NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

2025 Accountability Report

Medicaid

LFC's biennial *Medicaid Accountability Report* is intended to provide a systemwide look at Medicaid program indicators throughout the Health Care Authority and consolidate information on expenditures and health-related outcomes. The trend data indicates that outcomes are mixed compared to what was reported two years ago. Moreover, results of LFC's secret shopper survey indicate continued challenges for New Mexicans seeking new providers for physical and behavioral health.

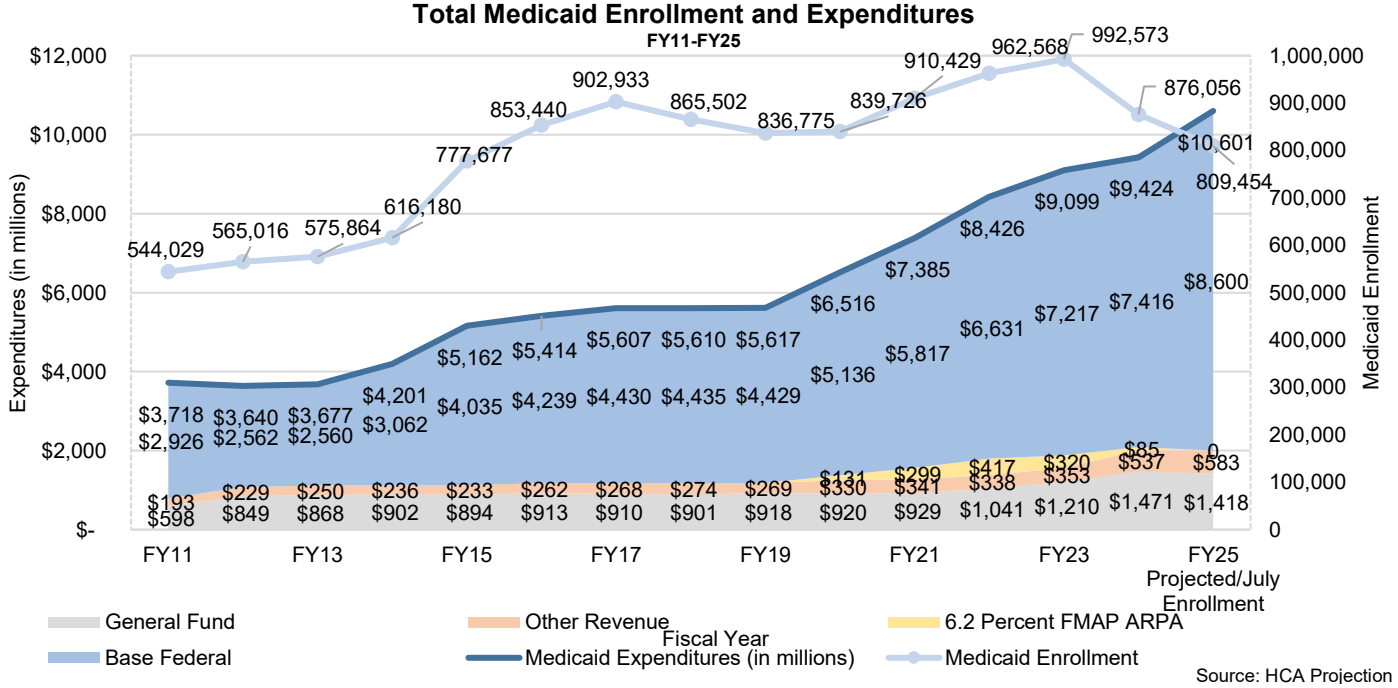
The Health Care Authority (HCA) is serving 31 thousand fewer New Mexicans through Medicaid than it did in 2016 and has nearly doubled total spending, now at $11 billion. Despite these investments, most outcomes on quality, access, and network adequacy have stayed the same or deteriorated. Significant investments include at least $2.2 billion in the past five years for healthcare provider rate adjustments, with the most significant increases scheduled for FY25. The rates adjustments include more than $1 billion for hospitals. However, rate adjustments do not seem to be improving appointment availability; a recent LFC statewide secret shopper survey showed that it is as difficult to get an appointment today as it was two years ago.

In general, this report has three key findings: (1) Despite a significant decline in Medicaid enrollment following the unwinding of relaxed rules during the pandemic-related public health emergency, Medicaid expenditures continue to increase. (2) Outcomes generally remain the same or have worsened since the 2023 Medicaid Accountability Report, despite the large influx of both state and general funds. (3) Data availability under Turquoise Care, the Medicaid managed care program, continues to be a challenge, and the public and LFC staff do not have access to utilization information that was previously available.

Medicaid Program Issues and Impact

- **Costs and Spending.** Per-member per-month costs for both behavioral health and long-term support services have increased significantly.
- **Outcomes and Quality.** Most outcomes have worsened since 2023.
- **Access and Network Adequacy.** Medicaid enrollees have less access than they did three years ago.
- **Utilization.** Increases in utilization are apparent for both physical and behavioral health. Outcomes, however, have not kept pace.
- **Administration.** Administrative aspects of Medicaid—in particular, the implementation of the Medicaid management information system replacement—remain an issue.

Total Medicaid Enrollment and Expenditures



Source: HCA Projection

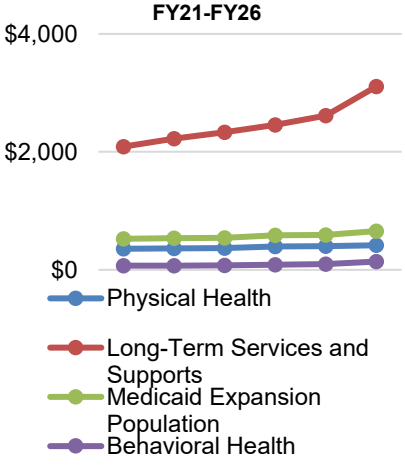
Costs and Spending	Turquoise Care Managed Care Expenditures *(in billions)*		Fee-For-Service Expenditures *(in billions)*		Per-Member Per-Month Cost for Physical and Behavioral Health		Primary Care, Behavioral Health and Maternal/Child Service Rates as a Percent of Medicare	
Enrollment July 2025	FY25		FY25		FY26		FY25	
809,454	**$10.96**		**$0.96**		**$416** **$140**		**150%**	
	FY23	$9.09	FY23	$1.01	FY24	$394 $88	FY24	120%
Source:	HCA Projection		HCA Projection		HCA Projection		HCA	

Table 1. FY26 Projected Medicaid Expenditures by Program
(in thousands)

Physical Health	$2,442,290
Expansion-Physical Health	$2,078,599
Long-Term Support Services	$1,824,898
Fee-for-Service	$959,962
DD Waivers	$1,047,497
Behavioral Health	$577,011
Dual-Eligible	$299,732
Expansion-Behavioral Health	$343,866
Healthcare Delivery and Access Act	$1,649,878
Other	$256,742
Total	**$11,480,475**

Source: HCA Projection

Chart 2. Medicaid MCO PMPM Rates
FY21-FY26



Costs and Spending

Medicaid costs have increased even as enrollment has declined. During the Covid-19 pandemic, New Mexico had the highest per capita enrollment in the country and served over 50 percent of the state's population. Today, Medicaid serves around 38 percent of the population within the state. Since FY23, expenditures for Medicaid managed care—also known as Turquoise Care—have increased from $9.09 billion to $11 billion. Costs are up, in part, because reimbursement rates for primary, behavioral health, and maternal and childcare providers increased in FY25 from 120 percent of Medicare rates to 150 percent. However, as evidenced throughout this report, most outcomes discussed are either worsening or the same—even after the state's increased investment.

Impact

Increased payments to the Medicaid managed care organizations (MCOs) have failed to improve outcomes for managed care members. HCA provides a per-member per-month (PMPM) payment to the four MCOs for the care of those enrolled. This does not include the cost of the state's fee-for-service program, which predominantly serves Indigenous populations. Within the managed care program, the state aims to negotiate MCO contracts with PMPM rates high enough to ensure quality care from providers while 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 within this monthly payment. Since FY21, behavioral health PMPM costs have increased by 97 percent and long-term services and supports (LTSS) PMPM costs have increased by 49 percent. This increase raises concerns, because outcomes have not improved in a meaningful way.

Issues

Between FY24 and FY26, the Legislature invested over $2.2 billion across funds to increase rates paid to providers and provide more funding for startup costs for new services with the goal of improving access for New Mexicans on Medicaid. However, as discussed in the "Access and Network Adequacy" section, the number of behavioral health prescribing providers and the ability of Medicaid enrollees to receive a behavioral health appointment decreased during this period. The federal budget reconciliation bill (Houe Resolution 1) caps hospital provider rates at 100

percent of Medicare rates, with reductions in rates over 100 percent phased in over 10 years. Providers may see reimbursements erode over time as provisions of the budget reconciliation act begin in 2025 but, in aggregate, will still receive higher rates than before.

Focusing on behavioral health, around $90 million in rate increases were approved in the last three years. LFC staff completed analysis of the 20 most used behavioral health codes by Medicaid patients in the state and compared New Mexico's rates to Medicare's rates, as well as to Arizona, Colorado, Oklahoma, and Utah's Medicaid rates. Except for three cases, New Mexico consistently had higher rates than any of the other states—sometimes by significant margins. While some of the comparison rates are close, if not the same, as those offered in New Mexico, some rates are significantly higher in New Mexico. When looking across every state, New Mexico has at least one behavioral health code that is at least 325 percent higher than what the comparison state offers. For example, New Mexico's reimbursement rate of $242 an hour for outpatient family psychotherapy—50 percent higher than Medicare—is up to 325 percent higher than the rates in neighboring states.

Table 3. Comparison of New Mexico Medicaid Reimbursement Rates Above Medicare and Border States for Behavioral Health Service Codes

	Medicare	Arizona	Colorado	Oklahoma	Utah
Minimum	9%	0%	11%	14%	3%
Maximum	84%	256%	225%	211%	325%

Source: LFC Files

Analysis of physical health codes yields similar, although smaller, differences. These findings are due to a greater focus and investment in increasing behavioral health provider's reimbursement rates than in increasing physical health provider's reimbursement rates in New Mexico. Except for one instance, New Mexico consistently had higher reimbursement rates than every comparison group for the 20 most used physical health rates for Medicaid enrollees. While the maximum differences across comparison groups are smaller than in the behavioral health category, there are still significant differences. Ultimately, New Mexico's Medicaid physical health reimbursements are at least 7 percent higher than any comparison and at the most 186 percent higher than neighboring states. As an example, outpatient visits are reimbursed at roughly double the rates compared to Arizona and Utah.

Table 4. Comparison of New Mexico Medicaid Reimbursement Rates to Medicare and Border States for Physical Health Codes

	Medicare	Arizona	Colorado	Oklahoma	Utah
Minimum	10%	36%	29%	62%	7%
Maximum	67%	176%	186%	72%	90%

Source: LFC Files

Finally, the Developmental Disabilities Support Division manages the implementation of both the Mi Via and Developmental Disabilities (DD) waivers, federal permissions that allow the state to provide certain services to the developmentally disabled and medically fragile outside of those traditionally allowed under the Medicaid program. As outlined in the 2024 progress report *Developmental Disabilities and Mi Via Waivers*, the cost of providing services to newly enrolled patients, especially in FY24, exceeded executive and legislative projections. While the difference between the expected cost per client and actual cost per client was relatively small for the Mi Via waiver program, it was relatively

Table 2. Recent and Upcoming Provider Rate Adjustments
(in millions)*

Provider Type	FY24	FY25	FY26
**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
Nursing Facility Rebasing			$40.2
Total	$389.8	$482.2	$1,462.4

* Includes both state funds and federal match funds

** includes $5 million EC trust for maternal and child health

*** FY26 based on FIR for Health Care Delivery and Access Act

^$10.8 million from EC trust

Note: Rates implemented between FY24 and FY26.

Source: LFC Files

large for the DD waiver program, with costs per client up to 39 percent higher than expected. Furthermore, total waiver costs exceeded Medical Assistance Division projections in FY24, with actual costs at $773 million compared with division projections of $733 million. The high cost per client and high total costs are due to a variety of factors, including more clients using high-level services, not enough outside oversight, and participants spending more than budget allotments and service caps. Other potential factors include increases in utilization of services, an aging population, higher needs of waiver recipients, and multiple rate increases.

Table 5. Per Client Actual versus Projected Costs

Traditional DD Waiver Services			
	FY22	**FY23**	**FY24**
Actual	$96,562	$123,407	$115,832
Projection	$72,500	$74,675	$76,915
Difference	25%	39%	34%
Mi Via Waiver Services			
	FY22	**FY23**	**FY24**
Actuals	$58,941	$55,319	$74,149
Projection	$60,000	$61,800	$63,654
Difference	-2%	-12%	14%

Source: LFC analysis of DDSD and LFC data

Additionally, in FY24, DD waiver program participants on average cost the state $115.8 thousand for a full fiscal year, $4,000 above that budgeted by the agency. A similar trend was found for Mi Via. LFC's 2018 program evaluation *Developmental Disabilities and Mi Via Waivers* found that expenditures for new waiver services recipients grew up to 78 percent between the first and second years of service and up to 23 percent between the second and third years of service. Budget projections may be underestimating growth caused by this trend, an important factor given the recent "super" allocation, a significant increase in funding intended to eliminate the waiting list for waiver program services.

Outcomes and Quality	One or More Well-Child Visit Ages 3-21		Newborns Whose Mother Received First Trimester Prenatal Care		Behavioral Health Follow-Up Emergency Department (30 Day)		Diabetes Management: HbA1c Poorly Controlled	
Enrollment July 2025 **297,329** Children, Including CHIP	2024		2024		2025 Q2		2024	
	48%		**77%**		**31.2%**		**44%** (lower is better)	
	FY23	44%	2022	80%	2022	37%	2022	52%
Source:	HCA/HEDIS		HEDIS		HCA		HCA	

Outcomes and Quality

Outcome and quality measures indicates enrollees are experiencing mixed outcomes when compared to two years ago. Only 31.2 percent of New Mexicans on Medicaid who visit the emergency room due to behavioral health needs receive a follow-up within seven days. This is 15.7 percent decrease from 2022. The percent of diabetic enrollees whose HbA1c test of long-term blood sugar indicates poor diabetes management is down to 44 percent from 52 percent in 2022—a 15.4 percent decrease—indicating that outcomes are improving for enrollees with diabetes. Overall, when considering the large increases in spending on Medicaid, outcomes are mixed when compared to 2022.

Healthcare Effectiveness Data and Information Set

HEDIS measures examine outcomes for individuals on Medicaid both within a state and nationally. It is helpful to include the median and the top quartile of HEDIS rates nationally to see if New Mexico is following national trends. HEDIS results have a year lag and are reported in the calendar year following the reporting year. MCOs have reported HEDIS rates for calendar year 2023; however, the state comparisons are not yet available. The 2023 rates are included when reported and can be updated once national statistics are available.

Impact

New Mexico has some of the country's highest prevalence of substance use disorder, and resources likely are not keeping up with demand. According to the annual report published by Mental Health America, New Mexico ranked seventh among all states for the incidence of substance use disorder. While the rates of those receiving follow-up care show improvement through 2021 (especially from 2017 and 2018), rates have leveled off in the most recent reporting periods. The state continues to have a shortage of mental health and substance use treatment providers, as discussed in the "Network Adequacy and Access" section. Since the last *Medicaid Accountability Report* published in 2023, the follow-up rate related to mental illness is higher for children than adults. However, the 30-day rate for children is lower than it was in both 2021 and 2022, 75 percent and 74 percent, respectively.

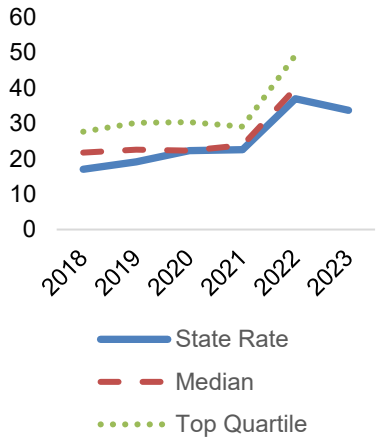
Table 6. Follow up after ER Visit for Mental Illness

All Ages - 2023

Age Range	Mental Illness - 7 Days	Mental Illness - 30 Days
Ages 6-17	51%	64%
Ages 18-64	33%	47%
Ages 64+	34%	48%
Total	53%	38%

Source: CMS compiled Medicaid HEDIS report and MCO HEDIS Reports 2023 measurement year

Chart 3. Percentage of ER Visits for Adult Substance Abuse Follow-Up Visit within 30 Days



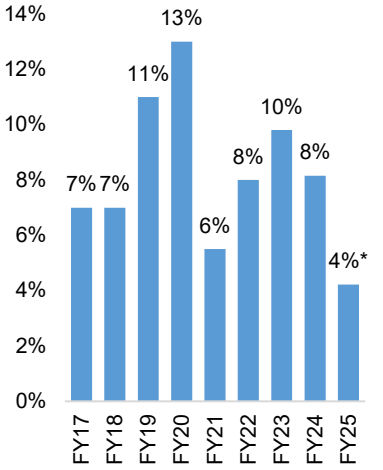
Note: the measure definition changed in 2022, likely causing the increase across the board.

Source: HEDIS

Issues

In 2023, a participant in a Developmental Disabilities Support Division's (DDSD) waiver program died due to abuse. This case led DDSD to perform routine health and wellness checks on all waiver program participants and evaluate the department's current processes to ensure the safety of all people in developmental

Chart 4. ANE Rate for DD and Mi Via Waiver Participants



Source: Report cards and DHI

disabilities waiver programs. Few cases of abuse, neglect, or exploitation (ANE) were found in these first wellness checks, and the state's overall rate of ANE has remained practically unchanged since FY17. In FY25, the rate of ANE for DD and Mi Via waiver program participants dropped from 8 percent in FY24 to 4 percent.

Because the state served 69 percent more waiver program participants in FY24 than in FY17, the effectively flat rate between those two years means almost 400 more waiver participants were subject to ANE in FY24 than in FY17. However, in FY25, the number of waiver participants subject to ANE fell to 344. Despite the decline, the state should continue to monitor the rate of ANE. According to HCA Division of Health Improvement staff, the phone system used for reporting ANE experienced intermittent quality issues in FY25 from July to mid-November—which could have led to the sharp decline in substantiated cases of ANE (note asterisk in Chart 3 and Table 7).

Table 7. Total Cases of Abuse, Neglect and Exploitation, FY22-FY25

	Total Cases	Victims with Substantiated Cases	% Cases Substantiated	Substantiated Abuse Cases
FY25*	1,828*	344	19%	58
FY24	2,409	645	27%	69
FY23	2,256	547	20%	22
FY22	1,701	341	23%	19

Note: * indicates the years that the phone system was offline.

Source: DHI

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	
	2024	2024	2024		2023	
	53.8%*	**52.5%**	**100%**		**78.3%** US-82.1%	
	New Measure	New Measure	2022	99.9%	2022	77%
	* Presbyterian MCO excluded due to lack of sampling for behavioral health.				MCO percentile ranking range from 12th to 40th compared with the nation (higher is better).	
Source:	MCOs	MCOs	MCOs		CAHPS	

Access and Network Adequacy

Results of the 2025 LFC secret shopper indicate continued challenges for New Mexicans seeking new providers for physical and behavioral health. While performance on timeliness for both physical and behavioral health, based on MCO surveys, could be interpreted to be positive, the results for the MCOs' surveys do not match external audit findings. In the 2023 external quality review technical report, Ipro, a research firm, completed a secret shopper audit and found results that varied from the outcomes reported by each MCO. In the Ipro report, overall appointments made for the sample of providers was 29.5 percent (19.1 percent timely) for primary care providers and 3.7 percent (3.4 percent timely) for behavioral health providers. Ipro also found significant numbers of providers that could not be contacted or were no longer practicing at the directory location. MCO data is skewed because unreachable providers are excluded, leading to improved results but results that are unrealistic for enrollees attempting to access care. LFC conducted its own survey, which indicates that accessing appointments for behavioral health is harder than it was in 2023.

Impact

Between 2022 and 2024, the state lost 1,082 prescribing and 427 nonprescribing Medicaid behavioral health providers.. Because of Medicaid's large role in the New Mexico healthcare system, it the greatest lever available to the state to reduce the prevalence of mental illness and substance use disorders, the decline in behavioral health providers is concerning. HCA asserts the cause of the decline is likely the ending of the public health emergency. Cibola County is the only county to see a significant increase in behavioral health prescribing providers, with an increase from 80 in 2022 to 106 in 2024. A vast majority of counties in the state saw a decline in prescribing providers. In addition, while the state experienced an overall decline in nonprescribing behavioral health providers, some counties experienced increases. Research is needed to determine if primary care physicians and other physical health providers are prescribing behavioral health medications and filling the gap.

Table 8. Percent Change in Medicaid Behavioral Health Providers
2022 and 2024

County	Prescribing Providers	Non-Prescribing Providers
Bernalillo	1%	7%
Catron	-36%	0%
Chaves	0%	-4%
Cibola	33%	0%
Colfax	-21%	-16%
Curry	-14%	-28%
De Baca	50%	-40%
Dona Ana	-3%	3%
Eddy	-12%	5%
Grant	5%	1%
Guadalupe	0%	29%
Hidalgo	14%	-57%
Lea	-7%	-21%
Lincoln	4%	-8%
Los Alamos	-11%	64%
Luna	20%	33%
McKinley	-31%	33%
Mora	0%	-60%
Otero	-6%	-4%
Quay	-13%	0%
Rio Arriba	1%	-14%
Roosevelt	-12%	5%
San Juan	-19%	-5%
San Miguel	-20%	-30%
Sandoval	0%	12%
Santa Fe	-3%	2%
Sierra	-9%	13%
Socorro	-28%	-34%
Taos	-1%	9%
Torrance	-42%	-12%
Union	-43%	0%
Valencia	-10%	30%
NM Total	**-4%**	**4%**

Source: HCA

Lack of Healthcare Workforce Data

The lack of quality data regarding the workforce remains a key issue in determining the outcomes of various interventions. The All-Payer Claims Database housed at DOH could be utilized to identify providers who have billed claims either to commercial insurance or Medicaid but population health reports are not publicly available. The New Mexico Healthcare Workforce Committee (created in 2012) creates an annual report that relies on data from the New Mexico Regulation and Licensing Board. Due to a data breach in 2021, data for PCPS, OBGYNs, and Psychiatrists will not be available until 2026. Other initiatives which the Legislature funded, such as the New Mexico Healthcare Workforce Dashboard are currently in development..

Table 9. LFC Secret Shopper 2025 Survey Results

Outcome	Primary Care	Behavioral Health
Provider number not listed or unable to locate provider	4% of calls	14% of calls
Determined provider was inappropriate for primary care or behavioral health care	14% of calls	5% of calls
Could not get through to provider	17% of calls	17% of calls
Left voicemail, call not returned	8% of calls	20% of calls
Left voicemail, call returned, but unable to connect	0% of calls	2% of calls
Provider no longer with office	18% of calls	14% of calls
Provider did not accept Medicaid	2% of calls	1% of calls
Provider not accepting patients at this time	8% of calls	7% of calls
Put on waitlist	3% of .calls	4% of calls
Might be able to schedule appointment after submitting paperwork or initial in person visit	9% of calls	11% of calls
Appointment offered	15% of calls	6% of calls

Source: LFC Secret Shopper Survey, 2025

The 2025 LFC program evaluation *Use and Impact of Endowment Appropriations for Higher Education Nursing, Teacher Education, and Social Work Programs* found that colleges and universities systematically did not fully use state endowment funding intended to grow education program capacity for nursing, social work, and teaching. Focusing on social workers, which could help fill the gap in nonprescribing behavioral health providers, the Legislature funded 39 new endowed faculty positions for social work, but only 13 of those faculty positions were filled. If growth in faculty positions continues, New Mexico should produce more social work positions than it previously did. However, it is unclear what impact this will have on the workforce broadly and increasing nonprescribing behavioral health providers specifically.

Issues

In August 2025, LFC staff completed a secret shopper study for primary care providers and behavioral health professionals. Based on LFC calls, an average patient would typically have to make six to seven calls to book a new patient appointment with a primary care physician and 14 calls to book a new patient appointment with a behavioral health provider. Among the appointments scheduled, 42 percent of primary care physician appointments and 47 percent of behavioral health provider appointments exceeded the standard waiting times (14 days for a primary care physician and 10 days for nonurgent behavioral health). On average, the LFC survey found that primary care physician appointments had an average waiting time of 21 days, and behavioral health had an average waiting time of 11.4 days. The number of appointments exceeding standards increased from the 2023 survey due to the change in the standards required in the new Turquoise Care contracts. Table 9 displays the results for the 2025 LFC secret shopper survey completed in August. Orange indicates the provider's information was either incorrect, not the correct specialty, or could not be contacted. Yellow indicates that LFC was able to contact the provider office, but the provider was no longer practicing at the location or was not accepting patients. Green indicates that the provider was accepting patients eventually, or an appointment was offered.

In the 2025 survey, more primary care providers were able to be located compared to the 2023 LFC survey, but the results found a higher rate of providers who were no longer practicing at the office contacted and providers who required paperwork in advance of scheduling an appointment. The study found a significantly lower rate of providers who were not accepting new patients. Fewer providers were not listed, but a greater proportion of the sample was identified as no longer at the office that was called. The appointment percentage was the same as it was in the study completed two years ago for primary care but decreased for behavioral health by 4 percent.

Passage of SB3 (2025)

The Legislature eliminated the Behavioral Health Collaborative and replaced it with a new Behavioral Health Executive Committee that will be charged with approving new behavioral health regions, reviewing and approving regional plans, establishing funding strategies and structures based on regional plans, monitoring and tracking deliverables and expenditures, and establishing management strategies led by a project manager at the Health Care Authority (HCA). The law also requires the Administrative Office of the Courts to complete sequential intercept mapping—identifying key points where offenders with behavioral health or substance use issues could be diverted from incarceration and connected with services—to improve regional understanding of needs and gaps. LFC, in coordination with HCA, developed an initial set of evaluation guidelines for behavioral health services for adoption and implementation of regional plans. The General Appropriation Act of 2025 includes significant amounts to carry out the provisions of the law, with over $565 million appropriated for behavioral health in nonrecurring funding.

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 Non-Emergency Needs	
	2024		2024		2024		2025 Q4	
	6,956		869		132,035		57%	
	2022	6,741	2022	620.1	2022	184,843	2022	87%
Source:	HCA		HCA		HCA		HCA	

Utilization

Utilization, which measures how often people are using Medicaid services and for what purposes, has increased in almost every area. Utilization has declined only for enrollees using the emergency room for nonemergency needs, a positive trend. However, those individuals might not be receiving the care they need elsewhere; performance on some quality of care measures is worse than it was in 2022. Even if individuals are using Medicaid more, their outcomes, in general, are not improving. Furthermore, while utilization rates grew only slightly or decreased, costs grew substantially from 2022 through March 2025.

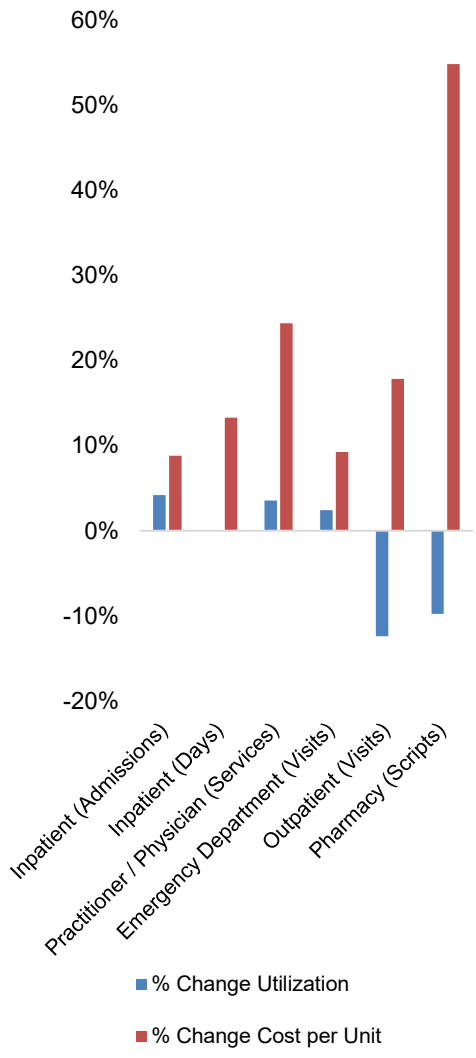
Impact

Under Turquoise Care, the Medical Assistance Division no longer produces public utilization reports on physical and behavioral health. In the transition to Turquoise Care, HCA retired the Centennial Care network adequacy report and created new reporting requirements to measure network adequacy. The 2024 fourth quarter report included a list of all providers in each MCO's network, but each MCO provided the list in a different format. This makes it difficult to analyze the data in the aggregate to compare MCOs and review the overall Medicaid managed care network landscape.

Issues

Importantly, 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. Prior to 2023, HCA discontinued reports that previously shared information about unduplicated client service utilization and costs. 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 behavioral health per-member per-month rate has increased by 97 percent since FY21, from $71 to $140. It is unclear if a few members are utilizing a large amount of behavioral health services or if many members are utilizing fewer behavioral health services. The state needs better reporting mechanisms and information to make informed decisions about Medicaid, the largest component of the state budget.

Chart 5. Physical Health Utilization Percent Change
2022-2025



Source: HCA MCO Utilization Data

Administration	MCO Penalty Fees		MCOs Meeting MLR Threshold (90%)		Medicaid Fraud Control Unit Recovery		Medicaid Fraud Control Unit Criminal Recovery	
	2023		2024		FY24		FY24	
	$34.4 million		**3 of 3**		**$0.02**		**$0.002**	
	2021	No Data	2021	2 of 3	FY23	$0.04	FY23	$0.002
Source:		HCA		MCOs		OIG		OIG

Administration

Administrative oversight of Medicaid includes key tools like IT systems, fraud detection, and recovery, along with implementation of federal requirements by HCA. The state's new IT system is now 12 years in the making and has suffered from delays and cost increases, with total projected costs now over $800 million. In addition, New Mexico's fraud recoveries still suffer from outdated statutes and rank among the worst in the nation. Finally, new requirements emerging from federal budget reconciliation is likely to result in new costs to the state, as well as fewer benefits and fewer beneficiaries.

Impact

HCA is pursuing the Medicaid management information system replacement (MMISR) project, which will replace the 21-year-old legacy monolithic system Omnicaid and will have eight modules that will service all of HCA's programs. Reflecting federal Centers for Medicare and Medicaid Services (CMS) 2011 standards that must be met by states to be eligible for enhanced matching funding, MMISR includes functions for managing the enrollment of Medicaid providers, processing claims, capitation payments, a cross-agency consolidated customer service center, fraud and abuse detection, and tracking foster youth behavioral health services.

The project is part of the federal Health and Human Services 2020 (HHS2020) initiative, which includes 13 assistance programs serving 1.7 million individuals, but delays have impacted MMISR and other related HHS2020 projects. HHS2020 aims to establish an integrated, customer-centric health and human services structure to more effectively deliver health and human services across state agencies, integrating various systems to provide more accurate data and reporting abilities, including the ability to adapt to constant changes in regulations and requirements using modular and integrated design. HCA's and the Children, Youth and Families Department's (CYFD) replacement projects will lay the foundations for HHS2020, helping the state receive federal certification and secure an enhanced federal funding match for Medicaid and child welfare system operations. The HHS2020 effort is intended to create a "one-stop shop" and "no-wrong door" approach to providing state health and human services. However, to receive federal funding, the agencies require federal approval of shared project budget and planning.

The project started in December 2013 with an initial estimated end date of December 2021 and an initial estimated cost of $221.1 million. Total cost has been revised three times since initial estimates and is now estimated at $533.8 million in nonrecurring state and federal funding alone. Considering the estimated cost of

nonrecurring and recurring funding combined, MMISR is expected to cost $832.2 million, as noted in HCA's FY26 funding request. CMS provides a 90 percent federal match, but it is contingent on the state fulfilling federal requirements during the system's implementation. While a majority of the project is financed by a high federal match rate, this translates to the state providing an estimated $53.3 million in general fund revenue just for nonrecurring costs, the largest state information technology investment for a single state agency. The project end date has been revised two times since initial estimates and is now set at January 2027, 14 years after the project started. While MMISR has some functionality, HCA expects the project to be finished sometime before July 2026, with contracts to close out in January 2027 in case additional enhancements to the system are needed after the system is capable of full use.

The current system, Omnicaid, is expensive to maintain and is difficult to adapt to changes in regulations and requirements. HCA states the maintenance of its legacy system is $50 million annually. HCA's Medical Assistance Division (MAD) manages the state's Medicaid services and is the business owner of MMISR. The project's procurement for Omnicaid's replacement is subject to the standards and conditions required by CMS; however, CMS gives states flexibility for individual business-focused modules. The modular approach requires separate procurement for each unique module, which has led to complexity and delays to the overall project.

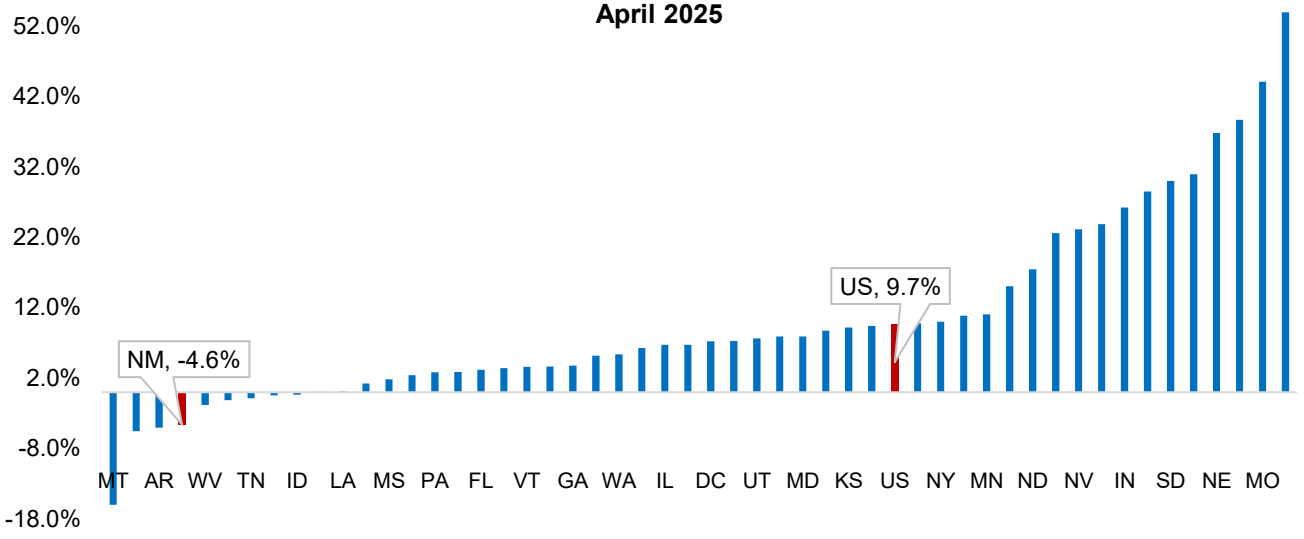
Issues

As outlined in a 2022 progress report, *Medicaid Fraud, Waste, and Abuse Controls,* the Medicaid Fraud Control Unit (MFCU) of the New Mexico Attorney General (NMAG) is not in compliance with the federal False Claims Act. The report further outlined that the Legislature should consider working with HCA and NMAG to pass legislation to bring the state into compliance. The U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) released a report detailing data on case outcomes for MFCU from each state for FY24. The return on investment (ROI) on every grant dollar expended by the NMAG's MCFU returned 2 cents in total recoveries. New Mexico ranks second to last in the country, with only Hawaii with a lower ROI. Further analysis shows that ROI on every grant dollar expended on only criminal cases was 2/10ths of a cent, ranking New Mexico 10th to last. Other than Hawaii, the states who ranked worse than New Mexico in ROI for criminal cases did substantially better for civil cases. NMAG's MCFU had a total of 353 investigations in FY24 with only five total indictments resulting in only two fraud convictions. HHS-OIG oversees, recertifies, and approves federal funding for each MFCU annually. Federal revenue is the primary funding source for the MFCU. General fund appropriations to the program usually do not exceed what is required to secure the 3-to-1 federal Medicaid match rate. If NMAG's performance does not improve, funding could be affected.

Four key sections of the federal budget reconciliation bill will impact both enrollees and providers. The two areas that will affect enrollees are work requirements and changes in eligibility. Adults, ages 19 to 64, who are a part of the "expansion" population (a group added under the Affordable Care Act with incomes between 100 and 138 percent of the federal poverty level) must be enrolled in a "qualifying activity" for up to 80 hours per month. This includes working, going to school, or volunteering. However, certain exemptions, including the enrollee having dependent children under 14 or being considered medically frail, exist. Importantly, if an adult is disenrolled for not meeting the outlined work

requirements, they will not qualify for subsidized marketplace coverage. This will potentially reduce Medicaid enrollment by 83 thousand people. The second impact comes from a provision that requires individuals to reenroll in Medicaid every six months, if they are a part of the expansion population. Both new rules must be implemented by December 31, 2026.

Chart 6. Cumulative Percent Change in Medicaid Enrollment, February 2020 to April 2025



Source: Kaiser Family Foundatio

The Healthcare Delivery and Access Act

The HDAA, initiated by the New Mexico Hospital Association, takes advantage of the multiplier effect of an almost 75 percent federal Medicaid match (FMAP). An assessment on hospitals is pooled and matched 3-to-1 with federal dollars, achieving a $3 revenue impact for every $1 investment. The pooled money is then returned to the hospitals, with 60 percent of dollars returned to the hospitals based on Medicaid service volume and 40 percent based on performance. All hospitals that fall under the act must report certain measures to HCA to determine performance. Ultimately, the bill aims to improve and increase access to healthcare services within the state. However, hospitals that do not have significant of Medicaid service volume will not see much benefit.

Medicaid care providers will be affected in two ways. The first area of impact is the reductions in state directed payments, which are a tool that allows additional payments to providers for specific purposes. This change caps the total payment rate for inpatient hospital and nursing facility services at 100 percent of Medicare. The state Healthcare Delivery and Access Act (HDAA) is the primary state directed payment that will be impacted. Directed payments through the HDAA will be reduced by 10 percent annually until the payments reach 100 percent of Medicare rates. Preliminary estimates indicate that hospital patient revenue will decrease by less than 2 percent annually. The rate cuts will begin in January 2028.

The second area of impact is the rural health transformation program, which will infuse $50 billion into healthcare nationally over a five-year period. The goal is to improve access to hospitals and other healthcare providers, with $10 billion of funding available each fiscal year beginning in FY26 and ending in FY30. Applications were distributed in mid-September. CMS will process the applications in November, and the first distributions are expected by the end of the year. Fifty percent of the grants will be distributed to the states equally, which equates to about $100 million for the state. The other half of the grants will be distributed based on rural population, the proportion of rural health facilities in the state, the situation of certain hospitals in the state, and other. There is no guarantee of awards.

Recent LFC Reports and Briefs on Medicaid

Over the last few years, LFC has produced a number of reports on Medicaid topics.

These reports include:

- Hearing Brief: Rural Healthcare in New Mexico, August 2023
- Hearing Brief: Medicaid Request and Forecast Update, September 2022
- Medicaid Accountability Report, September 2023
- LegisStat: Healthcare Access and Evidence-Based Services, May 2024
- Hearing Brief: Hospital Rates and Accountability, May 2024
- Hearing Bullets: Medicaid Waiver for Prison Reentry Services, August 2024
- Hearing Bullets: Medicaid Network of Providers, September 2024
- LegisStat: Healthcare Access, September 2024
- Staff Presentation: Behavioral Health and Substance Use Treatment Gap Analysis, November 2024
- LegisStat: Access to Health Care and Behavioral Health, June 2025

Appendix A: Secret Shopper Methodology

In August, LFC completed a secret shopper study for PCP providers and behavioral health professionals.

Providers were selected using directory files and extracting data from the insurance company websites. There were difficulties in acquiring clean data from each of the four MCOs. Insurance companies are NOT required to post machine readable files for Medicaid (like they are for other lines of business) however, LFC found that some MCOs were creating them:

- Molina – had a machine-readable complete Medicaid directory file with data as of July 2025.
- BCBS – had a JSON file that appeared to be inaccurate and could not be used – LFC utilized a converted PDF directory file
- Presbyterian – Did not have a file available. Data was scraped from the on-line directory and matched to the National NPI file
- United Health – LFC could not locate a machine readable file for Medicaid providers and scaped data from the on-line directory and matched it to the National NPI file.

The provider lists were matched, and samples were pulled from the list of Primary Care Providers (PCPs) and the list of behavioral health providers. PCP providers were identified as family practitioners, internal medicine, general practice, pediatrics and OBGYNs. Both MDs and nurse practitioners were included. For the behavioral health provider, LFC included psychologists, licensed clinical social workers and counselors.

Providers from across the state as well as out of state providers were included in the samples. The MCO was randomly selected from the list of MCOs that the provider was affiliated with.

LFC staff looked up the provider in the directory to pull the location and phone number. If the provider was not in the directory, LFC staff attempted to find the provider information using a Google search.

MCO provider directories were inaccurate, contributing to barriers in scheduling appointments. MCO provider directories indicate whether a provider is accepting new patients as well as the current phone number and address for the business. In making calls to the sampled providers, LFC staff found inaccuracies in the most recent MCO provider directory information, including:

- 19% of providers in the sample either could not be found in the directory or were determined to be inappropriate for the specialty;
- 17% of all providers could not be reached either because the phone number was incorrect or the call was not answered;
- LFC staff left voice mail messages for 14% of provider and the calls were not returned;
- The audit revealed that for 16% of the calls, the provider had left the office; and
- Compared to the 2023 survey, LFC saw a larger number of appointments that would be offered after completion of either intake paperwork or an intake appointment (10% of providers, with this more common for BH providers).

Appendix B: Rate Comparison Physical Health Table

		NM Medicaid	Compare to Medicare	Compare to AZ	Compare to CO	Compare to OK	Compare to UT
99214	Outpatient visit, established pat, mod complex (30+ min)	$182.19	15%	101%	51%	65%	91%
99213	Outpatient visit, established pat, low complex (20+ min)	$128.92	15%	101%	52%	65%	90%
99284	Emergency Department visit, mod complex	$176.25	31%	73%	69%	67%	92%
99285	Emergency Department visit, high complex	$255.43	11%	73%	65%	67%	92%
99204	Outpatient visit, new pat, mod complex (45+ min)	$238.74	15%	102%	40%	65%	89%
97530	Therapy procedure using functional activities	$51.18	15%	37%	186%	69%	60%
99215	Outpatient visit, established patient (40+ min)	$257.22	15%	101%	55%	66%	92%
99232	Subsequent hospital care (35+ min)	$113.10	28%	70%	74%	65%	89%
99233	Subsequent hospital care, complex (50+ min)	$170.16	11%	70%	74%	66%	91%
99203	Outpatient visit, new patient, low complexity (35+ min)	$158.71	16%	101%	32%	66%	88%
59400	Vaginal delivery, pre- and post-care	$3,555.08	24%	-4%	46%	72%	68%
97110	Therapy procedure w exercise (15 min)	$41.41	12%	38%	29%	63%	54%
92507	Treatment of speech, language, voice, communication, hearing	$108.39	10%	176%	45%	62%	86%
99223	Initial hospital care, complex (75+ min)	$248.42	11%	70%	50%	65%	90%
99291	Critical care, first hour	$390.59	26%	68%	62%	66%	89%
92004	Vision exam, new patient	$207.78	16%	37%	52%	66%	89%
97112	Therapy procedure for nerve-to-muscle function	$47.43	18%	37%	41%	67%	59%
92014	Visual exam, established patient	$175.07	11%	36%	54%	66%	89%
99205	Outpatient visit, complex, new patient (60+ min)	$315.33	20%	102%	61%	65%	89%
99391	Preventive pediatric care, established patient (>1 yr)	$138.34		64%	61%	65%	88%

Appendix C: Rate Comparison Behavioral Health Table

		NM Medicaid	Compare to MDCR	Compare to AZ	Compare to CO	Compare to OK	Compare to UT
90837	Psychotherapy,1 hour	$241.92	13%		77%	72%	55%
97153	Adaptive behavior treatment by technician, 15 min	$30.30			69%	75%	
H0015	Intensive Outpatient (IOP) for adults with SUD	$276.40		75%	49%		
H2015	Comprehensive community support services	$31.62		809%			
H0020	Methadone clinic services	$21.11		232%	30%		130%
S5145	Foster Care Therapeutic Treatment, lvl 1	$428.04		91%			53%
T1026	Mental health assessment	$206.33			-36%		
H0039	Assertive Community Treatment (ACT)	$79.50					
H2033	Multisystem Therapy (MST)	$69.94		75%			
90791	Psychiatric diagnostic eval	$286.60	24%		77%	89%	567%
90834	Psychotherapy, 45 min	$191.37	66%		104%	102%	52%
97151	Behavioral ID assessment by professional, 15 min	$124.83			215%	430%	239%
H2017	Psychosocial rehabilitation, 15 min	$14.73		-6%			117%
97155	Adaptive behavior treatment by professional, established plan, 15 min	$50.26			92%	113%	36%
90832	Psychotherapy w patient, 30 min	$122.71	12%		73%	71%	74%
90847	Family psychotherapy w/out patient, 50 min	$172.86	53%		87%	82%	132%
H0038	Peer support services	$18.25		-3%	137%		-14%
90833	Psychotherapy with E&M, 30 min	$114.77	15%		74%	74%	63%
90846	Family psychotherapy w/out patient, 50 min	$162.89	50%		82%	79%	363%
90853	Group psychotherapy	$44.88	15%	58%	84%	75%	326%