Medicaid: Access to Healthcare and Evidence-Based Services

The state of New Mexico could significantly improve its behavioral health and physical health outcomes. With nearly half the state enrolled, Medicaid is the greatest lever available to the state to reduce the prevalence of mental illness and substance use disorders and improve physical health measures related to women and children, such as maternal mortality and birth weight. Access to evidence-based services and physical health providers is key to improving these and other population based outcomes. Following recommendations from a fall 2022 LFC evaluation report on access, the Legislature invested significant amounts in the last two years to increase rates paid to providers and to fund startup costs for new services with the goal of improving access.

Added to this mix, the authority established the new Turquoise Care Medicaid managed care program, which established new network adequacy rules from the federal government and strengthened access requirements. While these steps are intended to improve access, the state needs more time to assess the impact. This is the second in a series of planned LegisStat hearings focusing on improving access to quality behavioral health and physical health services. This month's LegisStat is focused primarily on behavioral health.

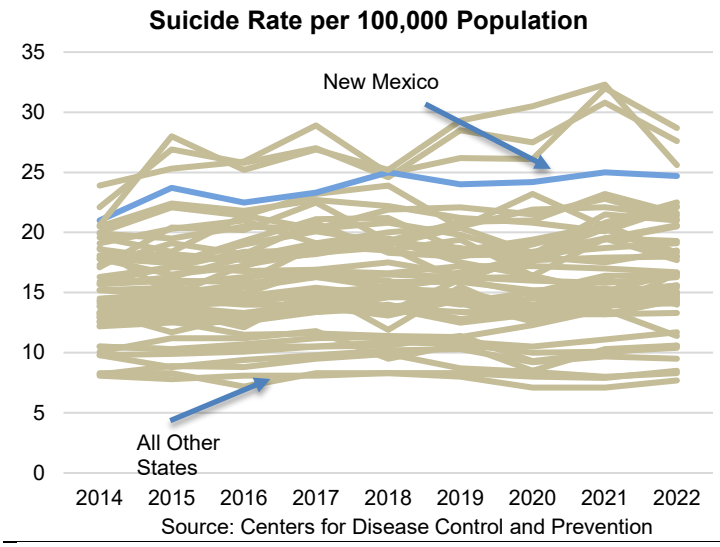
Key Data

2023 New Mexico Health Rankings (Lower Rank is Better)

Behavioral Health				Physical Health		
	Rank	Rate			Rank	Rate
Overall Mental Illness Prevalence, Adults and Children	36			Maternal Mortality	38	31 per 100,000 live births
Adult Substance Use Disorder	32	17%		Low Birth Weight	39	9%
Youth with Major Depressive Episode	42	19%		Neonatal Abstinence Syndrome	41	13 per 1,000 birth hospitalizations
Youth Substance Use Disorder	47	8%		Mortality Rate, Women	49	261 per 100,000 women aged 20-44

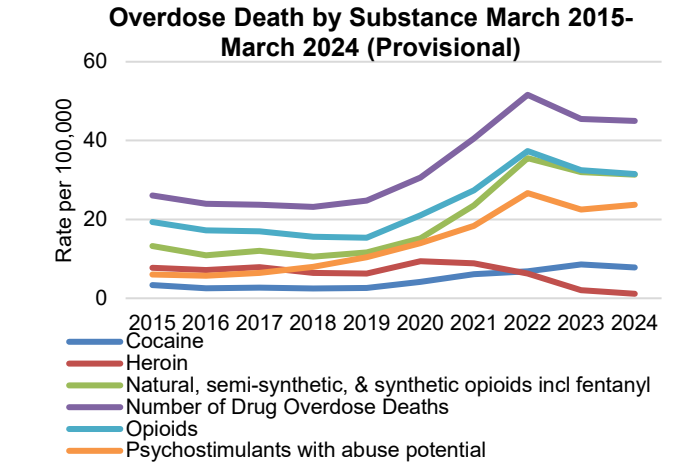
Sources: State of Mental Health in America 2023 and America's Health Rankings

- The state ranks low in key physical health and behavioral health outcomes.
- The state should examine whether evidence-based programs and services are widespread, whether the quality of the training mental health professionals receive is meeting the state's needs, and whether the state could use its workforce more effectively.
- Women's mortality is high; at the national level unintentional injury and maternal mortality are significant contributors.



Source: Centers for Disease Control and Prevention

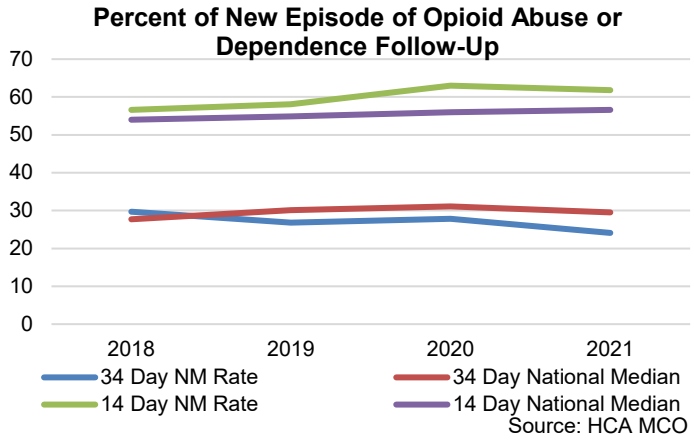
- New Mexico consistently ranked in the worst four states nationally for its high rate of suicides.
- Experts consistently cite mental health disorders (especially depression) substance use disorder, and social isolation as three of the top risk factors for suicide.
- As cited above, the state ranks poorly for substance use disorders and mental illness prevalence.



*The above categories are not mutallly exclusive

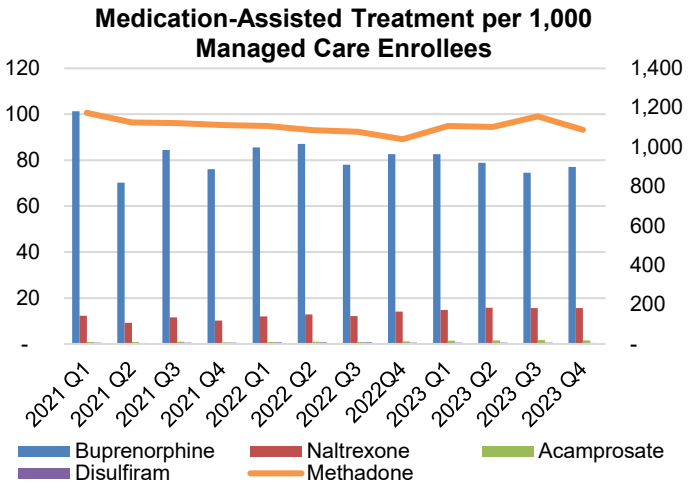
Source: Centers for Disease Control and Prevention

- The state experienced a significant increase in the number of overdose deaths between 2019 and 2022, more than doubling in total, and has not recovered to pre pandemic levels.
- New Mexico would have to prevent 430 overdose deaths to reach pre pandemic rates.
- The most available interventions to address substance use disorder (SUD) include improved access to medication assisted treatment, screening and early intervention, behavioral health integration into primary care, alcohol detoxification and rehabilitation, and telehealth.



Source: HCA MCO

- Managed care organizations perform near the national median in following up with patients after a new diagnosis or episode of substance use disorder.
- The disconnect between follow up and outcomes may be attributable to a lack of access to evidence-based interventions such as medication assisted treatment.



Sources: HCA MCO Reports and CMS Prescription Public Use Files

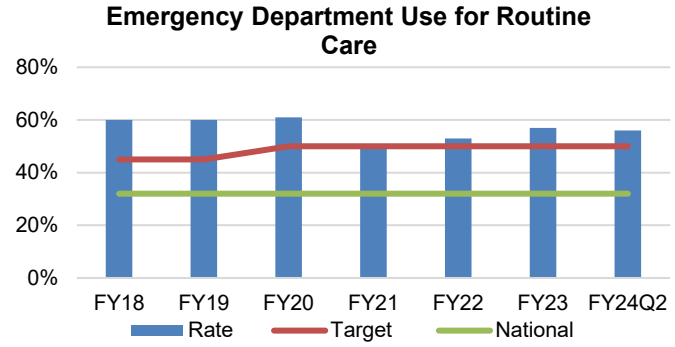
- Among managed care enrollees, medication-assisted treatment utilization remained mostly flat over the last few years, even with increased SUD deaths.
- Acamprosate, naltrexone, and disulfiram for alcohol use disorder remain little used despite being evidence-based interventions.

* Buprenorphine, naltrexone, and methadone treat opioid use disorder. The buprenorphine category includes the injectable Sublocade and the combination naltrexone and buprenorphine drugs Suboxone and Zubsolv. Naltrexone is also used to treat alcohol use disorder along with acamprosate and Disulfiram. All drugs are counted on a per prescription basis except Methadone which is typically administered daily in a clinical setting. A small percentage is suppressed from CMS source files due to privacy requirements for small numbers.

Utilization

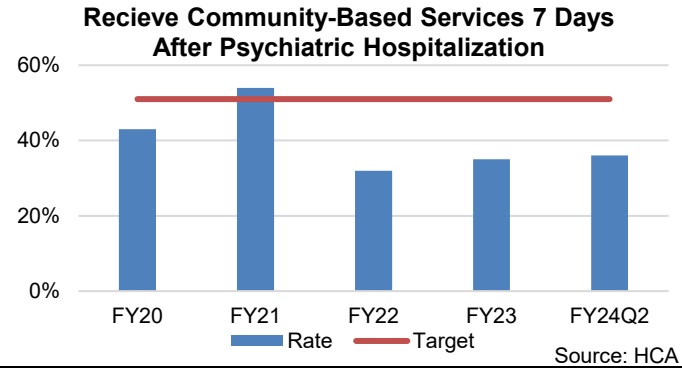
Physical Health Practitioner Visits per 1,000 Members		Behavioral Health Practitioner Visits per 1,000 Members	
2022		2022	
6,741		620	
2019	7,692	2019	250.7

- Without better access measures, utilization can be used to approximate whether Medicaid members are accessing the services the state is paying for.
- However, because the utilization metrics the Health Care Authority tracks are units of service, the state does not know if more or fewer clients are receiving care.
- A fall 2023 Medicaid accountability report found that utilization in key areas of physical and behavioral health have decreased since 2019.



Source: HCA and NIH

- Reducing emergency department (ED) use is important to reduce costs and improve quality.
- Routine care use of the ED may be a sign of a lack of access to primary care.
- New Mexico's rate is significantly higher than the rate cited by the National Institutes of Health.



Source: HCA

- Due to New Mexico's high rates of behavioral health prevalence, the state needs improved follow-up care after an emergency department visit for behavioral health reasons, especially for children.
- Follow-up care after psychiatric hospitalization can improve patient outcomes, reduce the risk of rehospitalization, and lower the overall cost of outpatient care. It can also be critical for suicide prevention during the high-risk period after discharge.

Performance Challenge: Despite Investment, Access to Evidence-Based Services Remains a Challenge

LegisStat Recap

At the last LegisStat on healthcare access on May 15, 2024, the Health Care Authority committed to providing claims data and other types of data so that LFC staff could assess access more thoroughly. As discussed, LFC staff have utilization data but cannot assess where services are used, who is using them, and make recommendations on where the state's money would best be spent. There were also questions about rural healthcare delivery grants, what services the funding was being used for, and whether the services are evidence-based. Members also wanted to know whether the authority was tracking healthcare workforce and access data to distribute the grants to ensure providers establish the right services or expand services in the highest need communities. Other members asked about the status of care coordination, improving services for families with infants exposed to substances, and single credentialing of providers to reduce steps related to becoming a provider in each managed care network.

The Legislature passed significant funding for hospital subsidies, hospital rate adjustments, grants to hospitals for service expansions, and other hospital grants during the 2024 session. However, because significant structural barriers remain, improving access will take more than increasing funding; addressing healthcare workforce shortages, overcoming geographic constraints, improving health insurance coverage rates, and ensuring healthcare services are high-quality and evidence-based.

The authority received administrative expansions for FY25 that will become increasingly crucial due to the demand for enhanced actionable data and the urgency to expedite the development of the long-delayed Medicaid management information system replacement project. This delay and the lack of good data is affecting most of the authority's programs, several other departments, and consequently, the quality of care. Since 2015, the state has spent nearly $200 million on the information technology project and has appropriations to continue spending significantly in the next few years.

Progress

Since the previous LegisStat, the authority has not provided the claims data referenced above and, consequently, LFC analyses on access measures have been limited to summary data. This data is the same data staff have had access to for several years and reported in previous Medicaid accountability reports.

The state's middling ranking nationally for access to physical and behavioral health services is disconnected from its poor showing on many of the outcomes discussed above. For example, New Mexico in 2023 ranked 11th among the states for the number of behavioral health providers per 100 thousand population. While New Mexico's rankings on some behavioral health issues have improved, the state is still in the bottom third of states for the prevalence of most behavioral health concerns. The disconnect may be related to a lack of access to evidence-based behavioral health services.

The lack of data makes it hard to determine the cause. For example, data on the number of visits per 1,000 people on Medicaid does not quantify how many of these visits were by unique patients. A small group of super users could be driving visit counts. There is no way to track whether high acuity diagnoses are driving utilization, what kinds of services people are receiving, and whether the services are evidence-based.

The authority made significant progress with its rural health delivery grant program. However, without better data, it is unclear whether the grants were targeted at the right types of services in the highest need communities. Of the $73 million in planned grants from the Health Care Authority's rural healthcare delivery grants, about $31 million

was allotted to behavioral health services, with allocations including $6 million for substance use disorder, $5.3 million for autism services, $12 million for therapists and other general behavioral health services, and smaller amounts for children's behavioral health and the incarcerated population. Included within these amounts, much of the startup funding, $13.8 million, is going toward personnel costs, such as hiring therapists and clinicians. The grants also cover some of the facility costs of expansion for leased space.

Suggested Questions

Overall access

1. Does the authority have a strategic plan to expand access to evidence-based behavioral health services?
2. What is the authority's plan to improve oversight of managed care organizations?
3. Does Medicaid or the Behavioral Health Collaborative measure the number or percent of clients served through evidence-based practices, prevention services, or high-fidelity wraparound services?

Data Collection

4. What is the authority doing to improve data collection?
    a. When will the authority begin sharing this data with LFC staff?
    b. In the past, claims data was shared with LFC and staff were able to answer many questions related to what kinds of services Medicaid recipients were receiving, utilization, and whether the services billed for were evidence-based. Does the authority plan on providing this data again?

Rural Access and Delivery Grants

5. During the 2023 and 2024 sessions, the Legislature appropriated a total of $126 million for startup costs to expand physical and behavioral services in rural or underserved areas that could then bill Medicaid.
    a. What is the authority doing to ensure these services are evidence-based?
    b. What are the authority's criteria for awarding the grants?
    c. What is the timeline for awarding the grants from the funds appropriated in the 2024 session?
    d. How is the authority deciding how much to award to each entity?
    e. How does the authority determine success with the grants?
    f. What are the performance metrics the authority is using to determine success?
    g. What is the authority doing to ensure the grants do not duplicate services that are already available?
6. What is the plan for using the $20 million appropriated to the Health Care Authority and Children, Youth and Families Department to develop evidence-based services that could then be eligible for Medicaid or federal Families First Prevention Services Act Title IV-E (for starting prevention services) reimbursement?
    a. What is the timeline of the plan?
    b. What are the goals and how is the state going to measure success?
    c. Does the plan include using $20 million for providers' startup costs?

Health Care Delivery and Access Act

7. During the 2024 session, the state enacted the Health Care Delivery and Access Act expected to generate about $1.3 billion in new revenue for the hospitals. Forty percent of the revenue will be linked to performance.
    a. What is the authority doing to ensure this funding does not result in a continued status quo over the next five years?
    b. What are the performance indicators the authority plans to track?
    c. What will determine how the performance-based funding will be distributed?
        i. For example, if a hospital fails to meet three out of seven metrics, will the authority withhold the funding?
        ii. How will the authority ensure the performance metrics hospitals report are quality?
    d. Is the authority going to do anything to ensure that hospitals use the funding to expand access to services?

e. Is the authority going to track whether the funding is staying within the state or going to out-of-state corporations?
f. How will the authority ensure that the funding goes to the hospitals most in need of financial help?

Network Adequacy

8. Each Medicaid managed care organization (MCO) oversees its own network of providers. It is important to ensure each MCO has an adequate network to ensure access to care, quality of care, continuity of care, access to emergency services, and choice and flexibility.
    a. What is the authority doing to ensure MCOs are monitoring the performance of their networks?
    b. Does the authority ensure MCOs are monitoring the quality of care their networks are providing to patients?
    c. How does the authority ensure that MCOs are ensuring that evidence-based services are being provided within their networks?
    d. Does the authority do anything to ensure MCOs conduct regular assessments to ensure ongoing compliance with network adequacy standards.