 2015, and then stayed flat between 2015 and 2016, a positive trend that may be partly the result of increased access to substance abuse treatment for the Medicaid expansion population.

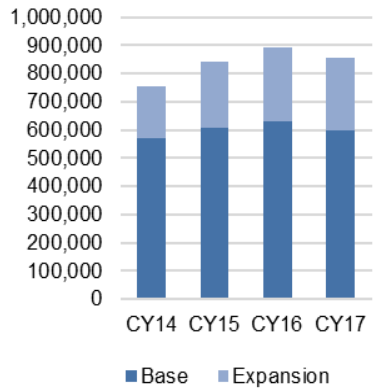
Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

New Mexico Legislative Finance Committee

Background

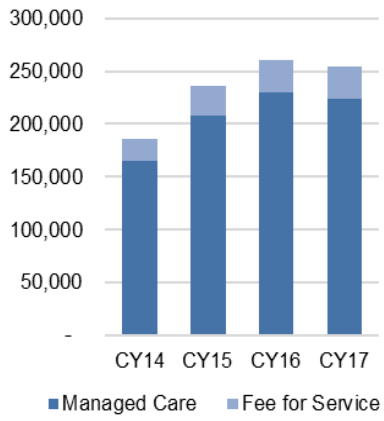
By December 2017, the expansion population included 254,000 people and made up 30 percent of the total Medicaid population.

Chart 2: Medicaid Enrollment Growth



*Source: HSD December monthly enrollment reports

Chart 3: Medicaid Expansion Population



Source: HSD December monthly enrollment

Since 2014, Medicaid expansion has provided health coverage to thousands of New Mexicans who were previously uninsured and lacked regular access to health care. In 2014 New Mexico implemented the Affordable Care Act's option to expand Medicaid coverage to all individuals with incomes less than 138 percent of the federal poverty level (FPL). Prior to expansion Medicaid eligibility was essentially limited to a handful of low income groups: children and their mothers, pregnant women, the elderly and the disabled. Expansion offered insurance coverage for the first time to anyone 19 to 64 years old who met the income criteria, and allowed low income childless adults access to the program.

One of the great promises of expansion was that provision of healthcare services for this new population would lead to improved health outcomes and begin to 'bend the curve' on a number of the state's challenging health indicators, including those related to behavioral health. Behavioral health includes mental health conditions such as depression, post-traumatic stress disorder, or bi-polar disorder, substance abuse disorders, and combinations of the two. Behavioral health conditions are key cost drivers for Medicaid and can contribute significantly to high rates of poverty, homelessness, and suicide. According to the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD), individuals with chronic physical health conditions as well as mental health conditions have health care costs on average 60 to 75 percent higher than those with no comorbid mental health issues.

Expansion population enrollment and demographics.

By December 2017, the expansion population included 254 thousand people and made up 30 percent of the total Medicaid population. Like the Medicaid program as a whole, the expansion cohort is diverse in terms of health risk. The Medicaid base includes many generally healthy children and adults as well as other recipients who are disabled or face chronic illnesses; the expansion population includes many generally healthy young adults as well as people with higher-than-average health care needs and previously untreated chronic conditions.

The Medicaid expansion population has, as expected, grown at a faster rate than the base population. Enrollment in the expansion population (managed care and fee for service) grew by nearly 36 percent from the end of 2014 through December 2017, from about 186 thousand individuals to 254 thousand. During the same period, the Medicaid population as a whole grew by 13 percent. The largest year-over-year increase was between 2014 and 2015, as the bulk of newly-eligible individuals enrolled in the program, followed by smaller increases in 2016 and 2017.

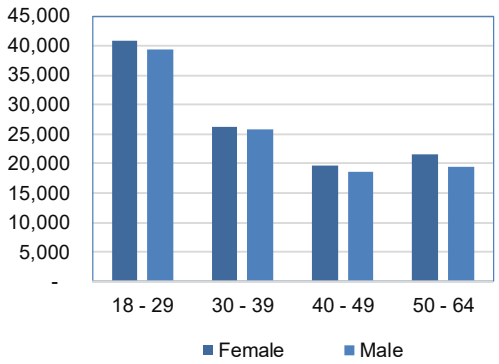
The majority of the expansion population is in managed care, but between 11 and 12 percent has remained in fee for service (FFS) Medicaid. This group is primarily Native Americans, who are not required to enroll with an MCO unless they are seeking long term services or are dually eligible for Medicare and Medicaid. Native American recipients have grown from about 13 percent of the total expansion population at the end of 2014, or about 25 thousand people, to nearly 15 percent as of December 2017, or over 37 thousand people. The FFS cohort makes use of essentially the same behavioral health network as other Medicaid recipients. However, the focus of this report is Centennial Care managed care behavioral health.

Therefore, the FFS expansion population is included in the total population count but not in any of the following discussions of utilization and spending; as LFC staff is able to more thoroughly analyze the claims data set, the FFS cohort may be addressed in a follow-up Health Note.

The expansion population is slightly more than half female, and while about 58 percent are between 18 and 39 years old, 42 percent are over 40 years old and 25 percent are over 50 years old.

Most of the expansion population is under 39 years old, but 42 percent are older and there are slightly more women than men in the group. While about 58 percent of the expansion population is between 18 and 39 years old, 42 percent are over 40 years old and 25 percent are over 50 years old (Chart 4). All members of the expansion population are able to access the same benefit package and the behavioral health MCO rate is the same for all ages and both sexes.

Chart 4: Managed Care Expansion Population by Age and Sex, CY16



Source: HSD

The state's homeless population is a small, but critical portion of the expansion population. Homeless individuals were especially unlikely to have any form of health insurance prior to Medicaid expansion and have historically relied most heavily on emergency rooms for health care of all types. Medicaid expansion offered the first stable payor source for healthcare to the homeless, although with no fixed residence, homeless people still face significant challenges getting and staying enrolled in Medicaid and obtaining services consistently.

There is no consensus on the precise prevalence of mental disorders among the homeless, although the Substance Abuse and Mental Health Services Administration (SAMHSA) estimate most commonly cited is between 20 to 25 percent of homeless individuals have some form of severe mental illness, which is between three and four times the national average. SAMHSA also identified substance abuse – primarily alcohol but also cocaine or opioids and frequently more than one substance – as one of the most critical mental health issues faced by the homeless population, again at rates much higher than the general population. There is no clear causal relationship between mental illness, substance abuse, and homelessness: some mental health and substance abuse disorders may contribute to homelessness, and some may be acquired as a result of being homeless.

Medicaid expansion offered the first stable source for healthcare to the homeless, who were especially unlikely to have any form of health insurance prior to expansion.

No comparable statewide data is available, but a 2007 random survey of homeless people in Albuquerque, conducted by the New Mexico Coalition to End Homelessness, found over 28 percent reported a mental disability or problems with alcohol and/or substance abuse. Over 18 percent of respondents said access to substance abuse treatment or detox would have been helpful in preventing their homelessness, while another 11 percent said access to mental health counseling, psychiatric medications, or psychiatric services would have helped.

Medicaid expansion has provided a way to connect many former jail and prison inmates (the justice-involved population) to health insurance coverage for the first time. In comparison to the general population, justice-involved individuals have high rates of both mental health and substance abuse disorders. According to the U.S. Department of Justice, nationally, 64 percent of those in jail experience mental illness and 53 percent suffer from substance dependence or abuse. In New Mexico 89 percent of offenders detained pretrial in a jail were diagnosed with a serious mental illness. A 2016 Pew Foundation report found that Medicaid coverage connects recently released individuals from incarceration to the care they need once they are in the community, which can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism for

justice-involved individuals.

Health care for incarcerated individuals is provided by the correctional facilities, but many inmates are financially eligible for Medicaid when they are released. Historically, this population has had to wait until after release to apply for Medicaid coverage, a process that can be lengthy and result in a break in continuity of care that may be particularly critical for individuals with chronic physical and behavioral health conditions, including substance abuse. HSD's Justice Involved Utilization of State-Transitioned Healthcare (JUST Health) program allows inmates who are enrolled in Medicaid to have their cases suspended, rather than closed, while they are in prison or jail. Cases can then be reactivated when the individual is released, without the individual having to wait through the application process before being able to access services.

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New Mexico is one of only 16 states that suspend (rather than terminate) Medicaid coverage for the full duration of time an individual is incarcerated.

New Mexico is one of only 16 states that suspend (rather than terminate) Medicaid coverage for the full duration of time an individual is incarcerated, and has been recognized nationally for its work in this area. According to HSD, as of September 2017 there have been 14,300 Medicaid eligibility suspensions, 7,600 reinstatements of Medicaid eligibility, and 3,000 Medicaid applications submitted with 2,500 of them being approved.

HSD's Justice Involved Utilization of State-Transitioned Healthcare (JUST Health) program allows inmates who are enrolled in Medicaid to have their cases suspended, rather than closed, while they are in prison or jail. Cases can then be reactivated when the individual is released.

Medicaid behavioral health data.

LFC staff made numerous information requests of HSD while preparing this report, at a time when HSD staff was burdened by many other responsibilities related to the renewal of the Centennial Care waiver and MCO contracts. HSD was able to provide relatively timely responses to most requests, and the department's assistance is appreciated.

One very large, and very important, request was for encounter data for Medicaid managed care and claims data for fee for service Medicaid for calendar years 2014 through 2016, using proper privacy protections and excluding personally identifiable information. The encounter and claims data set provides a wealth of information specific to expansion behavioral health, including how many expansion recipients use behavioral health services overall, which specific services they receive, from what type of provider, in what quantity and at what cost.

The encounter and claims data set provides a wealth of information. However, initial LFC staff analysis of the encounter data set found disparities between MCO spending as documented by encounters, and MCO spending as documented by MCO financial reports.

HSD receives and uses multiple sources of data from the MCOs about utilization and spending on services provided to the expansion population, and none of them are exactly the same. Timing differences and use of MCO and HSD estimates of additional costs for incurred claims not yet received explain some of the differences. For total MCO spending on behavioral health services to the expansion population, the financial reports and the encounter data, as analyzed by LFC staff, were $11 million dollars apart for CY16; the HSD actuary's analysis found an $8.3 million dollar difference. (See Appendix C for further information and a detailed chart of the differences.)

To provide as much information as possible, the utilization and expenditures section of this brief provides top line totals of MCO expenditures, from the MCO financial reports, on various categories of services. Each section notes gaps in cost data identified by LFC staff. Then the brief provides some of the utilization details from the encounter data set, which has more information than can be found anywhere else about behavioral health use among the expansion population.

LFC staff did not receive this data set until very late in the project, and intend to continue analyzing it and issue follow-up reports to this Health Note on potential topics of interest such as super-utilizers, FQHCs, and prescription drug use.

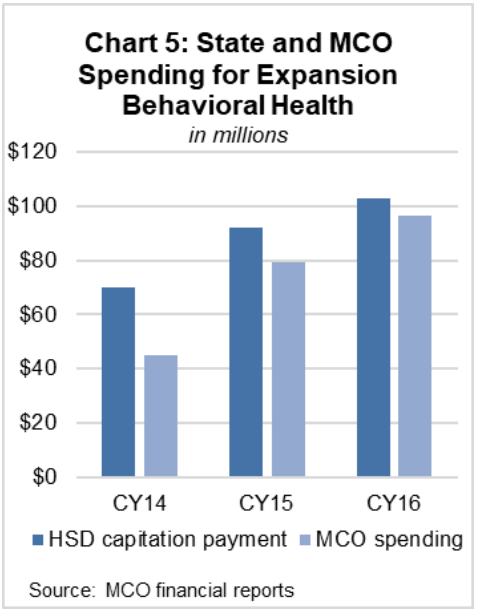
HSD has committed to a $175 million replacement for its current Omnicaid claims system that will, among other things, hopefully do away with underreporting by MCOs. Known as the Medicaid Management Information System Replacement, or MMIS-R, the new system is 90 percent federally-funded and therefore involves about $17.5 million of state funds. In the replacement system as currently envisioned, all claims, for both managed care and fee for service, will flow into HSD's system first, and then managed care claims will be pushed out to the MCOs for further processing. The department has spent $20 million so far for project planning.

HSD is in the planning phase of a $175 million replacement for its current Omnicaid claims system that will hopefully do away with the problem of underreporting by MCOs.

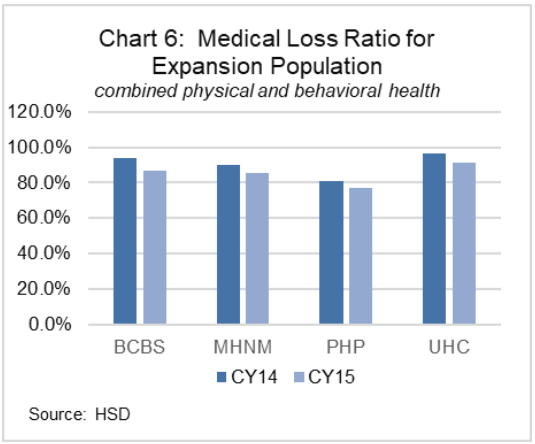
Centennial Care behavioral health costs and utilization

Medicaid spending on Centennial Care behavioral health.

The state's spending for managed care behavioral health services is tied to enrollment, in the form of capitated payments made to MCOs for their enrolled members. As Medicaid enrollment grew with expansion, capitated payments to the MCOs for behavioral health for the expansion population increased 47 percent between CY14 and CY16, from approximately $69.9 million to just under $103 million. During the same period, the total net amount the MCOs spent on expansion behavioral care health care – an amount that includes individual behavioral health services as well as related care coordination, member rewards and other costs – increased from $45 million to $96.2 million, or 114 percent. As Chart 5 shows, during the first year of Centennial Care the department significantly overpaid for expansion group behavioral health, but during the intervening years capitation payments have fallen more in line with MCO spending.



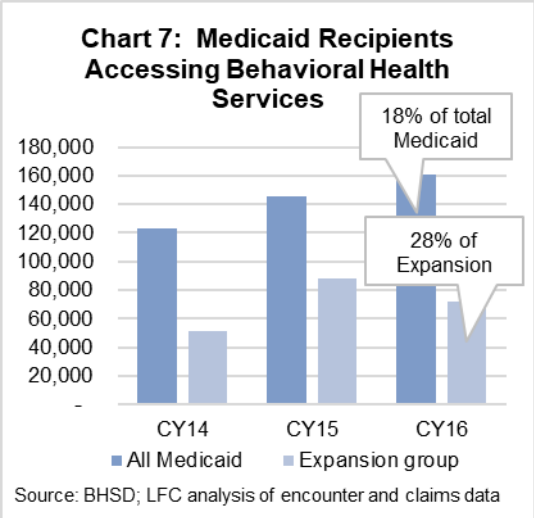
The first Centennial Care contracts required the MCOs to spend no less than 85 percent of the capitated payments they receive from HSD on healthcare services, and no more than 15 percent on administrative costs; this 85:15 ratio is referred to as the medical loss ratio (MLR). Contract amendments in mid-2016 shifted the MLR to 86:14. HSD calculates an aggregate MLR for expansion physical health and behavioral health; for 2014, the combined MLR for all MCOs was 90.8 percent, and in 2015 it was 84.9 percent. HSD has not yet finalized MLR calculations for 2016. Presbyterian Health Plan was the only MCO to miss the contractually-required MLR for both years. (Chart 6.)



There is no readily available detailed information on state spending on fee for service (FFS) behavioral health. HSD's Medicaid projections are the only source of information specific to this group, and the projections provide only total spending. Although FFS made up less than 9 percent of total behavioral health spending in FY17, spending for that small group increased by 79 percent between FY14 and FY17, from about $24 million in FY14 to $42 million in FY17.

Behavioral health service utilization for the managed care expansion population

Behavioral health services are used by a higher proportion of the expansion cohort than of the base population.



Not all Medicaid recipients will require behavioral health services, and among recipients who do seek services, there is a wide variation of the type and degree of care that might be needed. BHSD reports the total number of Medicaid recipients using behavioral health services has increased by over 31 percent since expansion, from about 123,000 in CY14 to over 161,000 in CY16, or 18 percent of all Medicaid recipients. According to the encounters and claims data set, the number of expansion cohort members using behavioral services increased by 40 percent between CY14 and CY16, from about 51,000 people in CY14 to over 71,000 in CY16, or about 28 percent of the expansion population. That trend includes an unexplained 19 percent decrease in utilization between CY15 and CY16, during which time the expansion population increased by 10 percent.

The most prevalent behavioral health diagnoses for the expansion cohort from CY14 through CY16 are depression and anxiety, which together accounted for 27.7 percent of primary and secondary diagnoses in CY16. The other leading set of diagnoses were for substance abuse or dependence involving opioids, alcohol, marijuana and other stimulants, at 15 percent (combined primary and secondary diagnoses). This is more than one and a half times higher than SAMHSA's estimate that 9 percent of New Mexican adults had a substance use disorder in 2015/2016, which makes providing accessible substance abuse services to the expansion population particularly critical.

In 2016, 15 percent of the expansion population who used behavioral health services had a diagnosis of substance abuse or dependence, which makes providing accessible substance abuse services to the expansion population particularly critical.

Behavioral health services are commonly divided into six primary categories:

- Outpatient services is the broadest category and includes psychiatric diagnostic and substance abuse evaluations, the full array of individual, family and group therapies, medication management, specialized behavioral health services like Assertive Community Treatment (ACT), and substance abuse services like methadone and suboxone administration;
- Inpatient services include hospital and facility charges as well as professional services provided while an individual is in a facility;
- Intensive outpatient services include intensive outpatient program services, as well as partial hospitalization and outpatient psychiatric services provided by hospitals for recipients under 21 years old;
- Residential services are provided only to Medicaid recipients who are under 21 years old; since eligibility for expansion begins at age 18, a small amount of these services are included in the expansion data;
- Recovery services include comprehensive community support and psychosocial rehabilitation services, and provide supports for Medicaid recipients who are diagnosed with serious mental illness (adults) or serious emotional disturbance (under 21 years);
- Prescription drugs are not technically a service, but are included in this analy-

sis as a major category of utilization and spending.

Outpatient services

MCO financial reports show rapidly increasing spending on outpatient services, rising 150 percent between CY14 and CY16, from $19.2 million to $48 million.

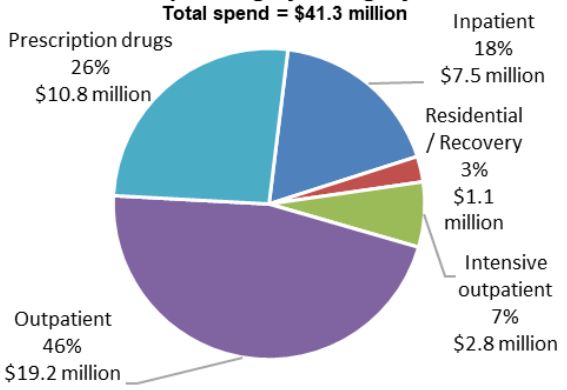
Review of Medicaid encounter data shows a similar trend, with spending increasing by 151 percent between CY14 and CY16, from $17.9 million to $45 million.

Encounter data includes over a dozen different Medicaid procedure codes relating to different therapy types, including diagnostic evaluations and testing, individual and family therapy sessions for different amounts of time, pharmacologic management, telemedicine, and other services. Combined, these services accounted for 45 percent of all spending in 2014, or $17.9 million, rising to 53 percent of spending by 2016, or $45 million. Notably, the number of claims have increased at a faster rate than expenditures: between 2014 and 2016 spending rose by 151 percent while claims rose by 155 percent. This trend indicates the MCOs are generally keeping a hand on rising prices, although as Chart 11 shows the space between claims and spending narrowed between 2015 and 2016.

There is little indication that members of the expansion population are receiving evidence-based therapies. While there is clearly increasing use of important behavioral health services, Medicaid encounter data does not include detailed information about types of therapy, just general categories like psychotherapy – patient, psychotherapy – family, group psychotherapy, etc. To determine whether evidence-based treatments like cognitive behavioral therapy, for example, are being used would require a medical records review or other additional information gathering process. The only specific therapeutic modality listed by name in this category is assertive community therapy (ACT), a treatment and case management approach that is relatively costly up-front but has the potential to be much less expensive than long-term hospitalization or prison. The LFC's 2014 report on evidence-based programs for adult mental health identified ACT as one of several programs that appeared to be potentially good investments for the state. However, ACT spending for the expansion population declined by 28 percent between CY14 and CY16, while the number of claims for services dropped by 32 percent.

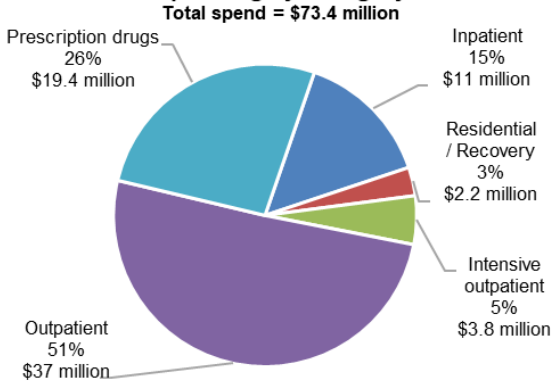
Spending on treatment for substance abuse disorder has increased rapidly since 2014. Substance abuse treatment is spread between the outpatient services category and the intensive outpatient services category, and for the purposes of this brief combines substance abuse and drug screening, methadone and suboxone administration, and intensive outpatient program (IOP) services. This group of services made up 10 percent of total expansion group behavioral health spending in 2014, or $4.2 million, rising steeply to $11.2 million, or 13 percent of the total by 2016. These figures do not represent all services provided to individuals with substance abuse disorders, since many are likely to

Chart 8: 2014 Behavioral Health Spending by Category
Total spend = $41.3 million



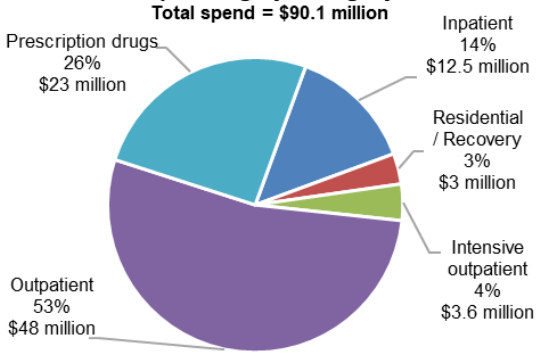
Source: MCO financial reports

Chart 9: 2015 Behavioral Health Spending by Category
Total spend = $73.4 million



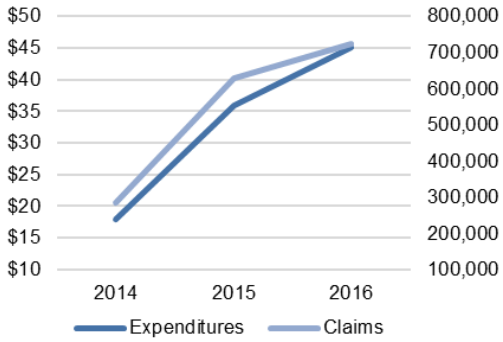
Source: MCO financial reports

Chart 10: 2016 Behavioral Health Spending by Category
Total spend = $90.1 million



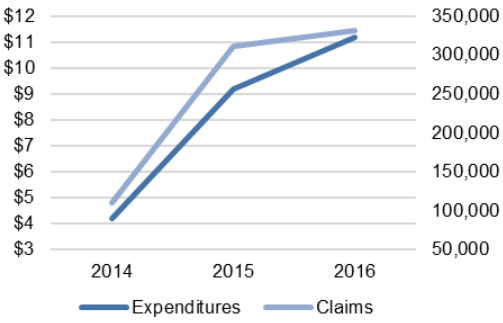
Source: MCO financial reports

Chart 11: Outpatient Services Claims and Expenditures



Source: LFC analysis of encounter data

Chart 12: Substance Abuse Disorder Claims and Expenditures



Source: LFC analysis of encounter data

use some of the other types of therapy as well. As with the larger category of outpatient services, expenditures here have increased more slowly than claims: between 2014 and 2016 spending rose by 167 percent while claims rose by 201 percent. (Chart 12.)

New Mexico has made progress expanding access to some types of evidence-based treatments for substance abuse disorders. In addition to recommending more investment in ACT, the 2014 LFC report recommended the state invest more in intensive outpatient program services (IOP), a time-limited, multi-faceted approach to discharge and transition services planning, therapy and education for individuals with substance abuse or co-occurring disorders. In FY13, the state spent $2.4 to provide IOP to 1,493 clients; by CY16, spending on IOP had increased by 46 percent to $3.5 million to provide services to 1,431 clients. The same trend, much more pronounced, can be seen among the expansion population, where spending on IOP increased by 136 percent between CY14 and CY16 and claims increased by 123 percent.

Lastly, medication assisted treatment (MAT) is an evidence-based approach to treatment for individuals with substance abuse disorders that uses counseling in combination with medications such as methadone, buprenorphine, or suboxone. In 2013, HSD removed the prior authorization requirement for buprenorphine to improve access, and between CY14 and CY16, state spending on MAT increased by 94 percent, from $7.4 million to $13.4 million. The increase for the expansion group was again higher, climbing from $3.2 million in CY14 to $7.9 million in CY16, or 150 percent; claims increased by 208 percent during the same time.

Prescription drugs

For prescription drugs, the MCO financial reports show notably less spending than does the encounter data, but with a greater rate of increase. The MCOs report spending $10.8 million in CY14, $19.4 million in CY15, and $23.1 million in CY16, for an overall increase of 115 percent.

Prescription drug spending has been the second largest category of expenditures for expansion behavioral health since 2014.

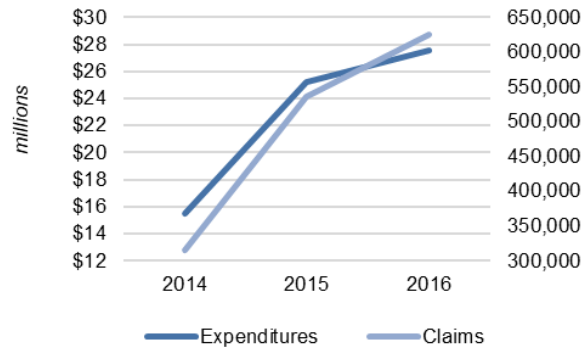
Review of Medicaid encounter data shows higher expenditures but less of a year-over-year increase: $15.5 million in CY14, $25.2 million in CY15, and $27.6 million in CY16, for an overall increase of 78 percent.

According to encounter data, prescription drug spending has been the second largest category of expenditures for expansion behavioral health since 2014. In 2014, prescription drug spending made up 39 percent of total expansion group behavioral health spending, approximately $15.5 million. Spending on prescriptions has continued to rise each year, increasing to $25.2 million in 2015 and $27.6 million in 2016. Despite the large increases in the cost of prescription drugs experienced by the Medicaid program as a whole, for this group expenditures have also increased at a slower rate than claims: between 2014 and 2016 spending rose by 78 percent while claims rose by 98 percent. (Chart 13.)

The relative proportions of therapies to drugs is very likely a positive sign; prescription medications can be an effective part of behavioral health treatment.

However, while the drugs themselves are generally equally effective at addressing symptoms, different people can respond to them very differently, particularly if they have multiple conditions or are younger or older, making medical management and monitoring important. Further, according to the National Alliance on Mental Illness, widely accepted clinical research shows that combining medication with some form of psychotherapy generally leads to better outcomes than only medication or only psychotherapy.

Chart 13: Prescription Drug Claims and Expenditures



Source: LFC analysis of encounter data

The impact of the expansion population on behavioral health prescription drug utilization can be seen in more than just the expenditures discussed above. There have also been major shifts in the types of drugs being prescribed. Prior to Medicaid expansion, children were the largest group of Medicaid recipients, and prescription drug trends reflected their needs. However, as more and more expansion adults have enrolled, prescription drugs have shifted towards the drugs most used by this new population.

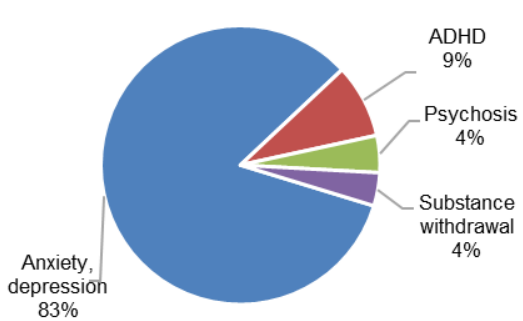
LFC staff reviewed data for the top 25 behavioral health medications for the combined base and expansion populations. For every year of Centennial Care, from 2014 through 2017, the 25 behavioral health prescription drugs used most by Medicaid recipients have been medications used to treat attention deficit hyperactivity disorder (ADHD), anxiety, depression, psychosis (psychosis, schizophrenia and bi-polar disorder), and substance abuse. Many, if not most, medications used for behavioral health conditions can be prescribed for more than one diagnosis. Prescription drug data provided by HSD to the LFC did not include prescription details to the level of diagnosis, so the categories used for this discussion are approximate and medications are grouped by the indication they are most commonly associated with.

Clinical research shows that combining medication with some form of psychotherapy generally leads to better outcomes than only medication or only psychotherapy.

In 2013, the year before Medicaid expansion, the most used 25 behavioral health drugs were dominated by medications used to treat anxiety and depression, with about 118,000 prescriptions, attention deficit hyperactivity disorder (ADHD), with about 64,000 prescriptions, and schizophrenia and bi-polar disorder, with about 59,000 prescriptions; there were only about 1,500 prescriptions for substance abuse.

By the end of FY14, the impact of Medicaid expansion and the addition of the first 186,000 or so adults to the program could already be seen clearly; between FY13 and FY14 the number of prescriptions for depression medications increased by 178 percent, while prescriptions for ADHD increased by only 2 percent, and prescriptions for substance abuse medications leapt by 733 percent, to over 12,500 prescriptions for 2,600 patients. That trend has continued, with large annual increases in spending and utilization for prescription drugs for depression and anxiety, and for substance abuse.

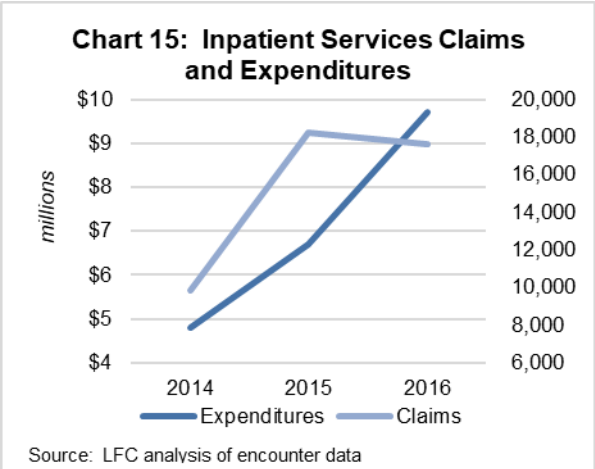
Chart 14: Behavioral Health Prescription Drugs
number of scripts by primary indication, 2016



Source: LFC analysis of HSD data

Inpatient hospital services

The MCO financial reports show markedly more spending on inpatient hospital services for the expansion population than does the encounter data, and a greater rate of increase. The MCOs report spending $7.6 million in CY14, $11 million in CY15, and $12.5 million in



Source: LFC analysis of encounter data

CY16, for an overall increase of 66 percent.

Review of Medicaid encounter data shows lower expenditures with higher year-over-year increases: $4.8 million in CY14, $6.7 million in CY15, and $9.7 million in CY16, for an overall increase of 102 percent. As Chart 15 shows, expenditures continued to rise from CY15 to CY16, even as the total number of claims dropped.

This category has both facility charges from hospitals and professional charges from the providers, and the encounter data show different trends for the two. Between CY14 and CY16, the number of hospital claims increased by 79 percent, but expenditures increased by 109 percent. On the other hand, claims for professional services increased by 86 percent, while expenditures increased by only 66 percent.

Access to care

There are positive signs that members of the expansion population have good access to some elements of the behavioral health provider network; however, the Centennial Care MCO behavioral health networks continue to have notable gaps.

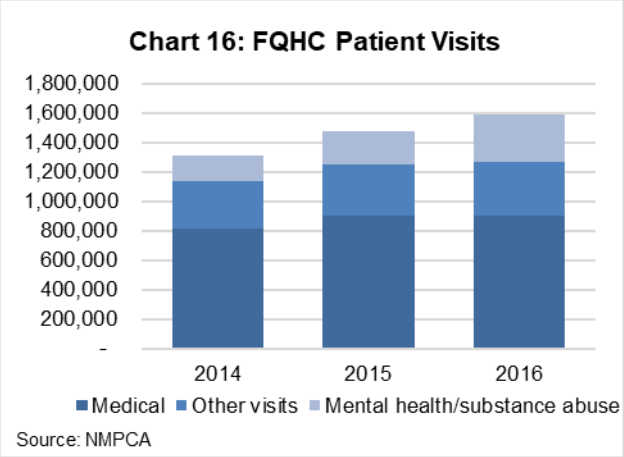
Having coverage is, of course, not the same as being able to get services when or where a recipient needs them. New Mexico has a well-documented shortage of behavioral health care providers and there is no way to separate access issues faced by expansion members from those faced by any Medicaid recipient seeking behavioral health. The 2017 report from the New Mexico Healthcare Workforce Committee is an excellent resource for examining the behavioral health provider shortage in detail; this discussion focuses only on areas of particular significance for the Medicaid expansion population.

The 200 percent growth in behavioral health visits to federally qualified health centers (FQHCs) is a positive sign of access to care.

The growth in behavioral health services provided by federally qualified health centers (FQHCs) is a positive sign of access to care. FQHCs have seen their behavioral health visits grow by over 200 percent since 2014. Historically at the core of New Mexico's primary care safety net, FQHCs provide a wide array of services, including medical, dental, and vision, as well as mental health and substance abuse treatment. Many FQHCs are dually licensed as diagnostic treatment centers and/or community mental health centers, and provide behavioral health services including individual, family and group counseling, crisis intervention, medication management, and psychosocial rehabilitative services. Specialized behavioral health services are provided by FQHCs that have met the additional requirements set by HSD, and include assertive community treatment, comprehensive community support services, intensive outpatient programs, and psychosocial rehabilitation services. This set of services is designed for high intensity interventions for patients with higher levels of need, and are focused on avoiding emergency room visits and hospital admissions.

Since 2014, Medicaid spending on all behavioral health services provided by FQHCs has increased by 142 percent; while still less than spending on the base Medicaid population, spending on services provided by FQHCs to the expansion population has increased by 148 percent. According to the New Mexico Primary

Care Association (NMPCA), mental health and substance abuse visits made up about 13 percent of all visits to FQHCs in 2014; by 2016, that proportion rose to about 21 percent.



The dramatic increase in behavioral health visits since 2014 is a strong indicator that the overall increase in FQHC behavioral health visits is due to a combination of Medicaid expansion and the 2015 departure from the state by the Arizona providers. Behavioral health visits increased by 62 percent from 2014 to 2015, and then by another 110 percent from 2015 to 2016. Particularly striking is the change in the number of clients seen for mental health and substance abuse treatment. Mental health clients increased by 66 percent between 2014 and 2016, while substance abuse clients increased by 584 percent. During this same time period, FQHCs increased their mental health providers, including psychiatrists, psychologists, licensed counselors, clinical social workers, and other mental health clinicians, by over 300 percent. Four FQHCs took on the majority of clients from the departing Arizona companies: Hidalgo Medical Services in Grant and Hidalgo counties, La Casa Family Health in Chaves, Curry, Lincoln and Roosevelt counties, La Clinica De Familia in Dona Ana county, and Presbyterian Medical Services, which operates in 16 counties. These four, among others, provided continuing employment for individual providers displaced by the behavioral health shake-up, as well as some degree of continuity of care for their clients.

Unfortunately, this brief does not provide detailed information about which behavioral services the expansion population receives through FQHCs. The MCO financial reports combine all FQHC services into a single expenditure line because FQHCs are paid a flat per patient per visit rate regardless of what service(s) are provided. LFC staff anticipated using the encounters and claims data set to unpack FQHC utilization, but were unable to do so due to time constraints; FQHCs may be addressed in a future Health Note.

Since 2014, Medicaid spending on all behavioral health services provided by FQHCs has increased by 142 percent; spending on services provided by FQHCs to the expansion population has increased by148 percent.

Albuquerque Health Care for the Homeless (AHCH) is one example of the success of Medicaid expansion at reaching the homeless. AHCH provides an array of direct services, including case management, and primary medical, dental and behavioral health services. In 2013, before expansion, about 10 percent of individuals served by AHCH were eligible for Medicaid; by 2016, that number flipped around and now only about 10 percent of AHCH clients are *not* enrolled in Medicaid. In 2013, the organization billed Medicaid for approximately $250,000 in claims; by 2017, that amount increased to approximately $2 million. Use of behavioral health services at AHCH is similar to the pattern seen with FQHCs: steadily increasing numbers of behavioral health clients, with the largest increase in both number of clients and service encounters occurring between 2015 and 2016, as the state's behavioral health network was disrupted by the departure of the Arizona providers and patients looked elsewhere for assistance.

There is no statewide entity collecting outcome measures regarding the impact Medicaid coverage may be having for the state's homeless population. As established in previous LFC reports, uncompensated care has dropped for all New Mexico hospitals as more patients are covered by Medicaid. AHCH reports its clients have seen dramatically reduced wait times for services: for most, the only

available option used to be UNM Hospital, where they faced wait times of up to six months. Now there are many more provider options and as a result wait times are generally less. ACHC notes that despite these improvements in access to care, homeless people still face a variety of potential barriers – from lack of transportation and reliable phones to the challenges posed by dealing with and recovering from illness without a clean and safe residence. As a result of these complexities, meaningful changes to health status are difficult to anticipate and it may take time before there are measurable improvements.

Albuquerque Health Care for the Homeless reports its clients have seen dramatically reduced wait times for services. There are now many more provider options and as a result wait times are generally less.

The Human Services Department is working to improve access to services for the justice-involved population as well. Molina Healthcare has been running a pilot care coordination project at the Metropolitan Detention Center (MDC) in Bernalillo County since June, 2016, working with incarcerated Molina members who are close to their release dates and voluntarily agree to be part of the project. The goal is to engage members in care coordination prior to release so they will have more timely access to health services once they have been released. Molina care coordinators work with MDC staff and directly with inmates at the facility to complete health risk assessments (HRAs) and comprehensive needs assessments (CNAs), and also educate inmates about the services available to them and assist with coordination of those services. Of the 317 inmates identified to date as Molina members, 296 initially agreed to care coordination when approached by MDC staff; 34 refused when subsequently approached by Molina, leaving 262 active participants. Early outcomes are discussed in the outcomes section of this report.

Molina Healthcare has a pilot care coordination project at the Metropolitan Detention Center (MDC) in Bernalillo County, working with incarcerated Molina members to engage them in care coordination and ensure more timely access to health care services after their release.

Despite these positive signs of improved access to care, the Centennial Care MCO behavioral health networks continue to have notable gaps. Centennial Care MCO contracts include minimum requirements for provider networks to ensure that enrollees can access a provider in their network within a reasonable distance from their home and obtain an appointment within a reasonable amount of time. Network adequacy is established when 90 percent or more of an MCO's members live within either 30, 60 or 90 miles of a provider, depending on whether they live in an urban, rural or frontier county.

Despite these positive signs of improved access to care, the Centennial Care MCO behavioral health networks continue to have notable gaps.

Geographic access is calculated using the total membership of an MCO, even though not all members will utilize all – or any – categories of behavioral health services. There will be regions where an MCO fails to meet the contractual requirements and yet succeeds at meeting the actual needs of its members. However, while the mixed picture provided by the MCO reports may not be an entirely accurate measurement of access, it does raise concerns about access to behavioral health services for Medicaid recipients, including the expansion population.

As of the first quarter of CY17, all four of the MCOs are meeting their contractual requirements for geographic access in all county types for only a single provider category: other independent licensed behavioral health providers. Review of the MCO geographic access reports found the MCOs as a group come close to meeting requirements for community mental health centers, core service agencies, psychiatrists, and psychologists (including those who can prescribe medications). There have been important gains in the number of physicians certified to prescribe suboxone, but at the same time there is a persistent shortage of methadone clinics in rural and frontier counties, physicians prescribing suboxone are in short supply in rural counties, and there has been an apparent decline from 2014 through 2017 in the number of providers who offer assertive community treatment and intensive outpatient services. To put the shortages into perspective, as of December 2017,

about 40 percent of the expansion population lives in rural counties and 9 percent lives in frontier counties. Appendix A has a detailed network adequacy table.

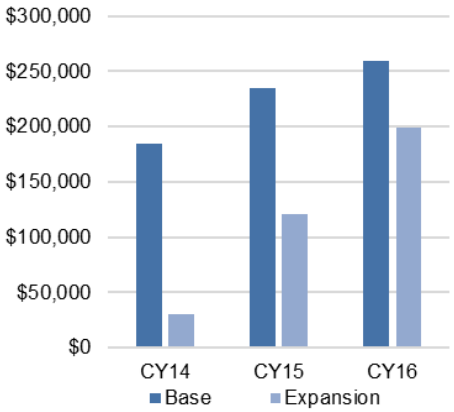
HSD and the MCOs have pursued a number of strategies for improving access, including continued reliance on telemedicine and the state's mental health crisis hotline, as well as focusing on expanding workforce capacity by developing a new supervisory protocol for mid-level practitioners and offering continuing education trainings.

Behavioral health telemedicine utilization and spending has increased, particularly for the expansion population and particularly in rural counties. Telemedicine is widely seen as a method for improved and timelier access to both physical and behavioral health care for people who live in remote and/or underserved areas, which may in turn lead to improved health outcomes and lower costs. In New Mexico, HSD has encouraged the MCOs to expand the use of telehealth to fill in the gaps in their provider networks, particularly in rural and frontier counties. Providers can use telemedicine to deliver nearly any behavioral service, although review of BHSD detailed data for 2017 shows the most use is for therapy and consultation with established patients, followed by psychiatric diagnostic and substance abuse evaluations.

Between 2014 and 2016, spending for telemedicine behavioral health services for the base Medicaid population increased by 40 percent, while expenditures for the expansion population increased by a dramatic 549 percent (Chart 17). Most of the growth for the expansion group can be seen in the 294 percent increase between 2014 and 2015, followed by another 65 percent year over year increase between 2015 and 2016. Utilization for both groups combined increased by 81 percent during the same time period.

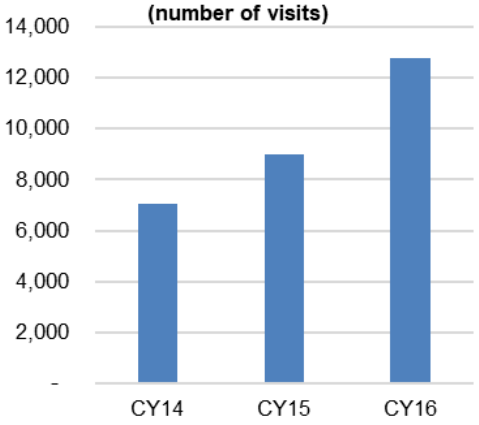
For FY17, Medicaid recipients living in rural counties accessed 60 percent of total behavioral health telemedicine services, while recipients living in urban counties used 24 percent and those living in frontier counties used 16 percent. The high utilization in rural counties appropriately reflects the pronounced gaps in the behavioral health network in those counties, as discussed in the access section of this report. Frontier counties have less severe but still quite significant gaps in access, certainly more so than urban counties, and despite the lower population of these counties there appears to be an imbalance between need and services for these two categories.

Chart 17: Behavioral Health Telemedicine Expenditures



Source: MCO financial reports

Chart 18: Behavioral Health Telemedicine Utilization (number of visits)



Source: Centennial Care 2016 Annual Report

Behavioral health outcomes

There are few meaningful and objective measures for behavioral health client or program outcomes, and the measures that do exist show at best mixed results.

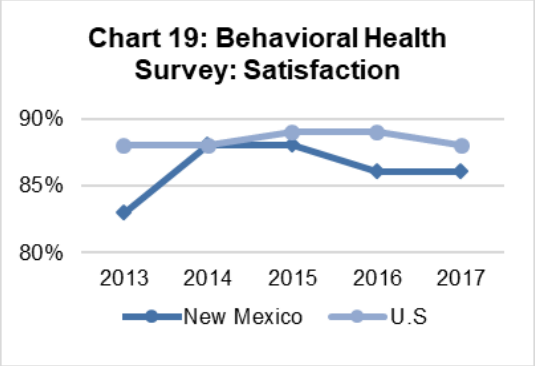
BHSD's position is that increased coverage and utilization of a relatively robust package of behavioral health services is itself a measure of success for the expansion behavioral health program in a state facing as many health and economic challenges as New Mexico does. That may be a fair starting point, but in this era of performance-based public policy it is also fair to look for objective outcome measures.

Consumer satisfaction with behavioral health in New Mexico was on par with the national average in 2014 and 2015, but dropped for 2016.

Measuring behavioral health outcomes is a challenging undertaking primarily because, unlike a physical injury or illness which has a clear beginning and end, behavioral and mental health conditions are often recurring, or marked by ambiguous episodes or repeated cycles of addiction and sobriety. Individuals may cycle in and out of treatment, as they feel appropriate, leaving no definitive start or end to their treatment and therefore no clear point at which to measure outcomes. BHSD also notes that the behavioral health services sector as a whole, including providers and institutional actors, lags in the development and implementation of performance measures and strategies to improve quality and outcomes, and cites a lack of sufficient evidence, inadequate infrastructure, and the absence of a cohesive strategy as key reasons for the lag.

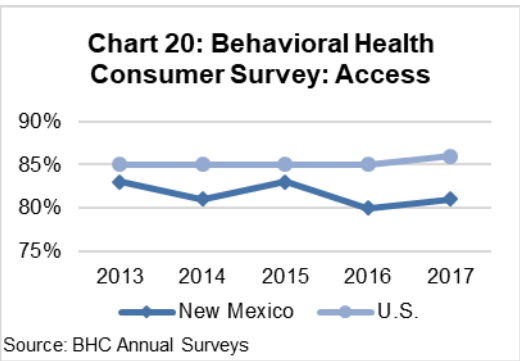
With this complexity in mind, the available outcome measures are less than precise, but they do provide some important information about Medicaid behavioral health in New Mexico. The sections below review consumer satisfaction survey responses, BHSD performance measures, and the prevalence of behavioral health critical incidents. These are measures for the entire Medicaid behavioral health program, but there is little reason to think the experience of the Medicaid expansion population is particularly different than any other New Mexican accessing publicly-supported behavioral health services.

Consumer satisfaction surveys show mixed results.



Consumer satisfaction with behavioral health in New Mexico was on par with the national average in 2014 and 2015, but dropped for 2016. The Behavioral Health Collaborative conducts an annual survey to measure consumer satisfaction among adults and the families/caregivers of children who receive behavioral health services from Medicaid or behavioral health collaborative programs. The survey's respondents are drawn from a sample of individuals who received behavioral health services from behavioral health providers, and therefore does not capture the experiences of the many New Mexicans who only receive behavioral health assistance from their primary care provider (PCP), possibly as limited as a prescription for medication and some follow-up monitoring. Nor does it capture the experiences of Medicaid recipients who are unable to access the system at all.

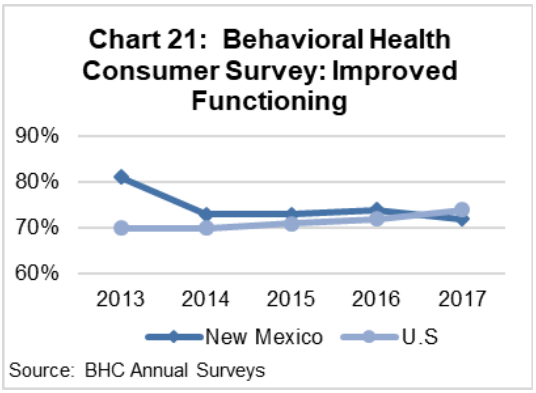
The core survey questions, part of the national Mental Health Systems Improvement Project, are divided into seven domains: access, participation in treatment, improved functioning, social connectedness, outcomes, quality and appropriateness, and satisfaction. Appendix B includes the entire set of questions for each domain. New Mexico is one of only a handful of states where the questions are asked by a team of trained peer support workers in the hope of putting respondents at ease and obtaining full and honest answers.



Satisfaction rates for New Mexicans have been consistently below the national average for the domains of access (currently 3.7 points lower) and overall satisfaction (currently 1.l9 points lower), as charts 19 and 20 show. The access trend dips in 2014, when the system was feeling the initial impact of HSD's shake-up of behavioral health providers at the same time as Medicaid expansion brought increased demand for services; it then stabilizes for a year, and then drops 2.1 points again in 2016, likely reflecting the disruption caused by the departure from the state of several of the Ari-

zona providers. Overall consumer satisfaction held steady for the first year after the departure and then declined for 2016 and stayed the same for 2017.

New Mexico scores equal to or better than the national average for the domains of improved functioning and overall outcomes. These two domains are quite similar, and include questions about whether an individual is better able to handle daily life, get along at work and socially, and cope when things go wrong or crises arise. New Mexico also scores higher than the national average in the social connectedness domain and for how much the individual feels they are empowered to participate in making decisions about their own treatment.



Given this fairly nuanced set of consumer responses, one interpretation might be that behavioral health clients are unhappy with the limitations and upheaval experienced by the New Mexico behavioral health system as a whole, but are generally seeing positive outcomes from the services they do receive.

In addition to questions related to the core domains, the Collaborative gathers information about participants' satisfaction with assistance they receive in the areas of housing, employment and substance abuse. The substance abuse questions in particular may help shed some light on this critical issue for the state and are likely relevant for a significant portion of the expansion population. The percentages in Table 1, below, reflect how many survey respondents said they agreed or strongly agreed with the statement. Based on statewide statistics on drug and alcohol abuse and deaths, these responses may appear overly optimistic, but the positive outcomes may indeed reflect the experience of the small percent of respondents who were willing to self-identify and voluntarily answer this set of questions. The responses may also represent the respondent's situation at the moment in time the survey was taken – a question here about relapse would provide more meaningful outcome information.

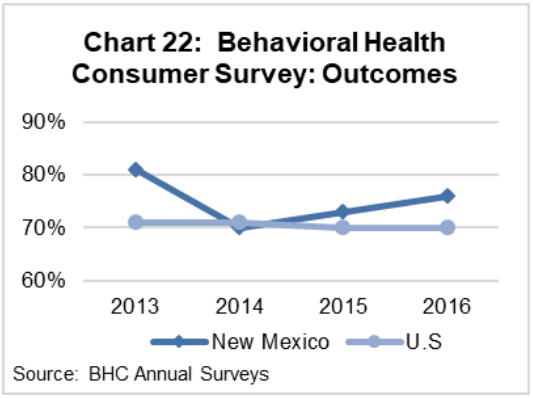


Table 1: Substance Abuse Outcome Questions

	FY14	FY15	FY16	FY17
Percent of respondents who self-identified with a substance abuse problem	50%	18%	19%	18%
The substance abuse services I received helped me reduce my use of drugs and/or alcohol	85%	90%	92%	95%
I have the tools I need to understand and prevent relapse	85%	93%	92%	95%

Source: BHC Annual Behavioral Health Consumer Satisfaction Surveys

Questions about care coordination, key to Centennial Care Medicaid's goal of providing appropriate and integrated physical and behavioral health care, have been asked differently each year and do not allow for year-to-year comparison. In 2016, the question was re-worded to ask about the experiences of only those respondents who had been assigned to higher levels of care coordination, reflecting HSD's decision that year to refocus care coordination efforts on only those needing the most assistance. For that year, about 71 percent of respondents assigned to care coordination level two or three said they felt care coordination had been helpful to them; by 2017, the number rose to about 75 percent.

Medicaid expansion members are among the least likely to require level 2 or 3 care coordination because they are generally healthier than the Medicaid base population. They are nonetheless likely to have unmet and undiagnosed physical and behavioral health needs, and unlikely to have much experience navigating the managed care Medicaid system, so it is unfortunate that their experience with care coordination is not being more closely and consistently monitored.

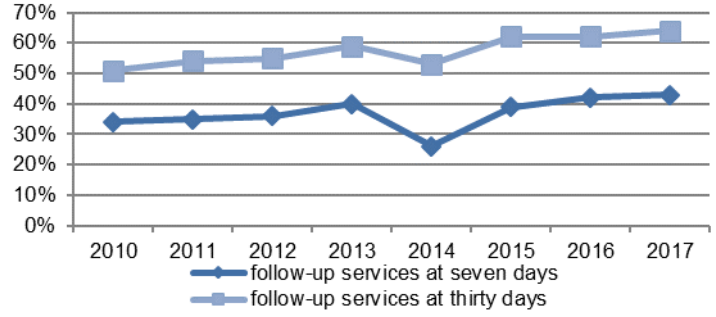
Five year trends for HSD and BHSD performance measures show mixed outcomes as well.

A relatively weak suite of performance measures, combined with poor performance on nearly all those measures, makes it very difficult to use this information to determine what impact the state's decision to expand Medicaid is having on behavioral health.

Tracking Medicaid behavioral health outcomes is challenging due to insufficient and inconsistent data reported by HSD. The Behavioral Health Collaborative and the Behavioral Health Services Division (BHSD) routinely provide only a handful of measures, not all of which are outcome oriented, and even within this small set, measures and measurement periods changed with the implementation of Centennial Care. The LFC has repeatedly emphasized that the lack of sufficient performance data provided by the department makes it difficult for lawmakers to know if current expenditures on behavioral health are targeted in the most cost effective manner at the best possible outcomes.

For the adult population, only two performance measures have remained consistent since before Centennial Care. Even these two are not purely adult measures, however, because they include all individuals age 6 years and older. The measures track individuals who are discharged from an inpatient behavioral health facility and then receive follow-up services at either seven days or thirty days. As Chart 23 shows, engagement in on-going treatment for both time periods showed slight improvement year-over-year prior to the 2014 implementation of Centennial Care and Medicaid expansion; the drop for both measures in 2014 may be due in part to the dislocation inherent in rolling out a new program, in part to the expansion population's lack of experience dealing with the health care system, and in part to the fall-out from HSD's 2013 audit of behavioral health providers. Performance for both measures has improved steadily since 2014 and in 2016 both were close to or better than the national average: for seven day follow up, New Mexico's rate of 42 percent was close to the national average of 44 percent, and the 30 day rate of 62 percent was slightly better than the national average of 61 percent. BHSD attributes the improvement in continuity of care to aggressive work on the part of the Medicaid MCOs to improve discharge planning and follow-up coordination.

Chart 23: Engagement in Care
Percent of individuals discharged from an inpatient facility who receive follow up services



Source: BHC and BHSD agency performance reports

For this discussion of performance measures, all figures for 2010 through 2016 are audited annual (calendar year) National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) figures. 2017 data are preliminary, unaudited numbers that reflect the first two or three quarters of the calendar year.

BHSD's five year trend on its performance measures is mixed, with downward or cautionary trends on most measures. Two of the measures simply count how many people have received services, which, while not a

meaningful outcome measure is nonetheless an important indicator of how Medicaid expansion is changing the behavioral health landscape in the state. BHSD does not report the proportion of individuals engaged in on-going treatment compared to those who have received partial services, such as a behavioral health screening or prescription medication, so the driver for the apparent increase in utilization is not clear. Telehealth utilization for behavioral health services is significantly higher than for physical health, and represents one of the program's primary methods for addressing the shortages in behavioral health providers. As noted above, even for measures where the trends are upward, each individual year has been below the agency's established target. A relatively weak suite of performance measures, combined with poor performance on nearly all those measures, makes it very difficult to use this information to determine what impact the state's decision to expand Medicaid is having on behavioral health.

Table 2: BHSD Performance Measures Relevant to Adults

	2013	2014	2015	2016	2017*	Five year trend
Individuals served annually in substance abuse or mental health programs or both administered through the collaborative statewide entity contract / the Behavioral Health Collaborative and Medicaid programs (new wording began in 2015)	87,723	114,723	160,843	173,781	124,580	↑
Individuals discharged from inpatient facilities who receive follow-up services at seven days	40%	26%	39%	42%	43%	↑
Individuals discharged from inpatient facilities who receive follow-up services at thirty days	59%	53%	62%	62%	64%	↑
Adults diagnosed with major depression who received continuous treatment with an antidepressant medication	*new*	41%	38%	35%	35%	↓
People with a diagnosis of alcohol or drug dependency that initiated treatment and received two of more additional services within 30 days of the initial visit (non-Medicaid only for 2014)	*new*	19%	14%	14%	15%	↓
Number of persons served through telehealth in the rural and frontier counties (annual unduplicated)	*new*	1,330	2,699	3,682	4,890	↑
Number of health homes established statewide	*new*	0	0	2**	2**	▽
Adults reporting satisfaction with behavioral health services	83%	88%	88%	86%	86%	↓
Adults with mental illness and/or substance abuse disorders receiving services who report satisfaction with staffs' assistance with their housing needs	70%	62%	47%	42%	52%	▽
Discharges for Medicaid managed care members 6 years of age and older, who were hospitalized for treatment of selected mental health disorders and received follow-up with a mental health practitioner within thirty days of discharge	*new*	*new*	*new*	*new*	*new*	
Emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug dependence, who had a follow-up visit for mental illness within 7 days and 30 days of emergency department visit	*new*	*new*	*new*	*new*	*new*	

* 2017 figures are unaudited, preliminary and partial year.
** The state has a total of 2 health homes; no new homes have been established since 2016.
Source: BHSD performance measure reports, 2016 and 2017.

When asked for its own big-picture measure of whether Medicaid's behavioral health program is succeeding in New Mexico, BHSD pointed first to the state's improved ranking in the 2018 State of Mental Health in America report. New Mexico improved from a national overall ranking of 46th in 2015 to 21st for 2018, which is an important advance for the state. However, much of New Mexico's apparent improvement in rank is actually due to other states losing ground while New Mexico has managed to hold relatively steady. Holding steady may indeed be a measure of success, given the challenges the state faces, but the state still ranks 40th nationally for adults with any mental illness, 39th for adults with substance abuse, and 51st for adults with alcohol dependence (national rankings include 50 states and the District of Columbia). At the same time, and no doubt reflecting the decision to expand Medicaid, New Mexico ranks 7th for the percent of adults with mental illness who reported not being able to receive the treatment they needed and 15th for the percent who are uninsured.

BHSD noted New Mexico's improved ranking — from 46th to 21st — in the 2018 State of Mental Health in America report. However, the state still ranks 40th nationally for adults with any mental illness, 39th for adults with substance abuse, and 51st for adults with alcohol dependence (national rankings include 50 states and the District of Columbia).

Interestingly, the Mental Health in America report lists New Mexico as 7th in the nation in terms of mental health workforce availability, with a ratio of 280:1, population to mental health providers. As noted in the access section of this report, this type of measure is unfortunately deceptive in New Mexico, as it is for other rural states, because health care providers of all types are maldistributed and concentrated in certain areas of the state, leaving other areas with scant assistance.

Other measures of success cited by BHSD (without quantification), include an array of system improvements such as expansion of evidence-based treatment models, and recent efforts to strengthen the behavioral health workforce through a supervisory certification process that allows non-independently licensed clinicians to bill directly for the services they provide while under the supervision of an independently-licensed provider.

Health homes promise improved outcomes and lower costs by providing integrated physical and behavioral health for Medicaid recipients with complex chronic conditions.

However, quantifiable benefits for the state remain uncertain: the state's first two health homes did not open until April, 2016 and at this point BHSD has collected data on fewer than 700 recipients served.

There are also future changes planned such as expanding access to crisis stabilization, in-patient rehabilitation services, and residential treatment centers for adults, as well as obtaining Medicaid service designation for screening, brief intervention and referral to treatment (SBIRT). A number of these initiatives are built into the Centennial Care 2.0 waiver now under consideration by CMS, meaning it may be several years at best before the state sees any potential benefit.

Lastly, after successfully piloting two health homes in Curry and San Juan counties, the department has approved an additional eight health homes to serve Bernalillo, De Baca, Dona Ana, Grant, Hidalgo, Lea, Quay, Roosevelt, and Sandoval counties, to become operational in spring, 2018. Health homes offer the promise of improved outcomes and lower costs by providing integrated physical and behavioral health for Medicaid recipients with complex chronic conditions: serious mental illness for adults and severe emotional disturbance for children. However, quantifiable benefits for the state remain uncertain: the state's first two health homes did not open until April, 2016, and at this point BHSD has collected data on fewer than 700 recipients served. Those individuals have turned out to be a relatively challenging population with multiple co-morbidities and significant pent-up demand for services that will address all of their behavioral and physical health issues. The information so far shows that the improved care coordination health homes provide has led to increased services and higher costs as recipients' conditions are addressed and stabilized. National studies are finding the same sort of trends, and BHSD cautions that the health home vision of healthier patients and reduced costs may take two to three years to materialize.

Molina's pilot project with the justice-involved population has promising, though unconfirmed, early outcomes.

After just one year, Molina has reported a decrease in costs and utilization for members who participated in its pilot care coordination project at the Metropolitan Detention Center in Bernalillo County. Compared to a control group determined by Molina, over the course of the program, participants have averaged 24 percent fewer emergency department claims per month, 35 percent lower utilization of behavioral health services, 14 percent lower utilization of physical health services, and 4 percent lower inpatient hospitalization utilization. Molina reported significant cost savings as a result of this lower utilization: the actively managed members averaged monthly costs of $3,941, while the control group averaged $11,795. Based on these early results, Molina has announced plans to expand its efforts to 27 additional detention facilities around the state. While these outcomes seem promising, they could not be validated by LFC staff; information provided by Molina was unclear about even the most basic elements of the project's methodology, such as the composition of the control group, and multiple requests for detailed information went unanswered.

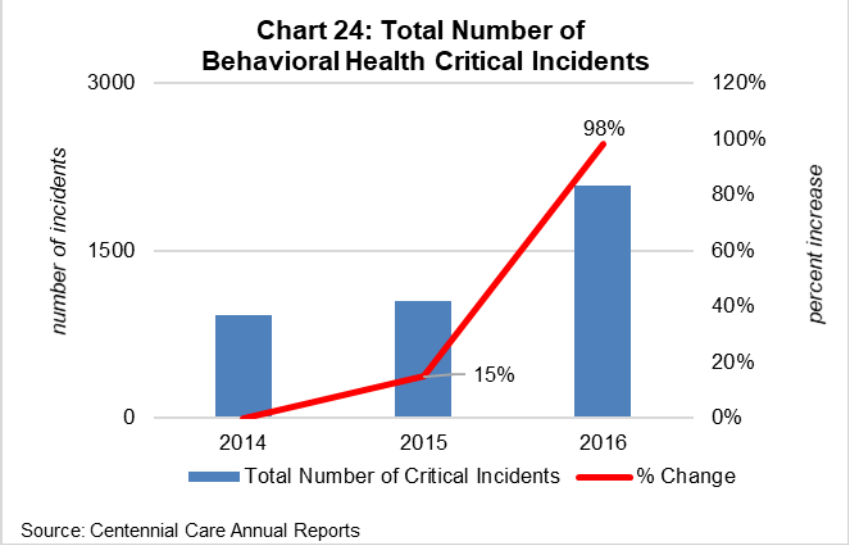
Molina reported a remarkably low recidivism rate of 14 percent for members who participated in the project and received the care coordination intervention.

MDC staff calculate the recidivism rate for all Molina participants as 43 percent, and noted that Molina's rate is based only on a select subset of participants.

Molina reported a remarkably low recidivism rate of 14 percent for members who participated in the project and received the care coordination intervention. MDC staff calculate the recidivism rate for all Molina participants as 43 percent, and noted that Molina's rate is based only on a select subset of participants. MDC staff also pointed out the Molina care coordination intervention efforts are not the only factors responsible for recidivism rates. Recidivism rates may also be lowered by parallel programmatic efforts like Alcohol Treatment Program (ATP) implemented by the MDC while offenders are in custody or court ordered alcohol and drug treatment programs in the community.

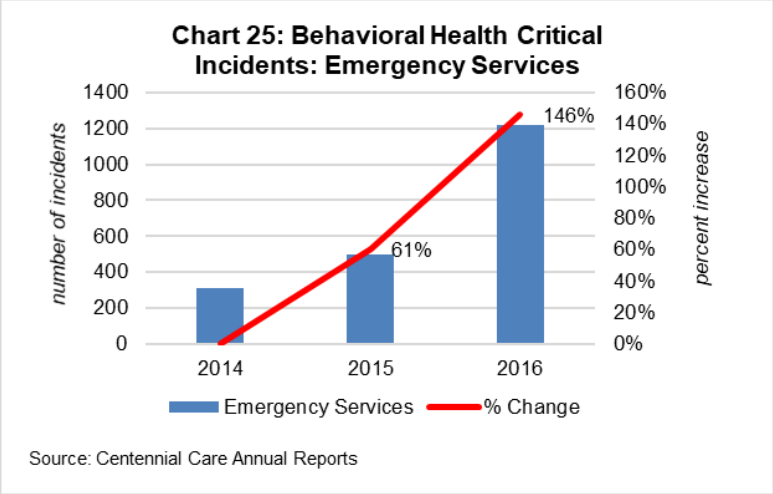
Behavioral health critical incidents are a rarely discussed aspect of the program, and they have increased by 127 percent since 2014.

A critical incident is defined as any event that poses actual or potential serious harm to a Medicaid recipient. Critical incidents for behavioral health increased from 916 in 2014 to 1,052 in 2015, and then nearly doubled to 2,083 in 2016. Some of the increase in incidents can be attributed to the 35 percent growth in the number of Centennial Care recipients who used behavioral health services during the same period. At the same time, HSD reports the increase is largely the result of its efforts in 2015 to educate providers about the department's reporting requirements and expectations. BHSD had noticed there seemed to be low levels of reporting, and also that providers seemed confused about how and when to appropriately report critical incidents.



Increases in the expansion behavioral health population and improved reporting are certainly part of the explanation, but those factors do

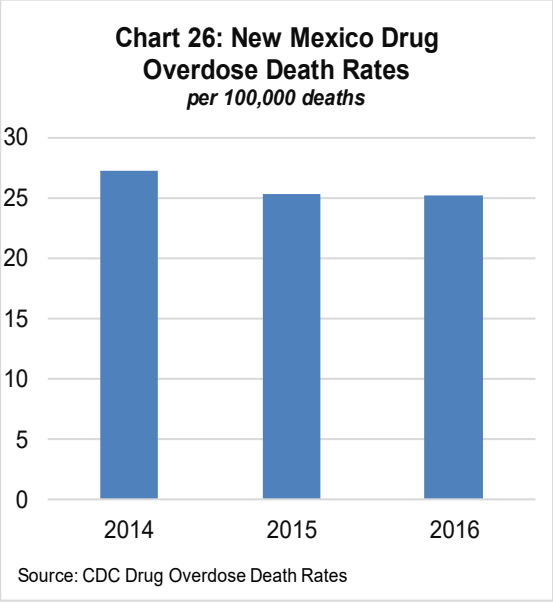
not fully explain why some types of critical incidents went up more than others or, in particular, why emergency service incidents increased by a striking 295 percent at the same time law enforcement critical incidents dropped by 30 percent. Further, most of the increase in critical incidents of all types occurred between 2015 and 2016, the same time the state's behavioral health system was disrupted for a second time as the Arizona providers began leaving the state.



HSD reports data on about a dozen categories of critical incidents. Three of the four largest categories have seen increases since 2014, while one category, law enforcement, has seen a notable decline. Allegations of neglect increased from 58 incidents to 140 incidents, or 141 percent, between 2014 and 2016, a rate over three times faster than the growth of the expansion population. Allegations of abuse have also increased, though more in line with population growth: there were 310 allegations of abuse in 2014 and 420 in 2016, a 35 percent increase.

Law enforcement critical incidents, which include the arrest or detention of a Medicaid recipient, have followed a different trend: despite a slight increase in 2015, the use of law enforcement services decreased by 30 percent between 2014 and 2016, from 132 incidents to 93.

Emergency services critical incidents, on the other hand, have increased so dramatically in both absolute numbers and percent growth that they are clearly the driver for the increase in critical incidents overall. Emergency services include all types of medical care for a member that was not planned or anticipated, whether the member goes to the emergency room themselves or gets assistance from EMTs or police. The use of emergency services increased by 61 percent between 2014 and 2015, and by another 146 percent between 2015 and 2016; there were 309 incidents in 2014 and 1,221 incidents in 2016.



Population level trends in New Mexico

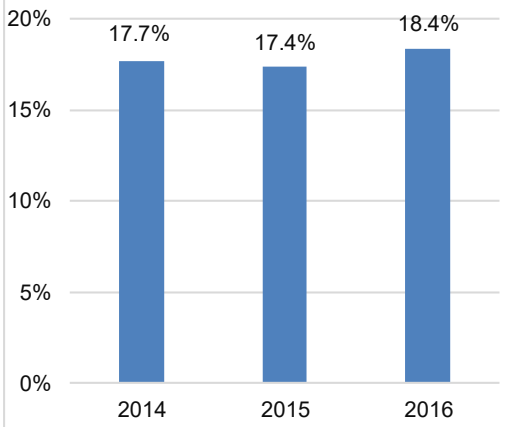
The Medicaid expansion population, with about 254,000 people, makes up about 12 percent of the state's total population; the roughly 71,000 people of the expansion cohort who are actively using behavioral health services are less than 4 percent of the state's population. That said, the promise of Medicaid expansion was that providing first-time coverage for physical and behavioral health services to this group has the potential to improve at least some of the state's seemingly-intractable population level health concerns: addiction rates, suicide rates, DWI fatalities, and overdose deaths are just a few possibilities.

A few years of coverage and services may not seem enough to make a significant impact, but given that the frequency of substance abuse diagnoses is reportedly more than 150 percent higher among expansion members who seek services than the general state population, as well as the remarkable 201 percent increase in claims for services to treat substance abuse disorders, some initial analysis of population level trends seems warranted.

Since 2014 drug overdose death rates in New Mexico have decreased slightly. In 2014 the Centers for Disease Control and Prevention (CDC) reported New Mexico's drug overdose death rate at 27.3 per 100,000 deaths. In 2016 the drug overdose death rate was 25.2 per 100,000. The decrease may be partly the result of increased access to substance abuse treatment for the Medicaid expansion population, combined with wider distribution of naloxone.

On the other hand, the percent of New Mexicans self-reporting poor mental health for six or more days in the past 30 days has increased very slightly. This measure is part of the New Mexico Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone survey of adults 18 years or older. As noted above, about 70 percent of New Mexicans receiving behavioral health services reported improved functioning; the 18 percent of New Mexicans reporting poor mental health — who may or may not be receiving behavioral health services — are the other side of that picture.

Chart 27: New Mexicans Reporting Poor Mental Health



Source: NMDOH NM Indicator Based Information System

Conclusion

Medicaid expansion has provided access to behavioral health services for over 250,000 New Mexicans, many of whom have made use of those services to address conditions they may have lived with untreated for years due to lack of insurance coverage. Particularly vulnerable groups, including the homeless and justice-involved populations, have gained access to services they have never before been able to obtain. Providing much-needed services to the expansion population is an important step forward for the state, but there is a frustrating lack of sufficient, clear, and consistent data for legislators and the public to determine whether the state is, indeed, meeting the Centennial Care goal of the right care, at the right time, in the right setting – and at the right cost – for behavioral health.

One of the great promises of expansion was that provision of healthcare services for this new population would lead to improved health outcomes and begin to 'bend the curve' on a number of the state's challenging health indicators, including those related to mental health. There is evidence that the Centennial Care managed care organizations (MCOs) are meeting their contractual requirements for an 85:15 medical loss ratio and, in some categories of services, appear to be managing the balance between cost and utilization of services well. The MCOs are meeting many of the requirements regarding access to care, with the assistance of a number of federally qualified health centers (FQHCs) that have stepped into the breach left when the Arizona providers left the state; there nonetheless remain some persistent gaps in the MCO provider networks.

However, despite relatively high rates of utilization and substantial expenditures, the outcomes for the program are unclear and appear mixed at best. Behavioral health outcomes are notoriously difficult to quantify, and this brief reaches the same conclusion as previous LFC reports: the Medicaid behavioral health program lacks sufficient meaningful outcome measures to reflect spending and utilization levels, and there are mixed outcomes on the measures that are available. Evidence-based treatment protocols – widely understood to be the best way to get

genuinely effective treatment at a cost-effective manner – appear to be used relatively frequently for substance abuse disorders, but less so for more widely used mental health therapy. Another available outcome measure is the number of reported behavioral health critical incidents, which increased significantly between 2014 and 2016. On the other hand, the state's rate of drug overdose deaths declined slightly between 2014 and 2015, and then stayed flat between 2015 and 2016, a positive trend that may be partly the result of increased access to substance abuse treatment for the Medicaid expansion population.

Lastly, the lack of complete and accurate encounter data poses a significant barrier to the ability of anyone — HSD, the LFC, the Legislature, or the public — to truly understand exactly what behavioral health services are being used, in what quantity, and at what cost. LFC staff will continue to work with the data set HSD provided to see what other analysis can be gleaned from it, and to work with the department to investigate alternative paths to meaningful information.

Appendix A: MCO Behavioral Health Network Adequacy

MCOs Meeting Behavioral Health Network Adequacy Standards
CY14 first quarter – CY17 first quarter

	Urban Counties				Rural Counties				Frontier Counties			
Geo-Access Standard	Urban = 30 miles				Rural = 60 miles				Frontier = 90 miles			
Provider Type or Service	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Assertive Community Treatment	2	3	0	1	0	1	0	0	1	1	0	0
Behavior Management Services	4	3	2	3	1	2	1	1	4	3	0	1
Community Mental Health Center	2	4	4	4	2	3	3	3	2	3	4	4
Core Service Agency	4	4	4	4	4	4	2	3	4	4	3	3
FQHC – BH Services	4	4	4	4	0	1	2	2	3	3	3	3
Intensive Outpatient Services	3	3	1	1	2	2	1	1	3	3	2	1
Methadone Clinic	0	2	3	4	0	0	1	0	0	0	0	0
Outpatient Provider Agency	3	3	3	3	1	2	3	3	2	2	3	3
Psychiatrist	4	4	4	4	4	4	4	3	4	4	4	4
Psychologist (including prescribing)	4	4	4	4	1	3	3	2	3	4	4	4
Other Licensed Independent BH Practitioners	4	4	4	4	4	4	4	4	4	4	4	4
Suboxone Certified MDs	3	3	3	4	1	1	2	3	2	3	3	4

Source: MCO Geo-Access Reports

Appendix B: New Mexico Behavioral Health Consumer Satisfaction Survey

	Percent answering 'strongly agree' or 'agree'					
Domain and all related questions	2013	2014	2015	2016	2017	2016 National Average
Access	**83.2**	**81**	**82.7**	**80.6**	**81.2**	**85.6**
The location of services was convenient (parking, public transportation, distance, etc.)	80	86.0	86.4	84.9	86.6	-
Staff were willing to see me as often as I felt was necessary	89	89.2	87.6	87.6	86.5	-
Staff returned my call in 24 hours	86	81.0	82.4	83.2	81	-
Services were available at times that were good for me	86	88.2	88.5	88.2	88	-
I was able to get all the services I thought I needed	88	85.1	85.6	84.0	82.6	-
I was able to see a psychiatrist when I wanted to	84	79.2	79.7	74.8	77.8	-
Participation in treatment	**81.1**	**80.9**	**83.3**	**82.3**	**82.2**	**81.7**
I felt comfortable asking questions about my treatment and medication	88	91.8	91.2	92	91.4	-
I, not staff, decided my treatment goals	81	81.7	84.4	83.4	83.9	-
Improved functioning	**81.0**	**73**	**72.9**	**73.9**	**72.1**	**73.8**
I do things that are more meaningful to me	84	78.5	79.7	81.4	78.3	-
I am better able to take care of my needs	82	79.3	79.1	80.7	79.8	-
I am better able to handle things when they go wrong	80	72.9	76.6	76.9	76	-
I am better able to do things that I want to do	77	72.1	74.7	74.4	74.1	-
My symptoms are not bothering me as much	76	62.3	63.4	65.1	63.3	-
Social connectedness	**82.3**	**77.1**	**77.9**	**79.1**	**77.7**	**74.4**
I am happy with the friendships I have	84	84	84.7	85.3	82.7	-
I have people with whom I can do enjoyable things	87	84.6	84.8	86	85.6	-
I feel I belong in my community	76	77.5	78.4	75.9	75	-
In a crisis, I would have the support I need from family or friends	87	85.8	86.8	88	87	-
Outcomes	**81.0**	**69.9**	**72.9**	**75.5**	**73.4**	**68.5**
I deal more effectively with daily problems	80	82.9	83.2	82.9	81.9	-
I am better able to control my life	84	81.9	82.5	82.9	81.5	-
I am better able to deal with crisis	82	79.7	80.3	82.6	79.2	-
I am getting along better with my family	83	79.2	79.8	80.5	80.2	-
I do better in social situations	82	69.3	71.7	69.9	68.5	-
I do better in school and/or work	80	72.3	74.2	76.4	73.1	-
My housing situation has improved	79	70.3	72.4	71.3	73.1	-
Quality and appropriateness	**89.4**	**87.8**	**89.8**	**89**	**88.7**	**88.2**
Staff here believed that I can grow, change and recover	87	85.3	89.2	89.6	89	-
I felt free to complain	89	89.2	90.5	87.6	88.6	-
I was given information about my rights	93	92.2	90.3	93.5	88.6	-
Staff encouraged me to take responsibility for how I live my life	91	86.4	90.9	89.2	89	-
Staff told me what side effects to watch out for	89	83.9	85.3	84.6	84.9	-
Staff respected my wishes about who is and who is not to be given information about my treatment	90	92.9	94.4	95.2	93	-
Staff were sensitive to my cultural background (race, religion, language, etc.)	89	90.6	92.6	91.9	90.7	-
Staff helped me obtain the information I needed so that I could take charge of managing my illness	85	89.4	88.8	87.1	86.9	-
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	81	80.2	80.7	79.2	77	-
Satisfaction	**83.2**	**87.7**	**88.0**	**86.4**	**86.4**	**88.3**
I like the services that I received here	89	92	91.3	91.5	90.9	-
If I had other choices, I would still get services from this agency	85	86.4	87.1	84.3	84.3	-
I would recommend this agency to a friend or family member	89	90	89.5	88.5	88.7	-

Source: Behavioral Health Collaborative 2014, 2015, 2016 and 2017 Behavioral Health Consumer Satisfaction Surveys

Appendix C: HSD and LFC Calculations for Encounter Data and MCO Financial Reports

The MCOs report their expenditures to HSD in two ways, through their quarterly and annual financial reports and through encounter data. Initial LFC staff analysis of the two sets of data found large discrepancies between them, with encounter data reporting less spending than financial reports in some areas and in one area, encounter data reporting larger amounts. HSD provided two explanations for the differences. Because there can be substantial time lags between when a service is provided and when it is paid for, the encounter data amounts are always somewhat less than the financial report amounts, which are a year-end accounting that includes estimates about what the full costs will be when all encounters have been paid for. In addition, previous actuarial analysis by HSD's contractor noted MCOs do not always report full cost data for some encounters; for this brief, HSD's actuary reported an aggregate 91 percent completeness of data for CY16. HSD also noted that its actuary performs a more in-depth analysis of the encounter and financial report data than LFC staff was able to, which involves a variety of adjustments using additional information LFC staff did not have access to.

HSD provided its calculations for 2015 and 2016 to the LFC in its response to a draft of this Health Note.

CY15					
Service category	**Data completeness**	**Encounter spending - HSD**	**Encounter spending - LFC**	**Financial report - HSD**	**Financial report - LFC**
Residential	0.6199	$65,059	n/a*	$104,944	$273,362
Recovery	0.9371	$1,170,685	n/a*	$1,249,211	$1,950,501
Outpatient	0.9378	$36,461,190	$36,040,778	$38,880,029	$37,013,249
Inpatient	0.7666	$8,178,929	$6,702,894	$10,669,145	$10,699,847
Intensive outpatient	0.7518	$1,953,669	$2,625,263	$2,598,490	$3,795,837
Pharmacy	0.9791	$25,040,054	$25,223,634	$25,575,109	$19,418,115
Total	0.9215	$72,869,586	$70,592,569	$79,076,928	$73,150,911

CY16					
Service category	**Data completeness**	**Encounter spending - HSD**	**Encounter spending - LFC**	**Financial report - HSD**	**Financial report - LFC**
Residential	0.5774	$44,521	n/a*	$77,112	$76,831
Recovery	0.9174	$2,108,634	n/a*	$2,298,475	$2,954,214
Outpatient	0.9189	$45,182,724	$45,022,750	$49,169,206	$48,063,614
Inpatient	0.743	$9,272,764	$9,744,877	$12,479,659	$12,462,602
Intensive outpatient	0.8917	$2,521,829	$2,946,093	$2,828,180	$3,595,598
Pharmacy	0.9803	$26,728,271	$27,111,482	$27,264,357	$23,087,753
Total	0.9123	$85,858,743	$84,825,202	$94,116,989	$90,240,612

* Note: LFC did not analyze encounter data for residential or recovery services separately.
Sources: HSD response to draft Health Note; LFC analysis of encounter data

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