NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

LegisStat

Priority: Healthcare Access | May 19, 2026

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Medicaid: Access to Healthcare and Evidence-Based Services

Despite investing over $2.4 billion in provider rate increases since 2022 leading to some of the highest rates in the region, there is little data indicating New Mexico's health and behavioral health outcomes are improving, or that access is better today than it was when this LegisStat series began. With about 38 percent of the state enrolled, Medicaid is the greatest lever available to reduce the prevalence of mental illness and substance use disorders and improve physical health for women and children, such as maternal mortality and birth weight. Prior LegisStat hearings raised the question of what the state's healthcare landscape will look like in five years and how progress will be measured. That second question, how progress will be measured, remains unanswered.

During the 2025 session the legislature appropriated $565 million for behavioral health services statewide including $141.7 million for behavioral health reform activities established by the Behavioral Health Reform and Investment Act (BHRIA). These reform efforts include the establishment of the Behavioral Health Executive Committee who meet regularly, identification of behavioral health regions who are developing regional plans, and $20.5 million in early access grants awarded to the regions for medication assisted treatment and residential treatment services. As the first regional plans are submitted, LFC staff are evaluating the plans to provide feedback to the regions.

Key Data

New Mexico Health Rankings — 2025 (Lower Rank is Better)

	2024		2025	
	Rank	Rate	Rank	Rate
Maternal Mortality	30	28 per 100,000 live births	32	28.5 per 100,000 live births (5-yr est.)
Low Birth Weight	43	10%	43	9.7%
Neonatal Abstinence Syndrome	42	13 per 1,000 birth hosp.	44	13.6 per 1,000 birth hosp.
Mortality Rate, Women	49	223 per 100,000 women aged 20-44	48	194.2 per 100,000 women aged 20-44

Sources: America's Health Rankings 2024 and 2025 Annual / Health of Women & Children Reports

- Between 2024 and 2025 the state's rates for maternal mortality, low birth weight, and neonatal abstinence syndrome all stayed relatively unchanged. However, the state's ranking in two of these measures slipped because other states improved.
- The state made progress improving the mortality rate for women and has continued improving this rate over the last several years.

2024 and 2025 New Mexico Behavioral Health Rankings (Lower Rank is Better)

	2024		2025	
	Rank	Rate	Rank	Rate
Overall Mental Illness Prevalence, Adults and Children	44		47	
Adult Substance Use Disorder	49	23%	45	22.3%
Youth with Major Depressive Episode	46	23%	45	21.4%
Youth Substance Use Disorder	51	16%	51	11.3%

Sources: State of Mental Health in America 2024 and 2025

- Between 2024 and 2025 the state's rank in overall mental illness prevalence slipped from 44 to 47.
- The state's ranking improved on adult substance use disorder and youth with major depressive episodes. However, the rates did not change significantly.
- The state still ranks last for youth with a substance use disorder, but the rate improved.

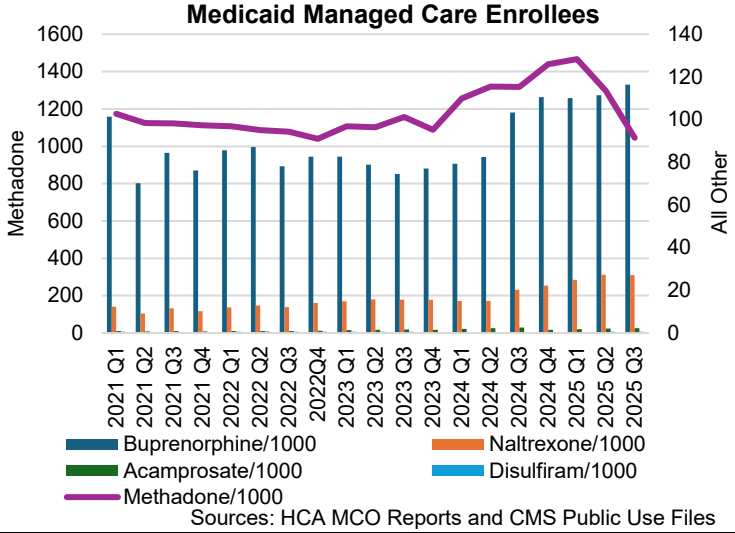
Recent and Upcoming Provider Rate Adjustments (Millions)*

Provider Type	FY24	FY25	FY26	FY27
**Maternal and Child Health and Primary Care	$222.5	$210.3		
***Hospital Rates	$105.9	$39.2	$1,361.4	
Maternal Health Services	$29.6			
Phase III Providers		$42.6		
Prior Year Rate Maintenance		$116.6		
Rural Primary Care Clinics and FQHCs		$9.0		
Medicaid Home Visiting		$6.7		
Birthing Doulas and Lactation Counselors^		$26.0		
Behavioral Health	$31.8	$31.8	$25.9	
Program for All Inclusive Care			$23.7	
Assisted Living Facilities			$11.2	
Personal Care Services				$43.9
Occupational Therapist Rate Parity				$16.2
Nursing Facility Rebasing			$40.2	$39.5
Total	**$389.8**	**$482.2**	**$1,462.4**	**$99.6**

Includes both state funds and federal match funds

- Over the last four years, the Legislature appropriated over $2.4 billion to increase Medicaid provider rates.
- Hospital rates increased, bringing them in line with the average commercial rate, beginning in April 2025.
- Rates for maternal and child health and primary care increased to 150 percent of Medicare.
- Behavioral health provider rates also increased by a total of close to $90 million.

Substance Use Treatments per 1,000 Medicaid Managed Care Enrollees



Sources: HCA MCO Reports and CMS Public Use Files

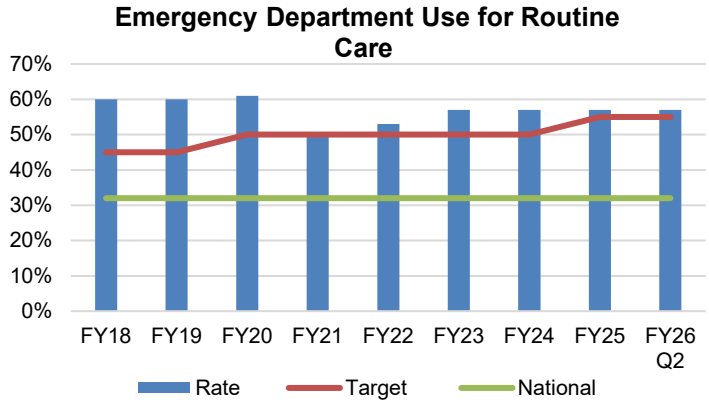
- Among managed care enrollees, medication-assisted treatment utilization started trending higher late in 2024 and continued that trend through late 2025.
- Acamprosate, naltrexone, and disulfiram for alcohol use disorder (AUD) remain little used despite high AUD prevalence rates and being evidence-based 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	
FY24		FY24	
6,956		869	
2019	7,692	2019	250.7

- Utilization of physical health practitioner visits over the last two years has remained relatively unchanged but is still lower than pre-pandemic levels. Behavioral practitioner visits have increased substantially.
- Utilization metrics alone give an incomplete picture, and they only tell us if more services were billed, not whether more Medicaid members are accessing more services.



Source: HSD 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 national rate cited by the National Institutes of Health.

Performance Challenge: Despite Investment, Access to Services Remains a Challenge

LegisStat Recap

During the last LegisStat in June 2025, LFC members asked about how the authority will know whether it is improving the delivery of care, given the passage of the Health Care Delivery and Access Act that greatly increased rates paid to hospitals, and whether the authority is on track to improve services within 5 years given the large investment in rate increases, the rural health delivery fund, behavioral health reform, and other areas. LFC members in past LegisStat hearings wanted to know when the state would see improved workforce retention and better outcomes because of the new rates.

At that time, members were concerned about the not yet passed federal House Resolution 1 which when enacted, made significant changes including phasing out hospital state-directed payments (a type of supplemental hospital provider rate), reducing allowable state taxes on providers, establishing a new work requirement for certain adults, requiring Medicaid co-pays for the first time, changing the eligibility redetermination timeline from once to twice annually, limiting retroactive eligibility, and excluding certain immigrants from the program. These changes will lead to significant new administrative burden for the authority and beneficiaries alike.

Prior LegisStat hearings raised 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.

Progress

Since the previous LegisStat, according to the latest data, appointment access is unchanged from two and a half years ago taking a significant amount of time to schedule a new behavioral health appointment, with the appointments that are offered, exceeding the required wait time. However, medication assisted treatment is trending up, early access grants tied to the BHRIA were awarded, the BHRIA executive committee has been meeting regularly, and BHRIA regions have been identified. The authority also completed a behavioral health needs assessment and LFC published a Medicaid accountability report, a health note on the rural health care delivery fund, and a Medicaid managed care behavioral health evaluation brief.

Yet, three years into the largest Medicaid rate investment in state history, the state does not have the data to determine whether access is improving. Managed care network adequacy reports have now been revamped, and behavioral health spending per member grew significantly between 2021 and 2025 while the state cannot say whether more or fewer clients are receiving more or less care. Whether the investment is working remains an open question, and the state currently lacks the tools to answer it.

What data exists paints an incomplete picture, and it is still too early to draw conclusions. The behavioral health evaluation brief from April 2026, noted that there are fewer Medicaid enrollees using more behavioral health services at a higher cost. Between 2023 and 2025 behavioral health managed care spending increased by 47 percent while utilization increased by 22 percent. The service lines with the greatest increase in spending include applied behavioral analysis (for people with autism), substance use disorder, and community-based services. However, per-member per-month rates paid to the Medicaid managed care organizations increased from about $75 in 2023 to $140 in 2026. This is partly due to the increased rates paid by MCOs to providers but is also due to increased utilization.

The LFC Medicaid accountability report found that spending is up and that outcomes are not improving. An LFC secret shopper survey found that it was just as difficult to get a behavioral health appointment at the time of the survey, as it was two years earlier. The report also found that the state's provider rates are now among the highest in the region with some rates as high as 325 percent higher than rates in surrounding states, including $242.00 per hour for outpatient family therapy. Additionally, it took an average of 14 calls to schedule a new behavioral health appointment and 47 percent of the behavioral health appointments offered exceeded the 10-day standard wait time.

The recent behavioral health needs assessment that the authority completed noted multiple areas for improvement within the state's behavioral health system. For example, the report found that assertive community treatment teams, an evidence-based service for people with serious mental illness, are under-deployed and are largely concentrated in urban areas, leaving many rural areas without access. Additionally, mobile crisis and youth crisis stabilization implementation is incomplete with seven mobile crisis teams operating around the state and zero providers offering mobile response and stabilization services, a youth crisis and stabilization benefit, nearly two years after the federal government approved these services. The assessment also found that crisis triage center capacity is concentrated in urban areas, permanent supportive housing does not meet the need, and that there are 44 patients living in hospitals as their primary residence because nursing facilities will not accept them due to behavioral health concerns.

The recent health note on the rural health care delivery fund (RHCDF), which has received a total of $196 million in appropriations between 2023 and the 2025 1st Special Session, found that providers spend the majority of RHCDF funding on operating costs for staffing which may present a sustainability risk. To be sustainable the new services added because of RHCDF will have to transition from the grant awards to billable services. The health note also found that a lack of standardized outcome measures at the program level resulted in inconsistent, noncomparable data, limiting oversight and making it difficult to assess impact. About $80 million of the appropriated $196 million remains to be spent as of early May, with none of the funding appropriated during the 2025 1st Special Session spent.

Rural Health Care Delivery Fund

	Appropriated	Allocated	Expended	Remaining
2023	$80,000	$8,202	$70,333	$1,465
2024	$46,000	$5,337	$14,590	$26,073
2025	$20,000	$4,817	$12,609	$2,574
2025 1st SS	$50,000	$0	$0	$50,000
Total	**$196,000**	**$18,356**	**$97,532**	**$80,111**

As of 5/4/2026

Source: SHARE

Suggested Questions

Overall Access and Strategy

1. Three years into substantial rate increases — over $2.4 billion across funds — is the authority seeing evidence that access has improved? What measurable outcomes can the authority point to?
2. The Manatt behavioral health needs assessment identified specific service gaps including under-deployed assertive community treatment teams, only seven mobile crisis teams statewide, zero Mobile Response and Stabilization Service providers, and only four adult and one child crisis triage centers. What is the authority's specific plan and timeline to close each of these service gaps?
3. The authority commissioned the Manatt assessment per legislative directive. Which specific recommendations is the authority committing to implement in fiscal year 2027, and what should the Legislature expect to see by the next LegisStat?
4. Does Medicaid or the Behavioral Health Executive Committee measure the number or percent of clients served through evidence-based practices, prevention services, or high-fidelity wraparound services?

Behavioral Health Reform and Investment Act Implementation

1. What is the timeline for all behavioral health regions to submit completed regional plans, and when will the executive committee be able to identify and address gaps across regions?
2. How is the authority ensuring the $20.5 million in early access grants is reaching providers in the regions of greatest need, rather than the regions best positioned to apply?
3. The authority distributed early access grants for medication-assisted treatment and residential treatment services. What measurable access improvements does the authority expect from this funding, and by when?
4. Will the authority track whether early access grant recipients are seeing new patients who previously could not access services, versus simply expanding services for existing patients?

Network Adequacy and Appointment Availability

1. A Legislative Finance Committee secret shopper survey found it took an average of 14 calls to schedule a new behavioral health appointment, with 47 percent of appointments offered exceeding the 10-day standard. What specific steps is the authority taking to address this and how will the authority know whether those steps are working?
2. The state now pays Medicaid behavioral health rates that are higher than every neighboring state and well above Medicare. If rates are no longer constraining access, what is constraining access, and what is the authority doing about it?

Rural Health Care Delivery Fund

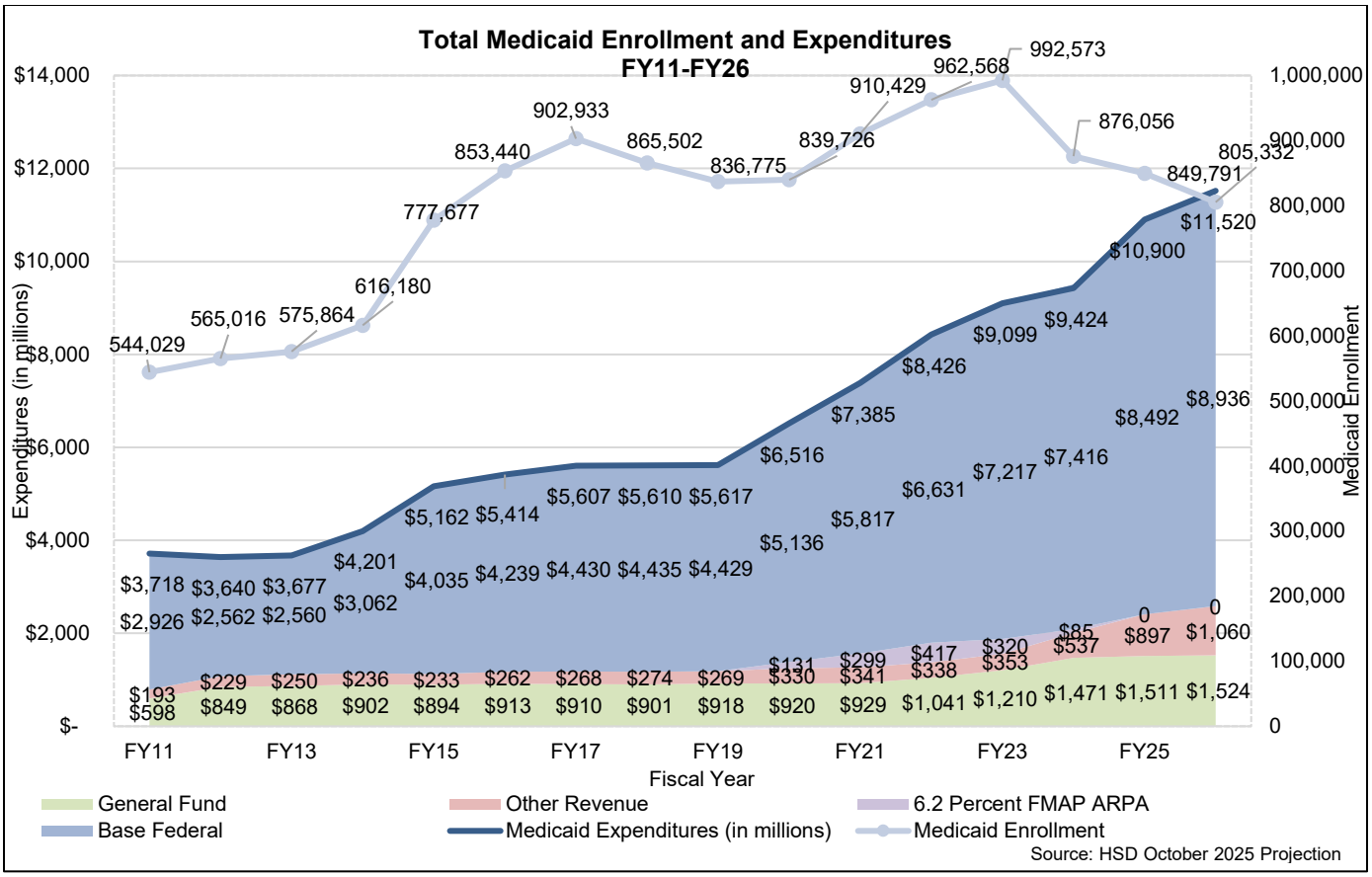
1. The recent Legislative Finance Committee health note found that the program lacks standardized outcome measures at the program level, that providers propose their own goals, and that there is no statistically significant relationship between award size and reported patient encounters. What is the authority's plan to establish program-level outcome measures, and when will those measures be in place?
2. The authority outsourced administration of the rural health care delivery fund to a third-party vendor through a statewide price agreement at roughly $697 thousand annually. What deliverables is the vendor responsible for, and is the authority planning to issue a competitive request for proposals tailored specifically to oversight of this program?
3. In November 2025, the authority issued a request for proposals for independent audit services for the rural health care delivery fund. What is the status of that procurement, when will an auditor be in place, and what is the audit scope and reporting timeline?
4. Funding decisions during the first cycle did not appear to be guided by a comprehensive needs-and-gaps analysis. The 2025 special session expanded eligibility to high-needs geographic Health Professional Shortage Areas. Does the authority now have a needs-and-gaps analysis in hand, and how is it being used to direct the remaining $80 million in unspent funds?

5. Of the $50 million appropriated in the 2025 special session, none has been allocated as of early May. What is the timeline for committing those funds, and how will the authority ensure the new "stabilization" use of the funds doesn't simply backfill existing operations rather than expand access?

Federal Rural Health Transformation Program

1. New Mexico received $211.5 million from the federal Rural Health Transformation Program in December 2025. How will the authority coordinate this funding with the existing rural health care delivery fund to avoid duplication and to maximize impact?
2. What outcome measures will the authority use to track results of the federal Rural Health Transformation Program funding, and will those measures be aligned with the rural health care delivery fund measures so the Legislature can assess both programs side by side?

Appendix


Total Medicaid Enrollment and Expenditures
FY11-FY26
Expenditures (in millions)
Medicaid Enrollment
Fiscal Year
FY11
FY13
FY15
FY17
FY19
FY21
FY23
FY25
General Fund
Other Revenue
6.2 Percent FMAP ARPA
Base Federal
Medicaid Expenditures (in millions)
Medicaid Enrollment
Source: HSD October 2025 Projection

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