

Medicaid Reform in New Mexico: Lessons from the Connecticut Experience

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Medicaid Delivery Models

- MCO: Capitated, risk-based contracts
 - FFS: Direct payment per service
 - ASO: Managed FFS — combines oversight with transparency
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- Connecticut diverged from the national trend by adopting an ASO model in 2012.

Why Connecticut Changed Course

- Access barriers (2006 Mercer 'secret shopper' survey)
- MCO overpayments (2009 Milliman audit)
- Accountability failures and transparency issues
- Bipartisan legislative frustration with system opacity

Implementation Strategy

- In 2012, Connecticut moved all medical services under the non-profit Community Health Network of Connecticut (CHNCT) acting as a sole ASO.
- Cost-Based Contracts: ASO is paid only for actual administrative costs plus an explicit 11% to 12% operating margin, removing incentives to deny care.
- Withholding Mechanism: The state retains 7.5% of quarterly administrative payments, released only if ASOs meet strict quality and provider satisfaction targets.

Financial Outcomes: Medicaid Expenditure Growth

- **Annual Percentage
Change in Medicaid
Expenditure (State Funds)**

Year	Connecticut	USA Average
2007-2008	8.6	3.2
2008-2009	26.2	-3
2009-2010	-7.1	-5
2010-2011	11.9	20.3
2011-2012	5.2	14
2012-2013	2.9	8.1
2013-2014	-39.1	4.4
2014-2015	-7.5	5.5
2015-2016	3.3	3.2
2016-2017	4.7	5.7
2017-2018	19.5	5.3
2018-2019	-3.3	1.7
2019-2020	2.4	0.5
2020-2021	1.8	0.2
2021-2022	2.2	5.4
2022-2023	7.8	14.7

Provider Payment Challenges

- No physician fee increases since 2007
- Specialist rates = 57.5% of Medicare
- CT average Medicaid rate \$163 (among lowest nationally)
- Fiscal control v. network adequacy tension

Access and Quality Improvements

- PCP participation +14.6%, specialists +11.4%
- EPSDT screening ↑ from 52% → 64%
- Pediatric checkups: 73% vs. 54% national avg
- Improved early-stage cancer diagnoses & survival post-2012

Transparency and Accountability

- Medicaid Oversight Council meetings public (CT-N)
- Unified DSS data system
- FOIA access restored
- Performance-linked payments (7.5% withheld quarterly)
 - Should the incentive to develop innovative cost control strategies be higher?

Are the Lessons from Connecticut Relevant to New Mexico?

Comparing Connecticut and New Mexico Population

	Connecticut	New Mexico
Total Population	3,564,000	2,078,200
% Female	50.9%	50.4%
Race/Ethnicity		
% NH White	60.5%	35.0%
% NH Black	9.8%	1.8%
% Hispanic	19.3%	49.3%
% Asian	4.8%	1.9%
% American Indian or Alaska Native	0.1%	8.4%
% Native Hawaiian or Pacific Islander	NA	NA
% Multiple Races	5.6%	3.5%
Age		
Under 18	21.1%	22.3%
18-64	59.5%	57.2%
65+	19.4%	20.5%

Comparing Connecticut and New Mexico Health Insurance

Health Insurance		
% with Private Health Insurance	56.6%	38.6%
% with Medicare	15.0%	16.6%
% Medicaid and private insurance	2.2%	3.3%
% with Medicaid only	15.7%	24.8%
%Dual Eligible (Medicare and Medicaid)	4.3%	5.1%
% Uninsured	5.7%	10.2%
Total Number of People on Medicaid	1,086,000	878,000

Comparing Connecticut and New Mexico Wealth, Spending, and Health

Wealth/Income	Connecticut	New Mexico
Gross State Product (millions)	\$365,723	\$140,542
Median Household Income	\$96,049	\$67,816
Percent Under 100% Federal Poverty Level	10.1%	16.8%
% of low wage workforce (paid less than \$20/hour)⁵	23.1%	40.0%
% of the state's total population estimated to live in a rural area¹	13.8%	24.7%
Health Spending		
Medicaid Expenditures per Capita²	\$8,289	\$8,991
Medicaid Expenditures as a % of Total State Expend.	25%	32%
Health Care Resources		
Hospital Beds per 1000	2.05	1.67
Physicians per 10,000³	36.6	24.2
% of physicians who accept Medicaid⁶	74.2%	91.6%
Health Care Related Outcomes		
% of adults (18+) going without medical care due to cost	9%	10.7%
Rates of premature deaths from preventable and treatable causes⁴	215.7/100,000	379/100,000

Similar Concerns in Connecticut and New Mexico: Access, Transparency, Cost

- "Secret shopper" surveys have confirmed that Medicaid clients face an ongoing access-to-care challenges in New Mexico
- Provider frustration with the credentialing, prior authorization, and billing systems of Medicaid MCOs operating in the state
- Concerns that MCO reporting is insufficiently transparent
 - "...data availability under Turquoise Care... continues to be a challenge" -- 2025 New Mexico Legislative Finance Committee Report

New Mexico Faces a Challenging Policy Environment

- Potential multi-billion-dollar federal cuts via the One Big Beautiful Bill Act (OBBBA) threaten the state's budget and coverage levels
 - 88,530 New Mexicans could lose Medicaid coverage
NM Health Care Authority
- Heightened immigration enforcement has created a "chilling effect," discouraging mixed-status families from accessing benefits

A Transition to an ASO Model Would Require Planning and Infrastructure Building

- New Mexico should follow Connecticut's roadmap by transitioning slowly to an ASO model first
 - The Connecticut transition appears to have happened quickly, but the state had years to prepare
- One possibility would be to follow the Connecticut example and start with behavioral health.

The ASO Approach Would Need to be Adapted to New Mexico's Unique Environment

- To account for extreme regional variation, NM may need to consider regional ASOs to tailor their care management approach to local needs
- New Mexico may wish to establish a state-administered rural provider stabilization fund to preserve volatile rural healthcare markets

Enhancing State Administrative Capacity

- Encourage greater integration of its All-Payer Claims Database (APCD) with the SYNCRONYS Health Information Exchange.
 - Pairing financial claims with clinical outcomes could allow regulators to identify opportunities for greater value in the Medicaid program and better assess the performance of ASOs