NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Medicaid

The Medicaid program is the largest expenditure in the state's budget and serves nearly half of the state's population. As such, LFC Accountability Reports seek to bolster reporting on Medicaid. Between February 2020 and February 2023, Medicaid enrollment grew 20 percent, peaking around 1 million—nearly half the state's population. Meanwhile, spending during this period grew at a faster rate. In FY23, spending on the state's Medicaid program surpassed $8.9 billion, growing 59 percent since FY19. Medicaid provides health care to almost half of New Mexico. With so much at stake, the Legislature and the public have an interest in understanding how well the state's Medicaid program is delivering healthcare to New Mexicans, as well as the associated health outcomes.

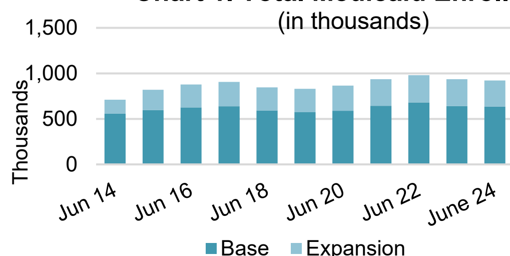
Since the start of 2023, nearly 100 thousand New Mexicans have been disenrolled from Medicaid. During the pandemic, the federal public health emergency (PHE) prevented states from disenrolling Medicaid recipients, pausing federally required checks for income eligibility. As a result, total Medicaid enrollment grew by roughly 20 percent between FY19 and FY23. For this reason, the cost and utilization sections of this report aim to compare pre- and post- pandemic costs and utilization. The federal PHE ended in the spring of 2023, and the Human Services Department (HSD) began the process of unwinding, or redetermining the eligibility of every Medicaid recipient. In April, HSD estimated 87 thousand New Mexicans were no longer financially eligible. HSD reached out to enrollees who they estimated would be ineligible, first. New Mexico has one of the highest rates of procedural denial among total closures in the U.S. Procedural denials are disenrolling a client from Medicaid for reasons other than income eligibility, such as not reapplying or failing to return paperwork. Between April and August 2023, 98 thousand New Mexicans were disenrolled from Medicaid, and HSD projects enrollment will stabilize around 923 thousand in June 2024. Removing individuals from the program who may still qualify can lead these individuals to lose coverage. These individuals may reapply, and HSD projects the program will experience churn.

Medicaid clients face challenges accessing timely care, and utilization has declined in several categories since 2019. Medicaid aims to provide healthcare for some of the state's most vulnerable populations, yet previous LFC reports have noted that insufficient numbers of providers cause Medicaid clients to experience challenges accessing care when they need it, while access is also a challenge for non-Medicaid patients. Though managed care organizations (MCOs) generally meet their contractual standards for "network adequacy" or enough providers, metrics related to patient experience suggest clients may be unable to access care when they need it. Additionally, use declined in many service categories. This trend mirrored decreased utilization among private health insurance plans during the pandemic. Strategies to improve network adequacy include strengthening MCO contractual standards and accountability and rate increases for healthcare providers. In FY24, the Legislature appropriated $98 million to increase the rates Medicaid providers are paid. HSD should evaluate outcomes associated with this strategy.

Delays in procurement result in delays in MCO contract improvements. The state's managed care program accounts for around 83 percent of all Medicaid enrollees. The state was set to renew its managed care program in January 2024 and initiated an RFP for MCOs in 2022. Draft contracts for the state's next iteration of managed care, known as Turquoise Care, include some promising improvements to MCO accountability, including strengthening quality and access standards. However, in January 2023, HSD halted the contracting process. Following an agreement with the State Ethics Committee, HSD will award the four MCOs initially selected in the RFP process. However, the implementation of the new contracts will be delayed until July 2024, delaying some of the new accountability measures, though easing implementation challenges.

Chart 1. Total Medicaid Enrollment

(in thousands)

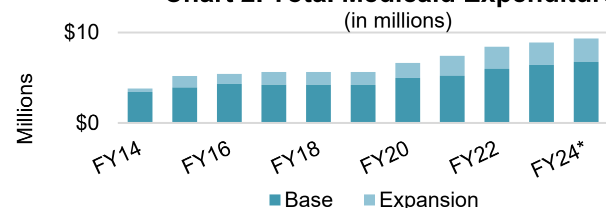


Note: FY24 is a projection

Source: HSD 8/2023 Medicaid projections

Chart 2. Total Medicaid Expenditures

(in millions)



*FY23 and FY24 are projections

Source: HSD 8/2023 Medicaid projections

Medicaid Administration

New Mexico has faced challenges within Medicaid unwinding the public health emergency.

In March 2023, the Centers for Medicare and Medicaid Services (CMS) ended its required nationwide maintenance of effort, which mandated states keep individuals on Medicaid rather than requiring reapplication to the program after one year. Unwinding is restarting these federally required eligibility checks. During the unwinding period, New Mexico has had high call center wait times, with 20-minute average wait times and upwards of one in five calls abandoned. Between May and July, HSD call centers handled 687 thousand calls, and 135 thousand calls were abandoned. Potentially related, the state's Medicaid program has also experienced high numbers of procedural terminations of coverage. Procedural terminations are when HSD disenrolls individuals from Medicaid for failure to confirm their eligibility due to incomplete paperwork, returned mail, or other noncommunication.

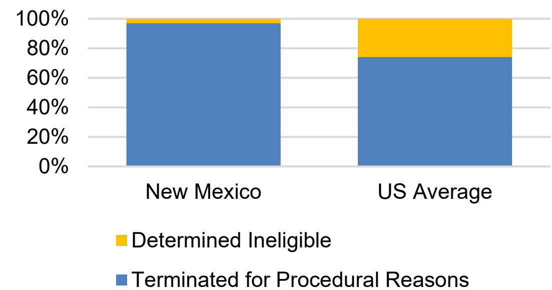
Table 1. Average Call Center Wait Times and Abandonment

	Average wait time (min)	Abandonment Rate	Procedural Terminations	Terminations not due to ineligibility over total terminations
May	16	23%	28%	99%
June	27	23%	23%	92%
July	25	20%	31%	98%
August	25	25%	Unavailable	Unavailable

Source: CMS indicator data and HSD PHE Unwinding dashboard

The Kaiser Family Foundation calculated the percentage of procedural terminations nationwide and found New Mexico to have the highest rate among reporting states, with the vast majority of people removed from Medicaid due to procedural factors, such as failure to return paperwork. If these individuals still qualify for Medicaid, then the state is inappropriately taking away their health coverage. As Medicaid is a federal program used by such a vast swath of the state population, this metric is especially concerning.

Chart 3. New Mexico is Disenrolling the Highest Percent of Individauls for Procedural Reasons, among States Reporting



Source: Kaiser Family Foundation

CMS sent letters to all states regarding their approach to the PHE unwinding, and New Mexico was one of five states that received notice from the CMS that it may have made it too difficult for enrollees to verify and to keep their coverage. CMS also sent a letter to HSD in March 2023 stating its long call center wait times were of concern. New Mexico's call center had even higher wait times in April 2023, meaning the state will need to improve to meet CMS standards.

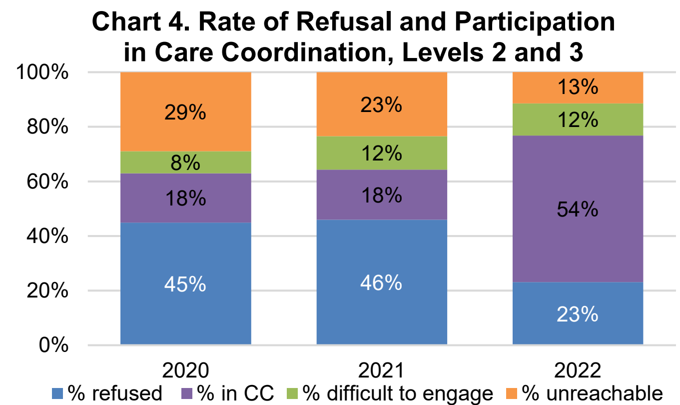
Because of long call center wait times and a large initial number of procedural Medicaid denials, HSD has a plan to improve the process of unwinding PHE. The department is giving Medicaid recipients an additional month to respond to renewal requests and has submitted a request to CMS to stop conducting renewals for children ages 0 to 6. The department is also contracting for call center staffing services with ATA, TEK systems, and Deloitte with the goal of bringing on 1,100 call center staff by the end of October. Additional staffing will cost an estimated $15 million. Lastly, the department penalized one of its call center contractors, Accenture, $150 thousand in both July and August and is withholding payment for its $3 million August invoice.

In addition, the department has partnered with the New Mexico's Health Insurance Exchange, beWellnm, to support people losing Medicaid coverage to find low or no-cost coverage on the exchange. As of September 2023, beWellnm reported receiving 144 thousand referrals related to Medicaid enrollment closures, either for procedural or eligibility reasons. Of these, 20.7 thousand have re-enrolled with Medicaid while 3.8 thousand have enrolled on the beWellnm exchange.

While the Turquoise Care Procurement Process is now moving forward, the delays in procurement delay planned improvements to contractual requirements related to transparency and access for managed care. In August 2023, the state ethics commission reached a settlement with the governor's office and HSD, requiring HSD

to move forward with the previously cancelled procurement process and make awards to the four MCOs selected through the initial Request for Proposal (RFP) process. The four MCOs under the new Turquoise Care contract will be Blue Cross Blue Shield, United Healthcare, Molina Healthcare, and Presbyterian Health Plan. HSD will now move forward with the contract negotiation process. These contracts specify what MCOs must do to ensure adequate care for their enrollees. As noted in the December 2022 LFC evaluation on Medicaid, the draft contracts had many positive stipulations that should be preserved during the negotiation process. These positive changes include increasing reporting requirements for outcomes around case management and other MCO services, requiring quarterly secret shopper surveys, specifying penalties for failure to meet network adequacy, providing direction for care coordination of families with a child born addicted to substances, and increasing the medical loss ratio (MLR) to 90 percent. However, total spending on administration may increase as the state has awarded four contracts instead of three under Turquoise Care. However, LFC staff recommended additional strategies to strengthen the MCO contracts, including improved network adequacy standards and better tracking of care coordination outcomes.

Care coordination has increased participation in 2022 and recently began tracking health outcomes of participants. Care coordination is a key aspect of the Centennial Care 2.0 program, meant to achieve both better health outcomes and lower costs by assessing and coordinating care for recipients, particularly those with complex medical needs. In 2021, the most recent year for which complete financial information is available, Medicaid spent roughly $115 million for care coordination to serve about 41.3 thousand individuals in higher level care coordination.



Source: LFC analysis of MCO data

The percentage of Medicaid managed care members accepting higher levels of care coordination increased in 2022. However, MCOs completed an assessment and offered higher levels of care coordination for about a third as many people in 2022 as in 2021. These trends suggest MCOs may be better targeting care coordination services to those who will accept. In 2022, 42.4 thousand were in higher level care coordination. Previous LFC reports noted that although care coordination is required in MCO contracts, the outcomes of the service are uncertain. In 2022, HSD began collecting additional outcome information about patients who receive care coordination services. The pilot data indicates mixed outcomes for patients (Appendix F). HSD should continue to measure and evaluate outcomes associated with care coordination and consider adding outcome measures to MCO contracts.

Creating the Medicaid Information Management System Replacement (MMISR) has taken longer than expected at a cost of over $400 million. At the same time New Mexico is transitioning to Turquoise Care, HSD is replacing its Medicaid Management Information System (MMIS). The IT system is now projected to cost a total of $418 million—the most recent in a series of cost increases, from $349 million in 2021 to $389 million in 2022—and is supported by a 90 percent federal funding match. The project has also experienced substantial delays and is now estimated to complete in FY27. The project initiated in 2013 and initially planned to complete in 2019 at a cost of $175.8 million. Previous LFC evaluations and IT spotlights have recommended HSD provide quarterly status updates about the project.

Recent LFC Evaluations and Reports

Program Evaluation: Medicaid Network Adequacy, Access, and Utilization

LegisSTAT: Behavioral Health Buildout

Progress Report: Medicaid Fraud Recovery

IT Note: Medicaid Management Information System Replacement Project

Costs and Spending*	Centennial Care 2.0 Managed Care Expenditures *(in billions)*		Fee-For-Service Expenditures *(in billions)*		MCOs Meeting MLR^ Threshold (88%)		Average Fee-For-Service Provider Physical Health Rate as a Percent of Medicare	
Enrollment June 2023	FY23		FY23		CY21		FY24	
936,969	$6.87		$1.01		2 of 3		120%	
2019 738,102	FY19	$4.27	FY19	$0.73	CY20	3 of 3	CY19	88%

*Total Medicaid enrollment, managed care and full benefit FFS. Source: Medicaid enrollment reports. Expenditures are HSD capitation payments, not the actual MCO expenditures. Source: HSD Medicaid projection, 8/2023 ^MLR is the Medical Loss Ratio or the percent of spending on direct medical care.

Medicaid is the largest healthcare provider in New Mexico, and the state has the largest Medicaid per capita enrollment in the country. Under the federal Affordable Care Act, New Mexico expanded Medicaid in 2014 to include all persons earning less than 138 percent of the federal poverty level (FPL), or $41,400 a year for a family of four in 2023. Roughly 83 percent of Medicaid enrollees participate in the state's managed care program, known as Centennial Care 2.0, and HSD provides a monthly per-member-per-month (PMPM) payment to MCOs for the care of these enrollees. Another 157 thousand New Mexicans participate in the state's fee-for-service program, and 90 percent of fee-for-service enrollees are Native American. Within the managed care program, the state aims to negotiate MCO contracts and set PMPM rates to ensure recipients receive quality healthcare for an affordable and predictable cost. From an economic perspective, HSD's goal is to establish high enough PMPM rates to ensure quality care from a sufficient number of providers while coming as close as possible to actual MCO expenditures to avoid paying for healthcare that members do not receive. Once the PMPM rate is set, MCOs must cover all healthcare costs for a client with this monthly payment. While HSD directly sets rates it will pay providers within the fee-for-service program, HSD does not set provider rates directly within managed care. Instead, MCOs negotiate the rates they will pay contracted providers for services. HSD also makes directed payments to MCOs that must be passed on to providers.

Medicaid expenditures are driven by enrollment and PMPM rate increases. Medicaid costs are generally driven by enrollment, and some of the cost increases since FY19 are also attributable to legislatively authorized provider rate increases or service expansion. Over the period of the PHE, enrollment in the Medicaid program grew by roughly 20 percent, while Medicaid expenditures grew by roughly 59 percent. Since FY19, PMPM payment rates, the primary Medicaid expenditure incurred by HSD, have increased between 22 percent and 29 percent. While enrollment is projected to stabilize around 923 thousand in June 2024, HSD is projecting continued expenditure increases, estimating total Medicaid expenditures of $9.3 billion in FY24, a 5 percent increase from FY23 expenditure levels.

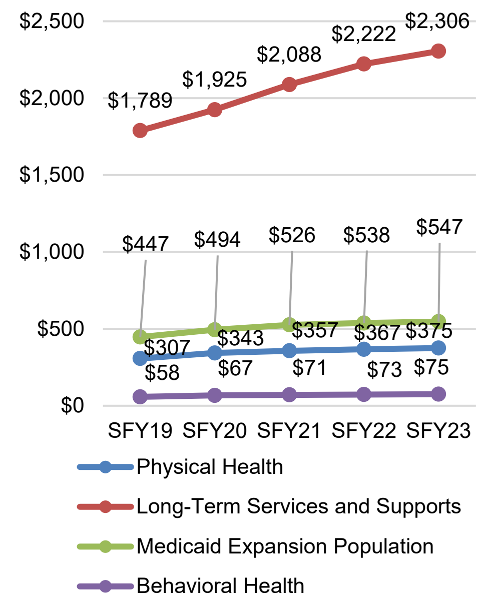
Mercer, HSD's contract actuarial firm, uses a variety of data about the state's Medicaid population, historical utilization and financial data, and assumptions about future costs and utilization to recommend a range of PMPM rates. Before the start of each calendar year, HSD must submit PMPM MCO rates to CMS for review and approval, and HSD may adjust PMPM rates by 1.5 percent during the year within limits established by

Table 2. FY23 Medicaid Expenditures by Program (in thousands)

Program	Amount
Physical Health	$2,487,744
Expansion-Physical Health	$1,990,368
LTSS	$1,639,066
Fee-for-Service	$1,011,085
DD Waivers	$656,839
Behavioral Health	$517,580
Dual-Eligible	$255,886
Expansion-Behavioral Health	$239,239
HCBS-ARPA Reinvestment	$85,512
Other	$35,207
Total	**$8,918,526**

Source: HSD Projection 8/23

Chart 5. Medicaid MCO PMPM Rates SFY19-SFY23



Source: HSD Monthly Projection Reports

CMS. However, HSD ultimately sets the exact PMPM rates. Once PMPM rates are set, the MCOs must provide services of sufficient quality to meet the terms of their contracts with HSD and to compete with other MCOs for Medicaid enrollees while at the same time managing costs to a level that allows them to earn a profit. Previous LFC reports noted HSD was setting the capitation rate toward the high end of the range developed by the state's actuary, Mercer, and rates were ultimately approved by CMS. HSD reports the PMPM is now set toward the lower end of the range but has not provided documentation about the PMPM placement.

Increases to the payment rates MCOs pay providers have contributed to PMPM rate increases.

Based on recommendations from New Mexico's actuary (Mercer) and available funding appropriated by the Legislature, HSD sets the per-member-per-month capitation payments to MCOs. However, HSD does not directly set the rates MCOs pay providers when patients in managed care access care. Instead, MCOs individually negotiate rates with providers. HSD does use assumptions about provider rates when setting PMPM payments, and HSD has issued letters directing MCOs to increase provider rates in the past. In 2022, HSD initiated a study of the payment rates providers are paid by MCOs. The report found most Medicaid fee-for-service rates paid to providers were 88 percent of Medicare rates in the aggregate, with certain rates below these averages. A 2022 LFC program evaluation of Medicaid network adequacy and access recommended bringing the state's fee-for-service rates up to 100 percent of Medicare, with additional targeted rate increases to address specific shortages. In 2023, the Legislature appropriated $98 million to HSD—enough to increase provider, facility, nursing homes, and rural healthcare rates up to 100 percent of Medicare rates, with primary care, behavioral health, and maternal and child health receiving additional targeted increases to bring provider rates up to 120 percent of Medicare rates. When federal matching funds are included, the budget for rate increases totaled $443 million.

Table 3. Medicaid Fee-For-Service Provider Rate Increases for Sample of Most Common Behavioral Health Procedures

Procedure Code	Procedure Description	2023 Medicare Rate	Old NM FFS Rate	New NM FFS Rate	New Rate as % of 2023 Medicare Benchmark
90837	PSYCHOTHERAPY, 60 MIN, W/PT AND/OR FAMILY MEMBER	$144.37	$141.37	$149.34	103%
S5145	CHILD FOSTERCARE TH PER DIEM	N/A	$253.64	$265.51	N/A
90834	PSYCHOTHERAPY, 45 MIN, W/ PT AND/OR FAMILY MEMBER	$98.15	$105.71	$132.70	135%
H0015	ALCOHOL AND/OR DRUG SERVICES	N/A	$64.43	$67.45	N/A
90847	FAMILY PSYTX W/PATIENT	$98.80	$118.25	$118.56	120%

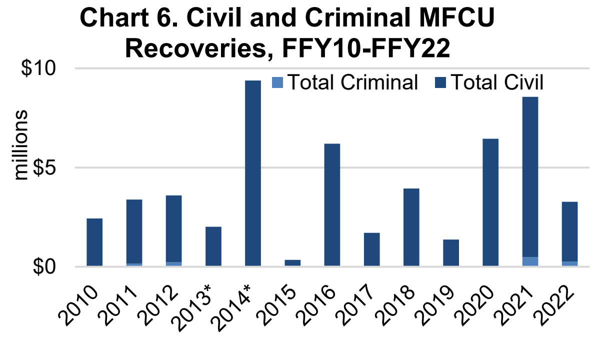
Note: Procedural codes reported include the most common procedural codes, according to the 2022 New Mexico Provider Rate Study. Procedural codes that do not have a comparable procedural code covered by Medicare are listed as N/A
Source: LFC analysis of HSD Files and Medicare rates published by CMS

However, despite significant appropriations for rate increases, the state will not know for certain if providers received all intended rate increases because MCOs are responsible for implementing these. The rate increases were issued by HSD as directed payments, and MCOs are contractually obligated to pass on the rate increases. The state can monitor MCO administrative spending through the Medical Loss Ratio, described below, and statute requires MCOs set managed care rates no lower than the state's fee-for-service rates. HSD implemented fee-for-service rate increases in July 2023, and LFC conducted a subsequent analysis comparing the old and new fee-for-service provider rates for the most frequently billed procedures in the 2022 Medicaid provider rate study. Provider's rate increases among this sample of procedures are evident, though a Medicare benchmark is not always available. However, particularly among some of the most common behavioral health rates, the rate for every service is not exactly 120 percent of the Medicare rate (See Appendix C). HSD's FY25 Medicaid budget request proposes bringing Medicaid provider rates to 150 percent of Medicare rates.

Increasing MCO contractual standards to spend more on medical costs (MLR) will be delayed as Turquoise Care contracts will go into effect in July 2024. The state aims to maximize spending on medical care by establishing limits on how much managed care organizations can spend on administrative costs, known as the medical loss ratio (MLR). Federal regulation and MCO rate-setting guidance require states to establish managed care capitation rates according to actuarially-sound principles that reasonably achieve an MLR of at least 85 percent. As a result, many MCO contracts in other states establish an 85 percent MLR. Following a 2015 LFC evaluation recommendation, HSD increased the MLR in Centennial Care contracts to 88 percent from the historical rate of 86 percent. The MCO contracts

currently stipulate that MCOs can use no less than 88 percent of net capitation revenue on direct medical expenses. In 2021, one MCO (Blue Cross Blue Shield) exceeded the 88 percent MLR threshold, spending less than 88 percent of capitation revenue on direct medical care and had to pay a remittance of $108.5 million. MLR data is not yet available for 2022. The draft Turquoise Care contracts scheduled to go into effect in July 2024 increase the contractual MLR threshold to 90 percent. However, with the delayed implementation of these contracts, this stronger provision will also be delayed.

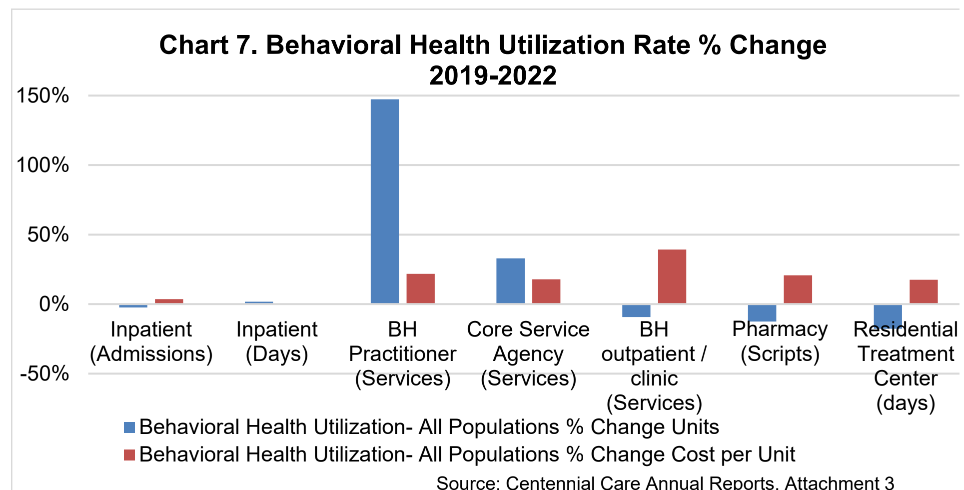
Recoveries from Medicaid Fraud have varied over time, and another legislative attempt to increase potential collections died during the 2023 legislative session. In FY22, New Mexico's Medicaid Fraud Control Unit (MFCU), housed within the Attorney General's office, recovered $3.3 million in overpayments, down from $8.6 million in FY21, however recoveries of fraud is highly variable. In 2022, LFC released a Medicaid Fraud recovery progress report highlighting that the state could collect a larger percent of these recoveries by amending the state's fraud statute to comply with federal rule. This amount totaled $4.7 million since FFY11. In 2023, SB`138 would have brought New Mexico into compliance, however the bill died. Additionally, the report found that the state's MFCU could improve collaboration with sister agencies in HSD and federal partners to increase the quantity and quality of fraud referrals. In the FY25 budget request, the Office of the Attorney General requested additional general fund dollars to partially fund two additional Medicaid Fraud Control Unit attorneys due to high caseload volumes during to the pandemic.

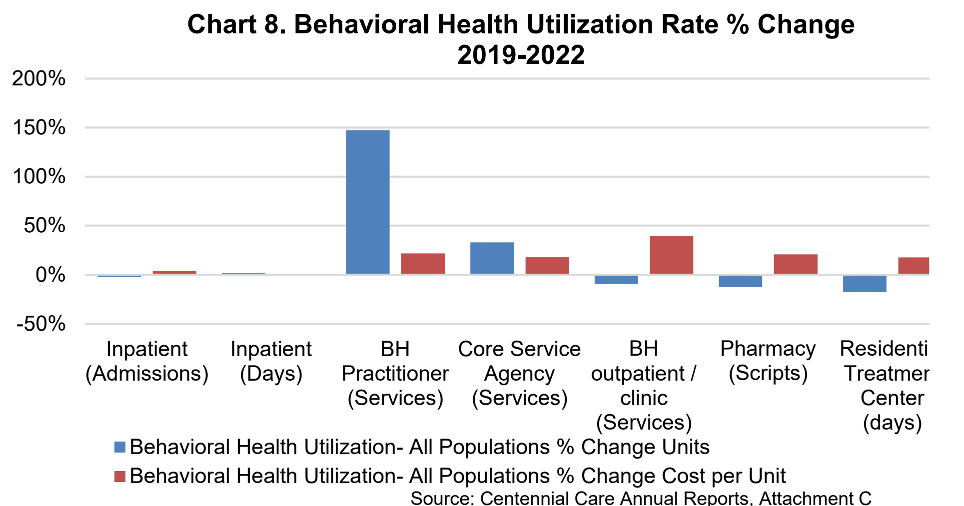


Source: HHS OIG

Utilization	Physical Health Practitioner Visits per 1,000 Members	Behavioral Health Practitioner Visits per 1,000 Members	Members Receiving a Telemedicine Service	Emergency Room Visits for Nonemergency Needs
2022	6,741	620.1	184,843	57%
2019	7,692	250.7	11,974	61%
Source:	HSD	HSD	HSD	HSD

Utilization in a few key areas of physical and behavioral health have decreased since 2019. HSD reports a variety of metrics related to utilization focused on units of service. During the pandemic, public and private health plans experienced a decline in utilization. Within Medicaid, physical health utilization has generally decreased since 2019, while behavioral health utilization has increased in two key service areas while remaining flat or declining in other areas. Physical health physician visits decreased 12 percent between 2019 and 2022. Within Medicaid managed care, the overall utilization of behavioral health services increased by 147 percent between 2019 and 2022, and core service agency (an agency that coordinates care and provides services to individuals with a serious mental illness or behavioral health problem) utilization increased by 33 percent between 2019 and 2022. However, utilization of behavioral health provider and outpatient visits declined between 2021 and 2022.

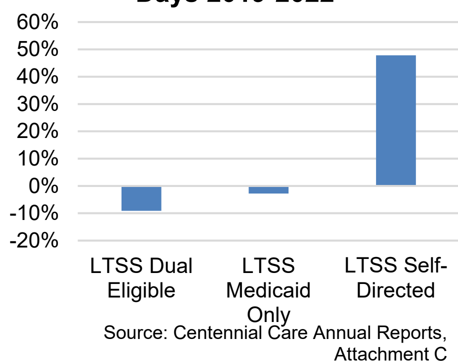


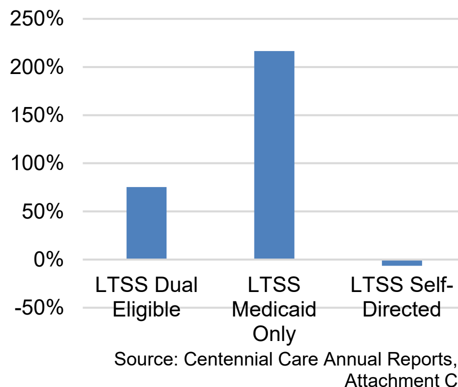


However, because the utilization metrics HSD tracks are units of service, the state does not know if more or fewer clients are receiving more or less care. Over the last decade, LFC reports have repeatedly highlighted a lack of utilization and performance data related to Medicaid behavioral and physical health, making it difficult to determine how many Medicaid clients are receiving what behavioral health services and the outcomes for these services. HSD has discontinued reports that previously shared information about unduplicated client service utilization and costs. The agency is currently working to replace its Medicaid Management Information System (MMIS) and reports the new system will include client utilization reporting capability. HSD initially scoped MMIS for completion in 2019. However, the project has experienced substantial delays and cost overruns, and HSD now estimates it will not complete the system until FY27. In addition, HSD pays Falling Colors roughly $78 million annually to act as the state's administrative services organization, and the organization houses claims data that could be analyzed to understand utilization trends. In addition, the state could

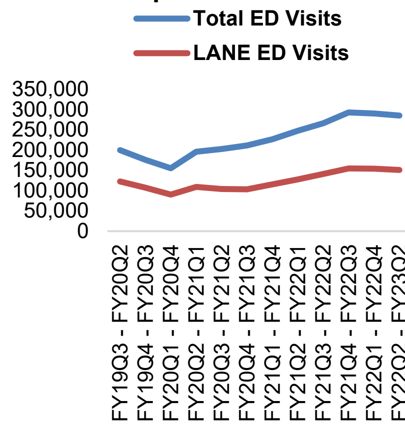
analyze claims data housed by the state's Health Information Exchange, Syncronys. Though the state is spending nearly $500 million for Medicaid data systems, previous LFC evaluations have noted less information is available about Medicaid utilization and outcomes. In general, New Mexico lacks timely information about how many clients are receiving what services, and this information could be used to measure progress or inform policy decisions. For example, the 2022 LFC Substance Use Disorder progress report noted New Mexico lacks comprehensive and timely information about how many clients are receiving substance use treatment, though HSD could publish reports sent to CMS that include some information about the number of Medicaid clients who receive substance use treatment annually.

Within the long-term care Medicaid program, nursing home use has mostly declined, while the utilization of home and community-based services has increased. The long-term services and supports (LTSS) program consists of care provided to older adults or people with disabilities whose limitations restrict their ability to care for themselves. Medicaid members may choose care provided in nursing homes or similar facilities, or as allowed under the state's waiver, in home-or-community-based settings. Previous LFC Medicaid Accountability reports have noted a shift in LTSS utilization, with less use of nursing homes and an increase in community-and home-based services. Between 2019 and 2022, nursing home days decreased in two LTSS populations but not among the self-directed population. The reverse is true among HCBS utilization trends; utilization has increased among the dual-eligible and Medicaid-only populations, but not the self-directed population. The self-directed program in managed care includes members who need nursing home levels of care, are disabled and elderly.





Telemedicine visits increased more than one thousand percent during the pandemic but decreased between 2021 and 2022. During the pandemic, telemedicine delivery expanded significantly. According to Centennial Care 2.0 annual reports, prior to the pandemic, nearly 11 thousand members received services via telemedicine, but that grew to 185 thousand members in 2021, a 1,443 percent increase. However, in 2022 telemedicine utilization declined from 2021, with 216 thousand Medicaid enrollees receiving a telemedicine service in 2021, and nearly 185 thousand receiving a telemedicine service in 2022. Shifting telemedicine trends are likely connected to the pandemic, and the 2022 decline may result from reopening opportunities for in-person medical services. Telemedicine utilization is important, particularly in rural areas that may not have as much access to in-person medical services, however some types of care may need to be conducted face to face, and telemedicine alone will not address all the state's provider shortages.



Emergency department use for non-emergency needs remains above national benchmarks. During the pandemic, emergency department utilization decreased but then rebounded in 2021. According to the National Institutes of Health (NIH), using hospital emergency rooms for non-urgent reasons may lead to excessive healthcare spending and unnecessary testing and treatment. However, the specific costs of unnecessary emergency department care are unknown. Medicaid could avoid the extra costs of these emergency department visits if MCOs or providers could provide better access and use of primary and preventative care. In FY23, non-urgent use of the emergency room by New Mexico Medicaid patients was 57 percent. This use of

emergency rooms for non-emergent needs is not as high as the peak in 2021 (60 percent) but it is higher than the average rate of 37 percent as reported by a national meta-analysis.

Outcomes and Quality	1 or more Well-Child Visit Ages 3-21	Newborns Whose Mother Received First Trimester Prenatal Care	Behavioral Health Follow-Up Emergency Department	Diabetes Management: HbA1c Adequately Controlled
	FY23	CY22	CY23Q4	FY23
	44%	80%	34%	52%
	FY22 39.5% HSD/HEDIS	CY21 70% HEDIS	CY21 33% HSD	FY22 77% HSD

Note: In both the outcomes and access section performance measures compare the most recent data available.

As Medicaid is the largest health insurance provider in New Mexico, ensuring clients receive high-quality care that results in improved outcomes is necessary. The state saw some positive outcome changes between calendar years 2020 and 2021 in Health Effectiveness Data and Information Set (HEDIS) data, including measures of child well visits. However, other measures have deteriorated, including the number of individuals receiving follow-up after a behavioral health crisis. Continuing to build the system of care and intervening early can lead to better long-term outcomes. This section relies upon the most recent HEDIS data, with a few metrics for which more recent unvalidated data is available from HSD.

Less than half of children enrolled in Medicaid. receive annual well-child check ups as recommended by the American Academy of Pediatrics, but pre-natal care appears to have improved. Guidance from the American Academy of Pediatrics says children should be seen by a doctor for a well-child visit annually from age 3 to 21, and more frequently before age 3. Ensuring children receive these preventative healthcare visits can aid in early diagnosis or prevention of potential health problems. In FY18, prior to the pandemic, 86 percent of all children and youth enrolled in Medicaid had a doctors visit, at that time the metric included all visits rather than only well-child visits.

In 2022, 80 percent of newborns mothers received prenatal care in the first trimester, slightly lower than the target of 82.73 percent and below the national average of approximately 84 percent. As New Mexico has such a high rate of births funded by Medicaid (76 percent in 2022), the Medicaid program has an outsized impact on population birth outcomes.

Due to New Mexico's high rates of behavioral health challenges, the state likely needs improved follow-up care post an emergency department visit for behavioral health reasons, especially for children. New Mexico has some of the country's highest prevalence of substance use disorder. However, follow-up visits for individuals with either mental illness or substance abuse are not occurring at high rates. The HSD report card tracks emergency department visits for Medicaid clients 13 and older who receive an emergency department visit with a principal diagnosis of alcohol or drug dependence who receive a follow-up visit within seven days and 30 days. These measures were 20 percent and 34 percent respectively in the fourth quarter of FY23, suggesting the state has quite significant challenges providing follow-up care. (See Appendix B). When looking at these data broken out by age, this metric is an externally validated HEDIS measure, and 2021 is the most recent year for which data is available. In 2021, only one-third of individuals who came to the emergency department due to mental illness or substance abuse received a follow-up within 30 days. The low rate is driven by those with substance abuse, where only 21 percent received follow-up within 30 days in 2021. Concerningly, follow-up for substance abuse was lowest for children under age 18, with only 9 percent followed up within 30 days, roughly one-eighth of the follow-up provided for children with mental illness. Low follow-up rates may be due to a lack of access to care or few providers who specialize in youth substance abuse. Nationally in 2020 20 percent of adults received a follow-up visit within 30 days after presenting at the emergency department for a substance use related issue. For New Mexico to have a follow-up rate of 50 percent, approximately 2 thousand more adult patients would need to receive follow-up care within 30 days.

Table 5. Thirty Day Follow-up Rates by Age and Behavioral Health Problem

	SUD	Mental Illness
Under 18	9%	75%
18+	21%	52%
Total	21%	58%

Source: LFC analysis of MCO 2021

Overall, New Mexico MCOs meet the target for fewer than half of their performance measures. HSD contracts with the state's managed care organizations outline ten performance measures, which track metrics associated with patient outcomes. In the state's 2022 Centennial Care 2.0 Annual Report, aggregate MCO performance met targets for half of the performance measure outlined in managed care contracts. The metrics are focused on behavioral and physical health, and none measure the outcomes for Medicaid clients in long-term care.

Table 6. HSD MCO Performance Measures
2022

PM #	Performance Measure	2022 Target	MCO Aggregate Q3 Performance
1	Well-Child Visits in the First 15 Months	65%	50%
2	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	58%	21%
3	Prenatal and Postpartum Care (Live births that received a prenatal care visit in the first trimester)	83%	59%
4	Prenatal and Postpartum Care (Deliveries with a postpartum visit 7 to 84 days after delivery)	66%	52%
5	Childhood Immunization Status	71%	57%
6	Antidepressant Medication Management	35%	43%
7	Initiation and Engagement with SUD Treatment	46%	49%
8	Follow-up After Hospitalization for Mental Illness	52%	54%
9	Follow-up After Emergency Department Visit for Mental Illness	47%	53%
10	Diabetes Screening for People on Antipsychotic Medications	82%	71%

Note: green rows are close to or exceeding the target, while red rows have not met the target.

Source: HSD Centennial Care 2.0 Annual Report 2022

Tracking of chronic disease management is crucial to ensure better outcomes for those struggling with disease. While the ten MCO performance metrics focus on children, behavioral health, and pregnancy, it is also important to understand how MCOs and the state manage chronic disease. New Mexico has a high percent of individuals with diabetes at 13.6 percent, higher than the national average of 10.9 percent. To best control this disease, patients must maintain adequate blood sugar levels, defined by HEDIS as below 8 percent. However, FY23, only 52 percent of individuals with diabetes in managed care had their HbA1c levels less than 9 percent, meaning their diabetes is under control.

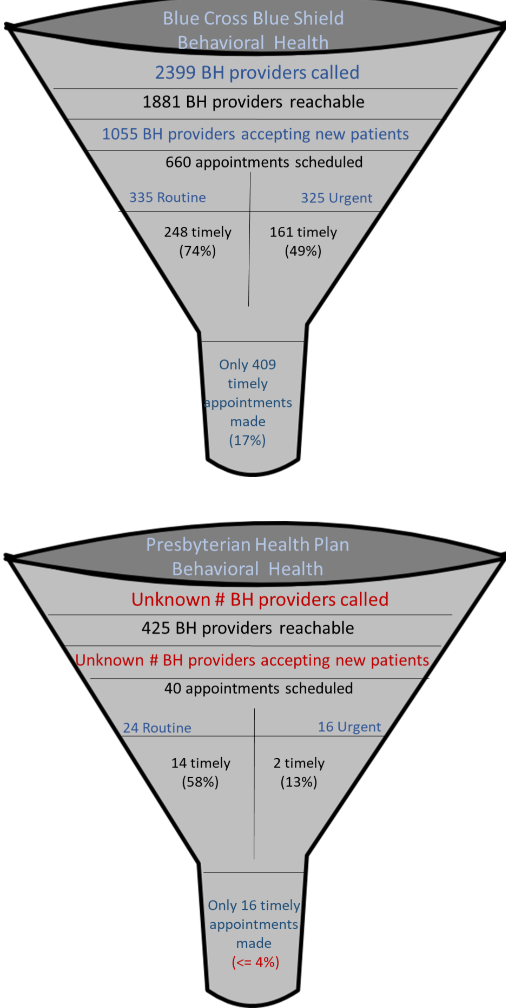
HSD is planning several quality initiatives to improve outcomes. These initiatives include:

- A value-based purchasing initiative that will pay hospitals to achieve specific improved outcomes, including follow-up care.
- A pilot program to pilot alternative payment models for primary care. This initiative provides four different models into which providers may opt in. At the highest level, providers may choose to receive a sub-capitated payment to deliver all primary care services for a client, and providers must demonstrate specific outcome measures approved by CMS. Potential benefits to patients could include improved quality of care, access to additional non-medical service providers, increased access to comprehensive and flexible services based on patient needs, and incentives for more preventive care. Some providers have expressed concerns with the model, including difficulties for smaller primary care providers not having enough financial resources to hire the additional staff needed for a team-based approach to care, not having adequate IT resources, and an undue focus on process measures. HSD is currently collecting feedback from providers and plans to implement the pilot beginning July 2024.
- The state has expanded its managed care benefits to include coverage of community health workers, a pilot program to deliver meals to specific vulnerable populations, and several other programs to address social determinants of health, such as the provision of supportive housing services in specific cases.

Access and Network Adequacy	Average Timeliness – Behavioral Health	Average Timeliness – Physical Health	MCOs Compliant with PCP Distance Standards	Adults Reporting Always or Usually Able to Get Needed Care Quickly
	CY22	CY22	CY22Q4	CY22
	15%*	24%^	99.9%	77%
				US 80.9%
	* Timely appointments over total sample; one MCO excluded due to insufficient data.	^Timely appointments over total sample; only one MCO used due to insufficient data		MCO percentile ranking range from 12th to 40th compared with the nation (higher is better).
	No previous comparisons available			
Source:	LFC	MCOs	MCOs	CAHPS

Ensuring timely access to needed services and an adequate network for Medicaid clients is an ongoing challenge for MCOs. As of 2022, MCOs report that only one in four of their Medicaid clients can secure a timely physical or behavioral health appointment. Furthermore, in 2021 the largest MCO had the fewest providers meeting timeliness standards for physical health appointments.[1] A 2022 LFC evaluation on access and network adequacy for Medicaid clients found low standards and a provider shortage exacerbates problems accessing timely care. This is true for both physical and behavioral health.

Figure 1. Summary of MCO Timely Appointment Data 2022



Note: WSCC did not provide sufficient information to create a figure. See Appendix D for BCBS physical health data.
Source: LFC analysis of MCO reports

Using the most recent available data, most providers do not meet timeliness standards, especially when using all providers sampled rather than only those with whom appointment were scheduled. If clients cannot make timely appointments, health conditions may worsen before the client can see a provider or the client may choose not to receive care because the burden of finding a timely appointment is too great.

Customer satisfaction surveys show somewhat better results than secret shopper survey data, with adult clients reporting they get needed care quickly most (77 percent) of the time. However, this is lower than the national average of 81 percent. For these metrics, the state's MCOs have lower percentile rankings when compared nationally, ranging from the 12th percentile to the 40th percentile (higher is better). Like the timeliness standards, the state's largest MCO had the lowest customer satisfaction rating.

To improve network adequacy, the state needs to regularly track and report meaningful metrics from clients, such as responses to questions like, "can I get needed care quickly from both a behavioral health or a physical health provider?" LFC's secret shopper survey conducted for the 2022 Medicaid Access evaluation found such reports are not shared online and have varying levels of quality. HSD should help MCOs conduct methodologically sound secret shopper surveys. The state should also monitor whether the recent rate increases for both physical and behavioral healthcare impacted the provider network. The Turquoise Care contract will increase the number of secret shopper surveys conducted annually and will add specifics regarding penalties for not meeting network adequacy standards. However, these positive changes were delayed.

[1] LFC did not receive a physical health secret shopper survey for this MCO in 2022.

Appendix A: HSD Medical Assistance Division Q4 Report Card

Medical Assistance Division

The Medicaid Program did not meet any of its performance during FY23. However, there was notable improvement over FY22 including well child visits, prenatal visits, and child and youth dental visits. For well child visits, HSD reports the reported rate is based on the Healthcare Effectiveness Data and Information Set (HEDIS), which are reported on a calendar year and do not align with the state fiscal year. MCO strategies to improve well-child visits include increasing outreach calls, instituting value-based contracts with providers, creating a reward program for well-child visit compliance, offering assistance with scheduling appointments and transportation, and implementing a member texting campaign.

Home Visiting. Participation in Centennial Home Visiting (CHV) remains low despite federal and Medicaid funding for the program. CHV provides in-home services to children and primary caregivers, seeks to improve maternal and child health and child development and school readiness, encourages positive parenting, and connects families to support in their communities. MAD will leverage the Centennial Rewards program to incentivize CHV participation, well child visits, and immunizations.

Budget: $7,269,255.3 **FTE: 219.5**

	FY21 Actual	FY22 Actual	FY23 Target	FY23 Actual	Rating
Infants in Medicaid managed care who had six or more well-child visits with a primary care physician during their first 15 months*	51%	45%	N/A	63%	
Children and adolescents ages 3 to 21 enrolled in Medicaid managed care who had one or more well-care visits during the measurement year*	39%	17%	67%	44%	R
Children ages 2 to 20 enrolled in Medicaid managed care who had at least one dental visit during the measurement year	56%	38%	72%	57%	R
Hospital readmissions for children ages 2 to 17 within 30 days of discharge	7%	7%	<5%	7%	R
Hospital readmissions for adults 18 and over within 30 days of discharge	9%	11%	<8%	9%	Y
Emergency department use categorized as nonemergent care	50%	53%	45%	57%	R
Newborns with Medicaid whose mothers received a prenatal care visit in the first trimester or within 42 days of enrollment in the managed care organization*	70%	60%	83%	80%	Y
Medicaid managed care members ages 18 through 75 with diabetes, types 1 and 2, whose HbA1c was <9 percent during the measurement year*	53%	77%	86%	52%	R
Program Rating	Y	R			R

*Measures are HEDIS measures, which represent a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The most recent unaudited data available reported under FY22 actuals includes the last quarters of FY22. The data for HEDIS measures is preliminary and will be finalized in June 2023.

Appendix B. HSD Behavioral Health Services Division Report Card Quarter 4 FY23

Provision of Behavioral Health Services. During the pandemic, New Mexico Medicaid managed care organizations (MCOs) and non-Medicaid programs allowed behavioral health providers to bill for telephone visits using the same rates as in-person visits. Since the end of the pandemic, behavioral health telehealth use decreased by nearly 20 percent in the fourth quarter of FY23 and telephone behavioral health dropped from 62.5 thousand in FY22 to 48.7 thousand people receiving services in FY23.

Budget: $924,292.1 **FTE:** 51

	FY21 Actual	FY22 Actual	FY23 Target	FY23 Actual	Rating
Adult Medicaid members diagnosed with major depression who received continuous treatment with an antidepressant medication	43%	43%	35%	43%	G
Medicaid members ages 6 to 17 discharged from inpatient psychiatric hospitalization stays of four or more days who receive follow-up community-based services at seven days	54%	51%	51%	53%	G
Medicaid members ages 18 and older discharged from inpatient psychiatric hospitalization stays of four or more days who receive follow-up community-based services at seven days	54%	32%	51%	35%	R
Increase in the number of persons served through telehealth in rural and frontier counties*	75%	-9%	N/A	-20%	
Readmissions to same level of care or higher for children or youth discharged from residential treatment centers and inpatient care	11%	10%	5%	10%	R
Individuals served annually in substance use or mental health programs administered by the Behavioral Health Collaborative and Medicaid	200,932	212,486	200,000	217,126	G
Emergency department visits for Medicaid members ages 13 and older with a principal diagnosis of alcohol or drug dependence who receive follow-up visit within seven days and 30 days	13% 7day; 20% 30 day	12% 7 day; 20% 30 day	25%	21% 7 day; 34% 30 day	Y
Persons receiving telephone behavioral health services in Medicaid and non-Medicaid programs	75,140	62,439	60,000	48,718	R
Program Rating	Y	R			G

*Measure is classified as explanatory and does not have a target.

Appendix C. Fee-For-Service Provider Rates: Comparison of Most Commonly Billed Codes

Medicaid Fee-For-Service Provider Rate Increases for Sample of Most Common Procedures

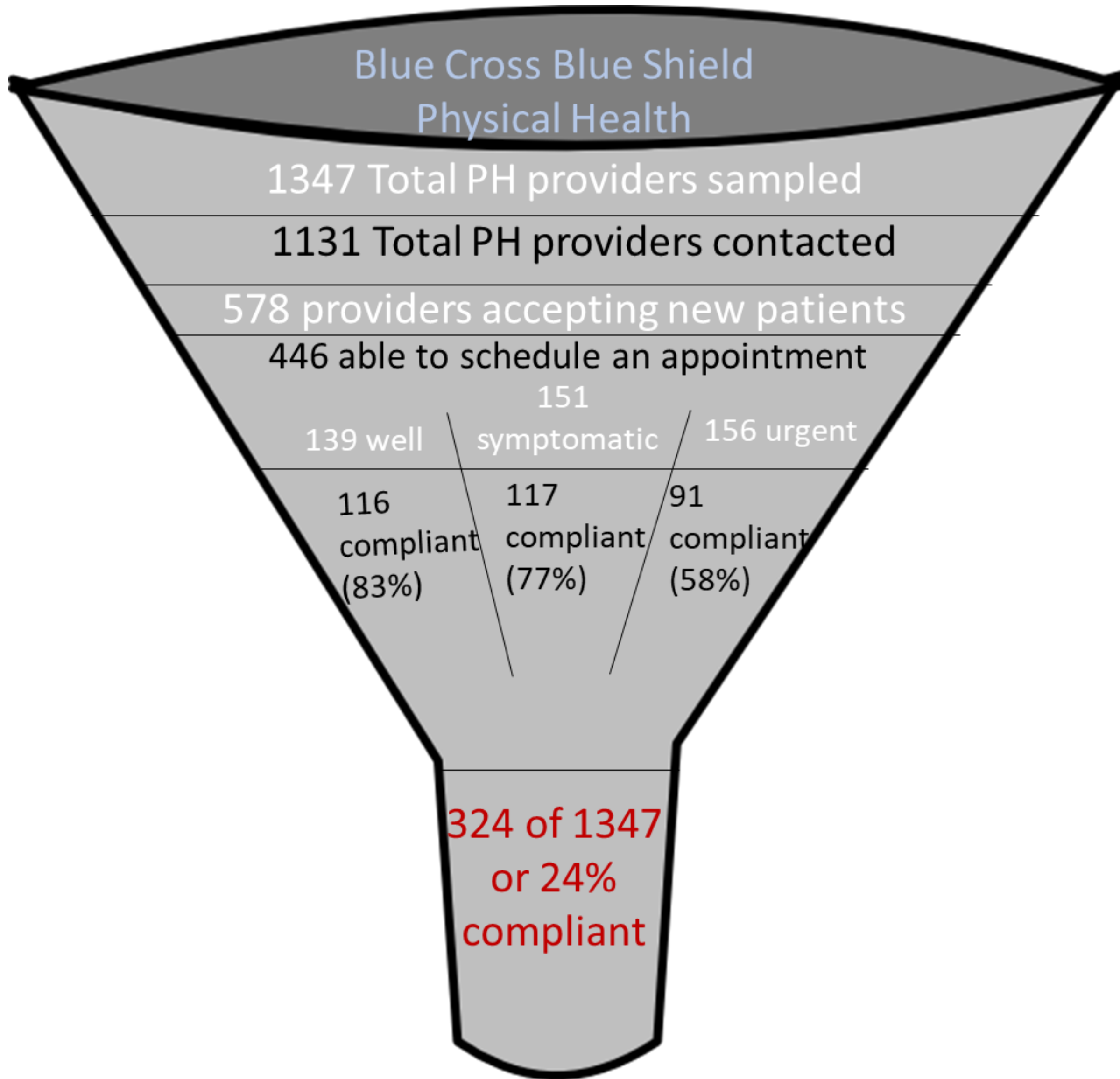
Category	Code	Procedure Description	2023 Medicare Rate	Old NM FFS Rate	New NM FFS Rate	New Rate as % of 2023 Medicare Benchmark
Physician and Practitioner	99214	OFFICE/OUTPATIENT VISIT, EST	$123.49	$96.31	$148.18	120%
Physician and Practitioner	99213	OFFICE/OUTPATIENT VISIT, EST	$87.14	$65.66	$104.57	120%
Physician and Practitioner	99285	EMERGENCY DEPT VISIT	$176.33	$159.52	$211.60	120%
Physician and Practitioner	99284	EMERGENCY DEPT VISIT	$120.97	$108.17	$145.16	120%
Physician and Practitioner	99203	OFFICE/OUTPATIENT VISIT, NEW	$108.64	$96.23	$130.36	120%
Maternal & Child Health	59400	OBSTETRICAL CARE	$2,407.43	$2164.73	$2,888.9	120%
Maternal & Child Health	59510	CESAREAN DELIVERY	$2,673.37	$1,142.71	$1,693.5	63%
Maternal & Child Health	59410	OBSTETRICAL CARE	$1,075.78	$1,080.18	$1,290.9	120%
Maternal & Child Health	76820	UMBILICAL ARTERY ECHO	$42.80	$102.51	$107.31	251%
Maternal & Child Health	76819	FETAL BIOPHYS PROFIL W/O NST	$79.86	$120.67	$126.32	158%
Behavioral Health	90837	PSYCHOTHERAPY, 60 MIN, W/PT AND/OR FAMILY MEMBER	$144.37	$146.83	$149.34	103%
Behavioral Health	S5145	CHILD FOSTERCARE TH PER DIEM	N/A	$253.64	$265.51	N/A
Behavioral Health	90834	PSYCHOTHERAPY, 45 MIN, W/ PT AND/OR FAMILY MEMBER	$98.15	$105.71	$132.79	135%
Behavioral Health	H0015	ALCOHOL AND/OR DRUG SERVICES	N/A	$64.43	$67.45	N/A
Behavioral Health	90847	FAMILY PSYTX W/PATIENT	$98.80	$118.25	$105.03	106%
HCBS	97110	THERAPEUTIC EXERCISES	$28.48	$27.31	$34.18	120%
HCBS	97530	THERAPEUTIC ACTIVITIES	$35.48	$35.09	$42.57	120%
HCBS	92507	SPEECH/HEARING THERAPY	$74.37	$58.77	$89.24	120%
HCPCS	G0483	DRUG TEST DEF 22+ CLASSES	$246.92	$232.10	$296.30	119%

HCPCS	A0100	NONEMERGENCY TRANSPORT TAXI	N/A	$1.68	$1.76	N/A
HCPCS	A0090	INTEREST ESCORT IN NON ER	N/A	$0.28	$0.29	N/A
HCPCS	T2001	N-ET; PATIENT ATTEND/ESCORT	N/A	$0.58	$0.61	N/A
Dental	D1120	DENTAL PROPHYLAXIS CHILD	N/A	$31.18	$32.64	N/A
Dental	D2392	POST 2 SRFC RESINBASED CMPST	N/A	$72.39	$75.78	N/A
Dental	D0150	COMPREHENSVE ORAL EVALUATION	N/A	$34.25	$35.85	N/A
Dental	D2930	PREFAB STNLSS STEEL CRWN PRI	N/A	$116.46	$121.91	N/A
Dental	D1208	TOPICAL APPLICATION FLUORIDE	N/A	$17.81	$18.64	N/A

Note: Procedural codes reported include the most common procedural codes, according to the 2022 New Mexico Provider Rate Study. Procedural codes that do not have a comparable procedural code covered by Medicare are listed as N/A

Sources: LFC analysis of HSD Provider Rate Survey, fee-for-service provider rate data, and CMS published Medicare rates

Appendix D. – Blue Cross Blue Sheild Physical Health Provider Survey results



Source: LFC analysis of MCO secret shopper report

Appendix E: Medicaid MCO Utilization Data 2019-2022

Physical Health Utilization 2019-2021

Physical Health Utilization (Units per 1,000 Members)

Service Grouping	2019	2020	2021	2022	% Change 2019-2021	2019	2020	2021	2022	% Change 2019-2022
Inpatient (Admissions)	91.5	97.7	81.7	71.0	-22%	$8,446	$10,858	$11,365	$10,132	20%
Inpatient (Days)	397.4	435.4	380.1	323.0	-19%	$1,943	$2,436	$2,442	$2,227	15%
Practitioner / Physician (Services)	7,692.4	7,225.6	6,847.4	6,741.0	-12%	$76	$82	$83	$82	8%
Emergency Department (Visits)	553.3	482.4	413.1	483.7	-13%	$379	$463	$519	$507	34%
Outpatient (Visits)	1,565.3	1,653.6	1,776.6	1,600.2	2%	$274	$277	$261	$275	0%
Pharmacy (Scripts)	4,767.7	4,451.8	4,039.9	4,285.7	-10%	$ 61	$73	$82	$80	2%

Source: Centennial Care Annual Reports, Attachment C

Physical Health Utilization- Expansion Population

Utilization (per 1,000 Members)

Service Grouping	2019	2020	2021	2022	%Change 2019-2022	2019 Cost per Unit	2022 Cost per Unit	% Change Cost per Unit 2019-2022
Inpatient (Admissions)	77.9	80.6	78.3	64.9	-17%	$14,507	$18,182	25%
Inpatient (Days)	775.2	586	601.6	827.6	7%	$1,458	$1,425	-2%
Practitioner / Physician (Services)	8290.4	8195.1	8176	7259.7	-12%	$87	$94	8%
Emergency Department (Visits)	670.8	641.8	580.3	436.9	-21%	$530	$665	25%
Outpatient (Visits)	2219.9	2372.7	2548	2055.2	-7%	$318	$326	3%
Pharmacy (Scripts)	9236.4	8926.5	7847.7	7530.9	-18%	$79	$111	41%

Source: Centennial Care Annual Reports, Attachment C

Behavioral Health Utilization- All Populations

2019-2022

Behavioral Health Utilization (Units per 1,000 Members)

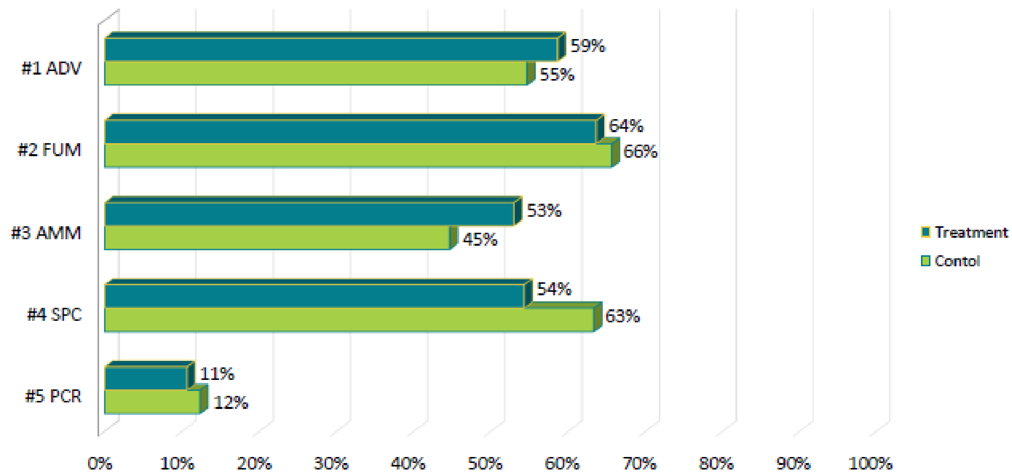
Service Grouping	2019	2020	2021	2022	% Change 2019-2021	2019 Cost per Unit	2020 Cost per Unit	2021 Cost per Unit	2022 Cost per Unit	% Change 2019-2022
Inpatient (Admissions)	36.6	40.1	35.3	35.7	-2%	$527	$742	$626	$546	4%
Inpatient (Days)	78.2	100.1	90.1	79.6	2%	$246	$297	$247	$245	0%
BH Practitioner (Services)	250.7	519.6	706.0	620.1	147%	$129	$163	$168	$157	22%
Core Service Agency (Services)	219.3	291.4	272.6	291.6	33%	$157	$170	$161	$185	18%
BH outpatient / clinic (Services)	3,483.0	3,811.3	3,566.1	3,156.7	-9%	$56	$71	$73	$78	39%
Pharmacy (Scripts)	1,748.7	1,779.2	1,589.4	1,529.1	-13%	$53	$59	$63	$64	21%
Residential Treatment Center (days)	36.7	42.1	38.2	31.2	-18%	$2,916	$3,254	$3,607	$3,482	18%

Source: Centennial Care Annual Reports, Attachment C.

Appendix F: HSD Care Coordination Pilot Outcomes

29

2022 CARE COORDINATION PMs



Source: QB/CCU CC PM Report

Investing for tomorrow, delivering today.

Note:

ADV= Annual dental visit

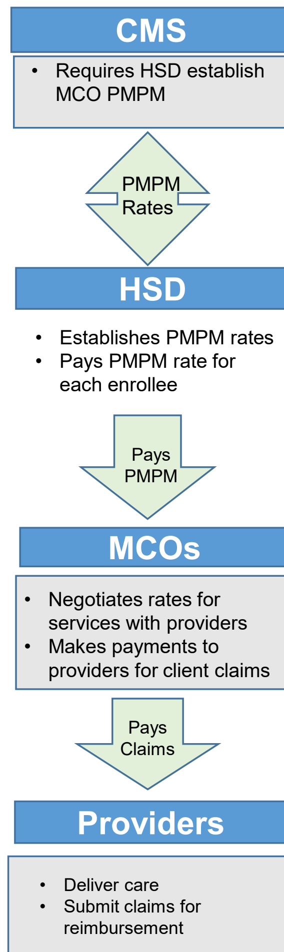
FUM= Follow Up after emergency department visit due to mental health

AMM= Anti-Depressant Medication management

SPC= Statin Therapy for Patients with Cardiovascular Disease

PCR= Plan All-Cause Readmission: the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days

Appendix G: Establishing Medicaid Rates



Note. In this report, LFC did not verify the extent to which MCOs passed on directed provider rate increases.