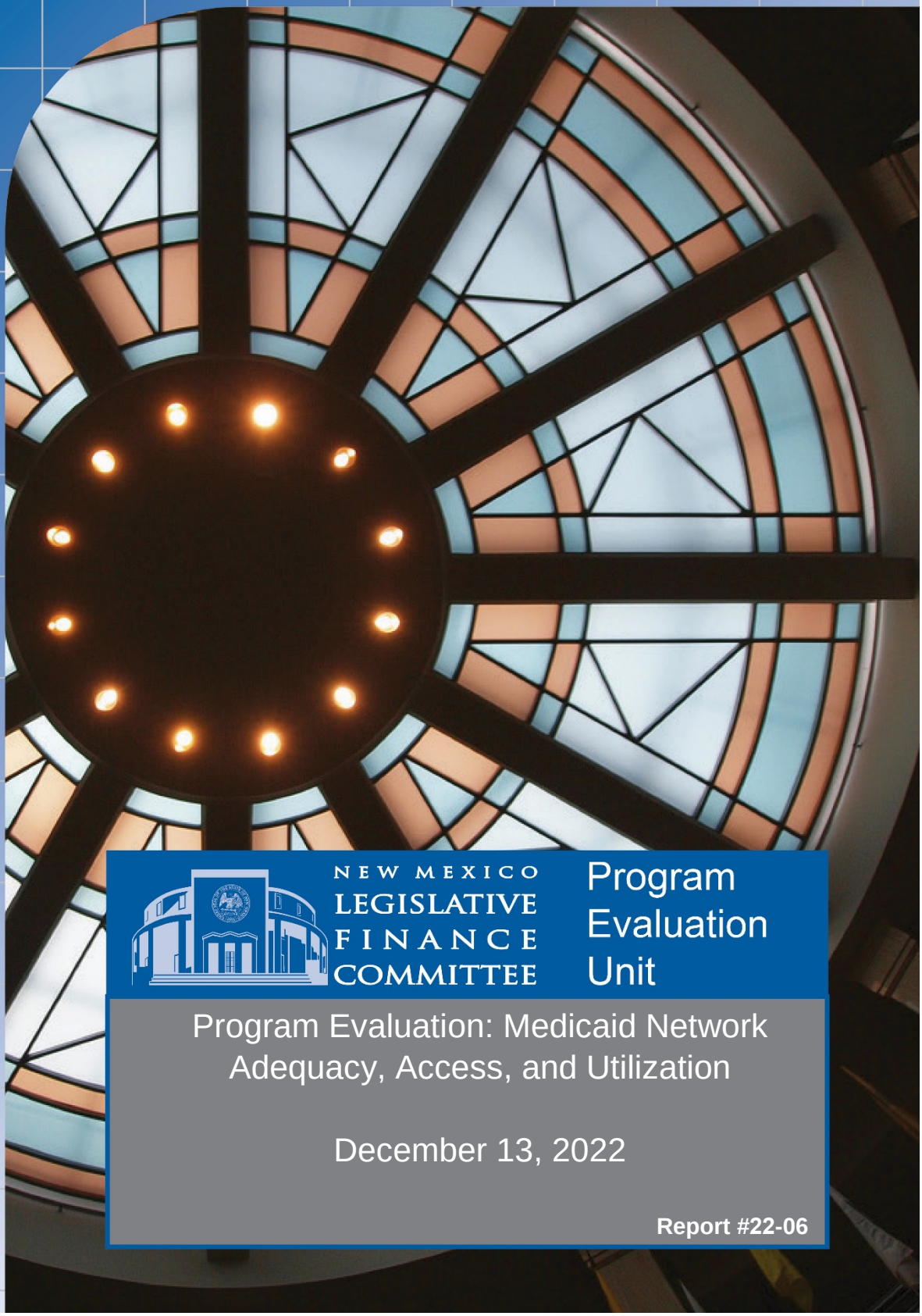

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Program Evaluation Unit

Program Evaluation: Medicaid Network Adequacy, Access, and Utilization

December 13, 2022

Report #22-06

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David Abbey
Director

December 13, 2022

Dr. David, Scrase, Cabinet Secretary
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504

Dear Secretary Scrase:

The Legislative Finance Committee (LFC) is pleased to transmit the evaluation, *Medicaid Access and Utilization.* The program evaluation examined the adequacy of New Mexico's Medicaid provider network, determined potential barriers to service access for Medicaid enrollees, analyzed Medicaid utilization rates, and examined how these relate to program funding and capitation rates. An exit conference was held with you and your staff on December 8, 2022 to discuss the contents of the report.

The report will be presented to the LFC on December 13, 2022. LFC would like plans to address the recommendations within this report from the Human Services within 30 days of the hearing.

I believe this report addresses issues the LFC asked us to review and hope the department will benefit from our efforts. We very much appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

David Abbey, Director

Cc: Representative Patricia A. Lundstrom, Chair, Legislative Finance Committee
Senator George K. Muñoz, Vice-Chair, Legislative Finance Committee
Courtney Kerster, Chief of Staff, Office of the Governor
Debbie Romero, Secretary, Department of Finance and Administration
Brian Colon, State Auditor, Office of the State Auditor
Russ Toal, Superintendent, Office of Superintendent of Insurance

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Medicaid Enrollees Face Significant Barriers Accessing Timely and Adequate Healthcare

New Mexico spends roughly $8.8 billion using state and federal funding on Medicaid, providing healthcare for nearly half of all New Mexicans. Between FY19 and FY23, growth in state spending to provide Medicaid far exceeded growth in enrollment (56 percent versus 16 percent, respectively); yet, the healthcare that Medicaid enrollees actually used remained flat or declined over the same time, with a few exceptions. This is concerning as the significant health challenges experienced by the state's Medicaid population will likely not improve if Medicaid enrollees cannot access the health care they need.

The state's inadequate healthcare provider network continues to be a significant barrier for Medicaid enrollees to access timely care. A Fall 2022 LFC secret shopper survey demonstrated these network shortages, with Medicaid enrollees only able to get an appointment with a primary care or behavioral health care provider 13 percent of the time. The survey also found inaccurate and outdated managed care organization (MCO) provider directories, with one in four providers unreachable and one in six not accepting new patients. MCO secret shopper surveys and consumer satisfaction reports corroborate these challenges in accessing timely health care.

MCO contract standards ensuring an adequate network of healthcare providers are insufficient and should be reexamined. Annual external quality reviews of MCO network adequacy concluded MCOs meet the network adequacy standards set by the state. However, these standards are too weak and have not ensured people can receive timely care from a healthcare provider. Therefore, the state lacks meaningful quality assurance review for network adequacy, despite spending $700 thousand annually.

Strategies to improve access to care include: strengthening and improving quality initiatives and contractual accountability, increasing Medicaid payment rates, and increasing the state's healthcare workforce. While New Mexico requires care coordination in its MCO contracts, the outcomes of the services are uncertain. Additionally, MCO contracts do not include provisions to levy penalties when MCOs fail to meet network adequacy standards. The draft Turquoise Care contracts, which will replace the Centennial Care 2.0 managed care program in 2024, partially address these concerns but could be strengthened.

In part to address Medicaid access concerns in the past, the Legislature has appropriated funds for payments to MCOs with the intention that the MCOs would pass those increases onto providers. A 2022 study of New Mexico's provider rates suggests while most rates Medicaid pays to providers are below Medicare and do not quite meet Human Services Department (HSD) targets, increasing provider rates, particularly in targeted areas, could improve access. However, HSD does not validate the extent state increases to MCO payments translate into increased provider rates. If New Mexico makes additional investments for provider rate increases, the state should verify that MCOs

Evaluation Objectives:

1. *Assess the adequacy of the New Mexico Medicaid provider network and identify potential service gaps;*
2. *Determine potential barriers to service access by Medicaid enrollees including uptake of Medicaid patients and time to treatment;*
3. *Analyze Medicaid utilization rates and examine how these relate to program funding and capitation rates; and*
4. *Identify primary cost drivers contributing to Medicaid expenses.*

implement intended provider rate increases and evaluate the impact on patient access.

As New Mexico needs more providers, and MCOs care for roughly half of New Mexicans, they should be proactive in bringing more providers to the state and creating incentives for providers to serve Medicaid clients. In addition, New Mexico should continue to invest in strategies to increase the overall healthcare workforce, including entering into interstate licensing compacts, investing in medical residencies, growing the number of mid-level providers, and expanding loan forgiveness programs.

Key Findings

Medicaid enrollees do not have adequate access to timely healthcare

New Mexico's quality initiatives and contracts need improvement to hold MCOs accountable for improving access to care

Increasing select Medicaid payment rates may help address access to care

To improve timely access to care, the state needs to invest in provider recruitment and retention strategies

Key Recommendations

The Legislature should consider:

- Appropriating funds for provider rate increases to bring Medicaid rates to parity with Medicare and provide additional targeted increases, including for primary care, behavioral health, and maternal and child health; and
- Enacting legislation to allow for New Mexico to enter into medical, psychology, counseling, and social work compacts.

Human Services Department should:

- Develop a comprehensive statewide network adequacy assessment and report to the Legislature annually about adequacy of the state's Medicaid provider network;
- Direct MCOs to enact targeted provider rate increases, monitor MCO rates to ensure intended provider rate increases are passed on, evaluate and report outcomes and impact to the Legislature;
- Ensure it keeps provisions in the Turquoise Care contract that include requiring quarterly secret shopper surveys with representative samples, specific penalties around network adequacy and nonemergency medical transportation; and
- Strengthen primary care provider ratios in MCO contracts to bring closer to current ratios and consider variation for urban, rural, and frontier geographies.

The Office of the Superintendent of Insurance should:

- Continue to conduct statewide assessments of network adequacy and, in partnership with the Human Services Department, develop statewide standards for network adequacy and access that take the state's payer mix into account

Background

New Mexico spends roughly $8.8 billion on the state's Medicaid program, which serves half the population. Because of the magnitude of this investment, and the critical healthcare needs of New Mexicans, the state has a significant interest to ensure this program leads to improved health outcomes.

Medicaid, created by Title XIX of the Social Security Act in 1965 to provide health insurance for families receiving welfare, is a federal-state-funded program for financing health services for low-income groups. New Mexico's Medicaid program aims to provide efficient and effective health care services to vulnerable New Mexicans. Every state operates a Medicaid program and is held responsible for setting the eligibility criteria for applicants and the scope of health services covered, setting provider rates, processing claims, and paying for a portion of the total program.

In 1998, New Mexico moved its Medicaid program from a fee-for-service approach to a managed care model for most recipients to improve their health status and contain costs. Managed care attempts to provide appropriate health care services cost-efficiently by paying managed care organizations (MCOs) a per-member-per-month rate (PMPM) to provide covered healthcare services for enrollees. The state's current managed care program is called Centennial Care 2.0. The goals of Centennial Care 2.0 include:

- Assuring Medicaid members receive the right amount of care, delivered at the right time, in the right setting;
- Ensuring care and services provided are measured in terms of quality and not solely by quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without inappropriate reductions in benefits, eligibility, or provider rates; and
- Streamlining and modernizing the Medicaid program.

The state's Medicaid population has grown over time, and nearly half (47 percent) of the state's population participates in the program. Furthermore, Medicaid covered an estimated 77 percent of births in 2021. Yet, the state continues to face poor health outcomes overall. The large share of births covered by Medicaid signals a heightened need to ensure this vulnerable population receives appropriate care.

Medicaid Key Terms

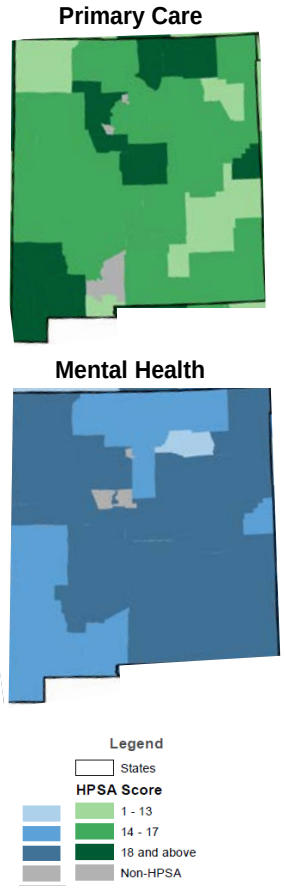
- **PMPM payment** – a monthly fixed payment by the Human Services Department to managed care organizations (MCOs) on behalf of each Medicaid beneficiary.
- **Centers for Medicare and Medicaid Services (CMS)** – the agency in the federal Department of Health and Human Services (DHHS) with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance (CHIP) programs at the federal level.
- **Managed care organization (MCO)** – entities that serve Medicaid beneficiaries through a network of employed or affiliated providers to provide a specified package of benefits to enrollees in exchange for monthly capitation payments.
- **Per-member, per-month (PMPM)** –the average per-member, per-month HSD pays to MCOs for enrollee care.

New Mexico ranks below the nation for a number of health outcomes for the general and Medicaid populations and has significant healthcare needs.

Both the state as a whole and the Medicaid population have worse health outcomes than the national average. These poor outcomes highlight the state's need for quality care.

New Mexico is among the bottom 10 states for premature death, mostly related to behavioral health issues. The state has a high rate of avoidable deaths due to suicide (fourth highest in the nation in 2020) and overdose (12th

Figure 1. Most of New Mexico is Designated as a Health Care Shortage Area for Both Primary Care and Mental Health



Note: HPSA Scores are developed for use by the National Health Service Corps to determine priorities for the assignment of clinicians. Scores range from 1 to 25 for primary care and mental health, with higher values indicating better access. The lighter shades have worse rankings compared to the darker. The grey area is the part of the state without healthcare shortages.

Source: HRSA

highest in 2020), highlighting behavioral health as a need in the state. Beyond behavioral health outcomes, the state is ranked 42nd for diabetes prevalence and 36th for the percent of children born with low birth weight. In light of New Mexico's 34th place ranking for preventive clinical care, New Mexico is unlikely to see improved health outcomes without establishing and maintaining a sufficiently strong Medicaid provider network.

New Mexico ranks in the bottom quartile of reporting states on several behavioral health, primary care access, and preventive care Medicaid quality metrics. Each state submits care metrics to the federal Centers for Medicare and Medicaid services (CMS) to assess Medicaid quality. Compared with other states, New Mexico ranks low in behavioral health, primary care access, and preventive care, underscoring these domains as potential challenges for the state (see Appendix B). For example, New Mexico was furthest from the national average in assessing weight and providing counseling for nutrition and physical activity for children and providing medical assistance for tobacco use cessation for adults. Because almost 50 percent of the state is enrolled in Medicaid, examining these health metrics is critical to determining how to improve outcomes.

The federal Health Resources and Services Administration has designated New Mexico a healthcare workforce shortage area, except for small parts of Bernalillo, Los Alamos, and Doña Ana counties. This designation highlights the shortage of providers and the need for New Mexico to recruit and retain the healthcare workforce and provide efficient care with its current resources.

Based on the age of current physicians and other statewide factors, New Mexico is forecast to have the second-highest provider shortage ratio per 100 thousand population in the country by 2030. New Mexico primary care providers are approximately 13 years older than the national median, which could lead to increased shortages as these providers retire. According to the 2021 annual Healthcare Workforce Committee report, the mean age of primary care physicians in the state is 53. This is significantly older than the national median of 40 years as reported by the American Board of Family Medicine and others.

Furthermore, New Mexico has the oldest physician workforce in the nation. Thirty-seven percent of New Mexico's physicians were over 60 years old in 2017 and facing retirement in the next 10 years. To address these workforce challenges, New Mexico has focused on recruiting and creating providers but should also examine retention strategies to keep the current workforce in the state.

Nearly half of all New Mexicans are enrolled in Medicaid.

Under the federal Affordable Care Act (ACA), New Mexico expanded Medicaid in 2014 to include all persons earning less than 138 percent of the federal poverty level (FPL), or $38,304 a year for a family of four in 2022.

Not only has Medicaid eligibility changed over the years, but services covered by Medicaid have also expanded (see Appendix C). For states that approve it, Medicaid can include basic dental care, preventive care, early diagnosis, prescription drugs, and similar services. The federal government allows states to set and adjust their eligibility criteria, the scope of services, and the rate of payment while following broad federal guidelines. However, to receive federal

funding, states must provide base services to certain groups, including those on Temporary Assistance for Needy Families and others.

New Mexico's health insurance payer mix is notably different from most states. In 2020, American Community Survey data showed New Mexico had the second-highest share of Medicaid patients within the state's payer mix. As such, Medicaid may influence provider income more heavily than in other states.

Overall Medicaid enrollment grew 16 percent during the pandemic and is projected to remain 9 percent higher than pre-pandemic levels after the anticipated end of the federal public health emergency. During the Covid-19 pandemic public health emergency (PHE), states are required to provide continuous enrollment and cannot dis-enroll people from coverage, except under limited circumstances. As a result, enrollment has increased significantly since 2020, and enrollment in the managed care program has grown 19 percent. During the PHE, the federal government increased the federal medical assistance percentage (the federal matching rate or FMAP) by 6.2 percent, lessening the need for general fund revenue to support increased spending.

During the pandemic, overall Medicaid enrollment grew. Between FY19 and FY23, Medicaid's average monthly enrollment is projected to grow from approximately 837 thousand to 966 thousand. In addition to the PHE, low workforce participation and growth in a few programs serving newborn, mother, and elderly populations has driven Medicaid enrollment growth, the Human Services Department (HSD) reports.

The federal PHE was expected to end in January 2023, with the roll-off of financially ineligible maintenance of effort (MOE) individuals beginning in February 2023. However, as of the first week of December 2022, the U.S. Department of Health and Human Services had not provided the 60-day notice they committed to provide when the PHE ends, suggesting the department may extend the PHE an additional quarter, which will impact the projections in this report.

Between FY19 and FY23, Medicaid expenditures are projected to grow by 56 percent. These expenditures are HSD's costs. Costs are primarily driven by three factors:

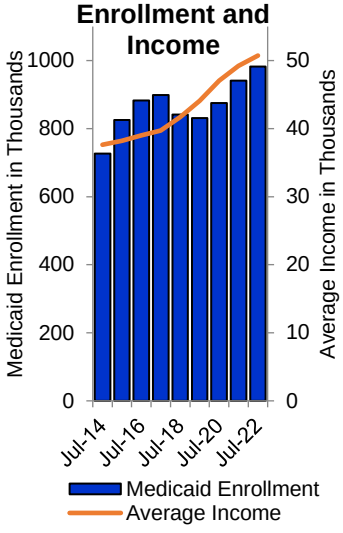
- **Average enrollment** grew by 16 percent between FY19 and FY23
- **Weighted average PMPM rates** grew by 20 and 26 percent between 2019 and 2022. These rate increases assumed provider rate increases. Assumptions about utilization in the PMPM are unknown.
- **Actual utilization** remained relatively flat or declined, with some exceptions in behavioral health

Source: HSD October 2022 Projection

As the public health emergency ends, an estimated 88 thousand New Mexicans will lose Medicaid coverage, but may gain other coverage options. Medicaid enrollment is projected to peak in January 2023 around 990 thousand and then decline. Projected enrollment levels are based on the assumption the U.S. Department of Health and Human Services will not renew the public health emergency (PHE) into FY24, marking the end of the additional federal financial relief, along with the maintenance of effort (MOE) requirements that effectively prohibit states from disenrolling existing clients..

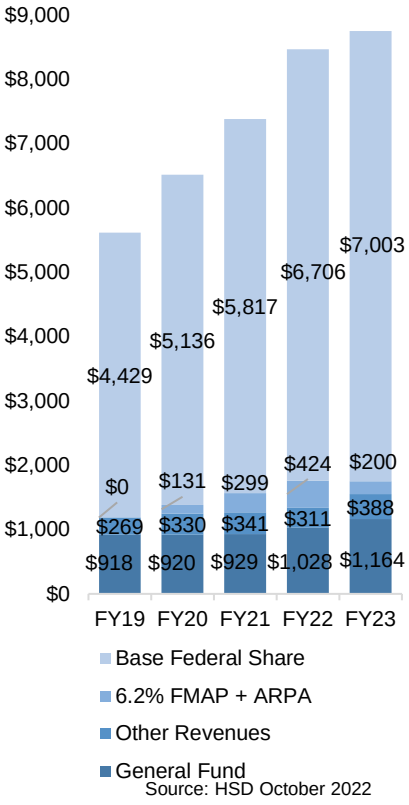
At the end of the PHE the MOE will expire and Medicaid will begin its enrollment unwinding. HSD projects more than 88 thousand people will be ineligible for Medicaid due to income or employment. Approximately 40 thousand of those individuals may be eligible for enrollment on the New Mexico health insurance exchange (NMHIX), beWellnm, and others may transfer to employer coverage.

Chart 1. Total Medicaid Enrollment and Income



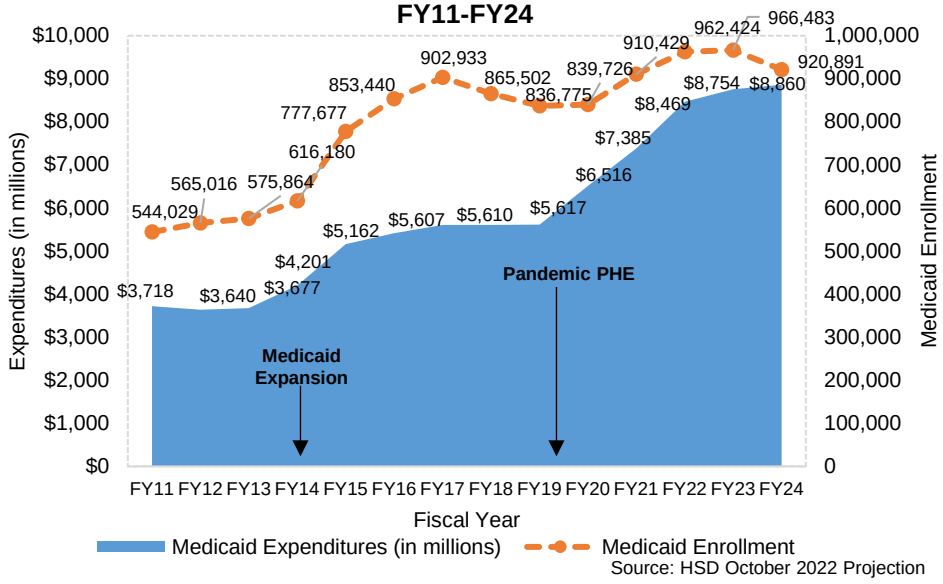
Source: HSD and BBER

Chart 2. Medicaid Revenue FY19-FY23 (in millions)



Source: HSD October 2022

Chart 3. Total Medicaid Enrollment and Expenditures FY11-FY24



Source: HSD October 2022 Projection

Between FY19 and FY23, HSD projects overall Medicaid expenditures will increase by 56 percent, driven by several factors.

Medicaid is the largest healthcare payer in New Mexico, and the state has the largest Medicaid program per capita in the country. Between FY19 and FY23, HSD projects total Medicaid spending to increase approximately 56 percent from $5.6 billion to $8.8 billion. 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 included within HSD rate increases for MCO PMPM. Additionally, the health care quality surcharge and increases to the health insurance premium surtax partially drove PMPM rate increases. Despite these rate increases, the state has not generally seen significant increases in utilization, with some exceptions in behavioral health.

CMS issues federal regulations related to setting PMPM rates according to actuarially sound principles, which include analyzing historical claims and encounter utilization data, to set rates that provide MCOs with sufficient revenue to cover MCO medical and administrative expenditures and avoid any compromises to patient care.[1]

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

Setting PMPM Rates

Within the managed care system, 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 rates that are high enough to ensure quality of care and sufficient providers, while coming as close as possible to actual MCO expenditures to avoid overpayment. Once the PMPM rate is set, HSD is relatively insulated from how much healthcare individuals use care or how much this care costs.

[1] Research from the National Institutes of Health notes that CMS' reliance on encounter and claims utilization data when setting base capitation rates may conflict with efforts to reform payment systems by preserving a reliance on fee-for-service incentives. One way to reform payment systems is through alternative payment models that are currently being explored through the Primary Care Council, discussed later in this report.

CMS for review and approval, and HSD may adjust PMPM rates during the year within limits established by CMS. However, HSD ultimately sets the exact PMPM rates. Previous LFC evaluations and Health Notes reported HSD had been selecting rates at the mid-point of the range recommended by Mercer, though HSD reports PMPM rates are now set lower in the actuarial range. HSD may make adjustments to PMPM rates during the year, within limits established by CMS.

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. These profits are managed through the terms of the contracts, discussed later in this report.

Since FY19, managed care PMPM rates have increased between 20 percent and 26 percent. For the managed care portion of Medicaid, HSD contracts with MCOs to provide Medicaid services on a prospective at-risk capitated payment basis. HSD pays the contracted MCOs a flat PMPM payment, and the MCO provides all necessary covered services, ideally containing all healthcare costs and managing and coordinating healthcare services within this payment. New Mexico currently contracts with three MCOs under Centennial Care 2.0: Blue Cross Blue Shield, Presbyterian Health Care, and Western Sky Community Care (MCO name have been masked throughout this report).

Even though more people are covered by Medicaid and expenditures have grown, healthcare use is flat or declining, with exceptions in behavioral health and telemedicine.

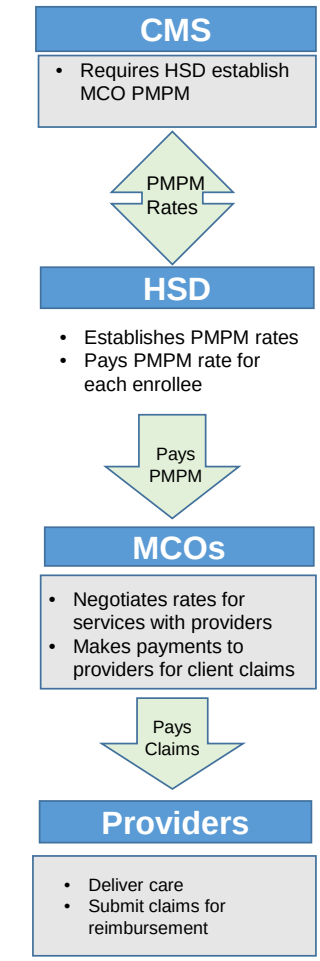
MCOs regularly track and report healthcare utilization data to HSD using standard utilization metrics. A 2020 LFC evaluation of Centennial Care 2.0 found while capitation rates increased between 2017 and 2019, Medicaid enrollees used relatively similar rates of care. Continuing this trend, between 2019 and 2021, utilization of physical healthcare has generally remained flat or declined, likely due to the pandemic. For example, in the physical health program, practitioner and physician services declined from 7,692 per thousand enrollees in 2019 to 6,172 per thousand in 2021. Emergency department visits declined from 553 per thousand enrollees in 2019 to 371 per thousand in 2021. Utilization trends across all three of these categories were mirrored among the adult expansion- physical health population. These trends may have been influenced by the pandemic, because people were dissuaded from accessing care that could be delayed.

Table 1. Physical Health Utilization 2019-2021

Physical Health Utilization (Units per 1,000 Members)				
Service Grouping	**2019**	**2020**	**2021**	**% Change 2019-2021**
Inpatient (Admissions)	91.5	91.6	70.8	-23%
Inpatient (Days)	397.4	408.1	311.5	-22%
Practitioner / Physician	7,692.4	6,706.8	6,529.3	-15%
Emergency Department (Visits)	553.3	408.6	417.3	-25%
Outpatient (Visits)	1,565.3	1,668.2	1,660.9	6%
Pharmacy (Scripts)	4,767.7	4,149.3	4,137.3	-13%

Source: HSD.

Figure 2. Establishing MCO and Provider Rates



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

The State Implemented 988 in July 2022

- 988 aims to be the emergency response system for behavioral health in the same way 911 is for physical health.
- From July through October 28 percent of the calls to 988 were regarding suicide
- Within the 988 roll out the state is planning to expand mobile crisis teams, at a cost of $1.4 million.

Source: BHC quarterly meeting

Telemedicine and the Pandemic

HSD has made permanent provider rate parity that allows Medicaid providers to charge equivalent rates for in-person and telehealth visits. However, infrastructure and broadband needs may impact access.

When the PHE ends, providers will again be subject to CMS regulations that require providers use technology compliant with HIPAA (Health Insurance Portability and Acountability Act) and providers who do not have compliant technology may be impacted. In FY21, the Behavioral Health Services Division made grants to 29 providers, totaling $775 thousand, to support HIPAA-compliant technology investments.

Utilization in behavioral health was less consistent. Within the behavioral health program, utilization in some categories remained flat or declined. However, behavioral health practitioner services doubled from 2019 to 2021.

Table 2. Behavioral Health Utilization- All Populations

Behavioral Health Utilization (Units per 1,000 Members)				
Service Grouping	**2019**	**2020**	**2021**	**% Change 2019-2021**
Inpatient (Admissions)	36.6	36.6	32.8	-10%
Inpatient (Days)	78.2	96.5	77.0	-2%
BH Practitioner (Services)	250.7	532.3	517.1	106%
Core Service Agency (Services)	219.3	304.0	304.3	39%
BH outpatient / clinic (Services)	3,483.0	3,733.2	3,294.4	-5%
Pharmacy (Scripts)	1,748.7	1,748.9	1,591.5	-9%

Source: HSD.

Current reporting by MCOs makes it difficult to disentangle which of many factors may have influenced utilization trends during this time. Factors include expanded needs for behavioral health services during the pandemic, shifts to outpatient models of care and increased telehealth utilization, and increased utilization of behavioral health care among existing patients. During this time, MCOs reported a roughly 10 percent increase in behavioral health providers, however utilization outpaced growth among providers. The state should consider directing MCOs to review behavioral health claims data to better understand the drivers of increased utilization, including the role of telehealth and the services driving increases, and if utilization growth is driven by existing or new patients. (Refer to Appendix D for trends in overall utilization metrics for all physical, behavioral, and long-term healthcare.)

While overall utilization increased in behavioral health, MCOs do not provide reporting about specific service utilization or their outcomes. MCO reporting about behavioral health focuses on high-level roll-ups within broad categories, including in-patient care and pharmaceuticals, while annual Centennial Care reports and the HSD public-facing dashboard tend to also roll-up utilization into broad categories, such as behavioral health encounters or provider services (see Appendix F). Thus, while it is clear that overall behavioral health encounters and behavioral health provider utilization has increased since 2019, the type of services, whether the services are evidence-based, and the outcomes associated with the uptick in utilization are unknown.

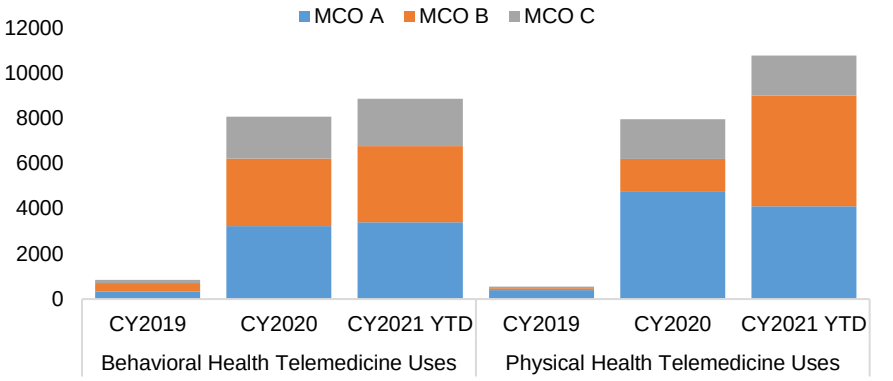
Before Centennial Care 2.0, MCOs were required to provide more information on enrollee utilization for both physical and behavioral health, but HSD removed this utilization reporting in the Centennial Care 2.0 contract negotiations. A lack of reporting on evidence-based therapies has been flagged through program inventories conducted by HSD's Behavioral Health Services Division (BHSD) in the past to meet legislatively mandated requirements. BHSD reports it is are currently implementing new encounter codes to track the utilization of evidence-based services for psychotherapy to include five specific therapies. This utilization data should be available to BHSD beginning in January 2023.

Nationally, the pandemic presented unprecedented disruption to healthcare utilization. According to the *British Medical Journal*, people delayed or avoided primary and preventive care during the pandemic, reducing utilization by roughly one-third. People are now likely experiencing more

acute health needs because of the deferral of preventive care amidst a healthcare system disrupted by Covid-19 and national healthcare workforce shortages, according to the American Hospital Association. Similarly, demand for anxiety, depression, and trauma-related care rose during the pandemic. At the same time, burnout and a shortage within the behavioral health workforce increased, according to a study by the American Psychological Association.

Telemedicine increased 1,700 percent since the start of the Covid-19 pandemic. In 2019, 12 thousand Medicaid enrollees had a telemedicine visit, compared to over 140 thousand in 2020 and 216 thousand in 2021. Increases in telemedicine use were accompanied by increases in providers offering telemedicine services following the pandemic in 2020, with all MCOs reporting increases ranging from 5 percent to 13 percent.

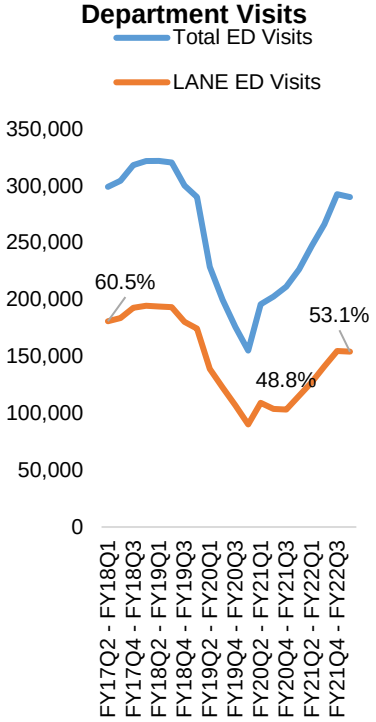
Chart 4. Unique Number of Providers Who Delivered Telemedicine Services CY19-CY21



Source: MCO Telemedicine Reports

Emergency room visits for non-urgent reasons have increased, potentially leading to worse outcomes. In the most recent reporting periods, non-urgent use of the emergency room by New Mexico Medicaid patients increased to 53 percent, higher than the average rate of 37 percent as reported by a meta-analysis published in the *American Journal of Managed Care*. According to the National Institutes of Health (NIH), using hospital emergency rooms for non-urgent reasons may lead to excessive healthcare spending, unnecessary testing and treatment, and weaker patient-primary care provider relationships. These emergency room visits could be avoided through better use of primary and preventative care.

Chart 5. Total Emergency Department (ED) Visits and Low Acuity, Non-Urgent (LANE) Emergency Department Visits



Source: Mercer Non-Emergent Emergency Room Utiilzation Reports June, 2020, to July, 2022

New Mexico managed care contracts set adequacy and access measures at levels that do not ensure timely access to healthcare.

HSD will submit a five-year waiver renewal application to CMS in 2022 for an anticipated effective date of January 1, 2024. The new 1115 demonstration waiver, which renews the state's managed care program, will be effective through December 31, 2028, and is known as Turquoise Care. This renewal creates an opportunity for the state to revise and update adequacy standards and other contractual requirements.

Contracts between HSD and MCOs under the waiver govern program administration and accountability, including program offerings, enrollment procedures, quality assurance and reporting standards, procedures for receiving capitation payments, financial risk-sharing limitations, and how

penalties may be assessed if MCOs do not meet contractual requirements. The contracting process provides an opportunity to update network adequacy standards and increase accountability.

HSD has issued a request for proposals for MCOs that will operate Turquoise Care. HSD submitted an RFP in September 2022 for MCOs interested in administering the Medicaid managed care program. The submission of proposals and review by HSD will occur through the end of 2022. HSD will select MCOs by the beginning of 2023 and will begin onboarding the new MCOs throughout 2023. The new MCOs contracts will be in full effect on January 1, 2024, and will be effective for at least four years, with extensions possible.

Table 3. HSD Managed Care Select Provider Network Adequacy Standards in Centennial Care 2.0

Ratios	
PCP case ratio	1:2,000
Distance Requirements (General Practice) 90 percent of members	
Urban	Within 30 miles
Rural	Within 45 miles
Frontier	Within 60 miles
Select Timeliness Requirements	
Routine Asymptomatic primary care	30 days
Routine Symptomatic primary care	14 days
Urgent Care	24 hours
Behavioral Health Crisis	2 hours
Prescription Fill Time	40 min

Note. See Appendix G for adequacy standards for specialty care.
Source: HSD Quality Strategy

According to federal rule, the state is required to determine and publish provider adequacy standards that MCOs must meet. The Medicaid program measures and evaluates the adequacy of its managed care network using three standards:

- *Provider ratios,* measured by the ratios of providers to Medicaid enrollees according to different standards for various healthcare specialties
- *Distance standards*, measured by the distance enrollees must travel to a provider and dependent on whether the enrollee lives in an urban, rural, or more remote frontier area and the provider specialty;
- *Timeliness*, measured by the amount of time it takes for a Medicaid enrollee to receive a variety of appointment types

In addition, MCOs collect client satisfaction data, which reports Medicaid enrollees' perceptions about their access to care. Together, these measures provide a comprehensive picture of adequacy and access to healthcare available to New Mexico Medicaid enrollees.

HSD stipulates that for general practice providers, 90 percent of urban members travel no more than 30 miles. This distance extends to 45 miles for rural members and 60 miles for frontier members. In addition, primary care providers must not have a member caseload of more than 2,000 per provider. Timeliness standards ensure patients can see a provider quickly when needed and range from care within two hours for a behavioral health crisis to 60 days for routine dental visits. Appointment wait times are required to be assessed by MCOs via a "secret shopper" survey semi-annually and these surveys are submitted to HSD in January and July (see Appendix G for full list of standards). While MCOs must report about specialty care ratios and distances, contracts do not currently establish ratio standards for specialty care.

Currently, New Mexico's managed care programs are generally meeting the contractual obligations for provider ratios and distance requirements though the state experiences shortages in specific specialty areas and rural communities. However, as previous LFC evaluations have noted, provider ratio standards are set too high, based on previous targets and actual provider ratios, and may not reflect access to timely care. Additionally, the current reporting does not take into account how many providers serve multiple MCOs, so the reports could be overestimating the state's total provider network.

HSD contracts for $700 thousand to provide an external audit of Medicaid network adequacy, but this review does not provide meaningful quality assurance. CMS requires states use an external quality review organization to validate state required MCO performance improvement projects, validate state and CMS-required performance measures, and MCO network adequacy and review MCO compliance with state and federal quality standards. The network adequacy component was added in 2016, with the external quality review organization assessing how well MCOs meet the network adequacy standards prescribed by the state. As noted later in this report and in previous LFC reports, these standards need to be strengthened. New Mexico contracts with IPRO, a nonprofit focused on health policy, to perform this external quality review, as well as conducting compliance reviews, a performance improvement project review, performance measure validation review, a nursing facility level of care audit, and supporting reports submitted to CMS. IPRO primarily focuses their network adequacy review on verifying information submitted by MCOs, including reports about provider ratios, distance, and secret shopper surveys conducted by MCOs. The goal of the review is to help determine how to bolster state performance on set quality metrics as measured through the national *Healthcare Effectiveness Data and Information Set* (HEDIS). These reviews must occur annually and be publicly available. HSD publishes the annual review on their website. Because the validation is focused on if the MCOs are meeting state standards, the subsequent report may not be a meaningful picture about access to care if state targets for network adequacy are set too low.

The Office of Superintendent of Insurance, created in 2012, is the state's oversight arm for insurance.

The insurance code gives OSI the power to oversee various types of insurance. OSI funded at $52 million in FY23 with 102 full-time employees, has two bureaus devoted to managed care, including both public and private healthcare, the Managed Health Care and Managed Health Compliance bureaus. According to OSI's 2021 annual report the Managed Health Care bureau assists consumers in appealing matters such as quality of access to care, premium payments, termination of coverage, as well as claims and benefits denials as they are offered under commercially managed healthcare plans..

Medicaid Enrollees do not Have Adequate Access to Timely Healthcare

The United States faces healthcare provider shortages, as a reported 300 thousand healthcare workers nationally left the profession following the Covid-19 pandemic, according to the health care data and analytics firm Definitive Healthcare. As a state, New Mexico has faced a healthcare provider shortage for decades, as noted in LFC reports dating back to 2012. The state has made significant investments that aim to address healthcare shortages. According to the annual New Mexico Health Care Workforce Committee report, the overall number of practicing healthcare providers, including primary care physicians, nurses, and behavioral health providers in the state has generally increased since 2019. However, New Mexico continues to face a shortage, particularly among primary care and behavioral health providers.

While the state faces an overall provider shortage, an inadequate Medicaid provider network currently results in Medicaid clients experiencing significant barriers to accessing timely care. This chapter reviews current network adequacy standards and performance and concludes current ratio standards may not be meaningful, timeliness and patient panel data is not reported consistently, and neither of these measures may be particularly useful as currently reported if patients are unable to access timely care when they need it. Despite spending over $8 billion to provide healthcare for Medicaid enrollees, the LFC secret shopper survey, MCO consumer surveys, and panel data suggest access to timely care is a particularly acute challenge for Medicaid enrollees in New Mexico.

Table 4. LFC Secret Shopper Survey Results of Primary Care Physicians (PCPs)

Top Survey Results	Percent
Provider number not listed or unable to locate provider	21%
Left voicemail, call not returned	8%
Provider no longer with office	8%
Provider not accepting new patients at this time	19%
Appointment offered	15%

Note: See appendix H for full table
Source: LFC Secret Shopper Survey

Table 5. LFC Secret Shopper Survey Results of Behavioral Health Providers

Top Survey Results	Percent
Provider number not listed or unable to locate provider	10%
Left voicemail, call not returned	25%
Provider no longer with office	8%
Provider not accepting new patients at this time	16%
Appointment offered	10%

Note: See appendix H for full table
Source: LFC Secret Shopper Survey

LFC secret shopper surveys led to an appointment only 13 percent of the time.

LFC staff attempted to contact a sample of almost 500 primary care providers (PCP) and behavioral health (BH) Medicaid providers identified through the most recent quarterly network adequacy report through a secret shopper survey to determine appointment availability and wait times for Medicaid enrollees (see Appendix H for survey methodology). Together, LFC staff were able to make an appointment with a PCP or BH provider for 13 percent of providers from the sample. LFC staff found:

- Roughly one in six PCP calls resulted in an appointment;
- One in 10 BH calls resulted in an appointment;
- In half of all calls, LFC staff did not connect with a provider due to wrong phone numbers, inappropriate provider type, or an unreturned voicemail;
- When a provider was reached, 27 percent of PCPs were not accepting new patients or the provider had left the practice. For BH this was 24 percent of the calls.

New patients would typically have to make six to seven phone calls to book an appointment with a PCP and make 10 phone calls to book an appointment with a BH provider.

New patients who are able to connect with a PCP or BH provider often face waiting lists or appointment times exceeding MCO contract requirements. LFC staff were able to schedule appointments with only 15 percent of PCPs and 10 percent of BH providers contacted. Based on LFC calls, an average patient would typically have to make six to seven calls to book a new patient appointment with a PCP and 10 calls to book a new patient appointment with a BH provider. Among the appointments scheduled, 34 percent of PCP appointments and 9 percent of BH provider appointments exceeded 30 days. Centennial Care 2.0 contracts require wait times for routine,

asymptomatic appointments to be less than 30 calendar days. Eight percent of BH providers offered to put LFC staff on a waiting list. Additionally, several BH providers asked LFC staff to instead schedule online or complete intake paperwork before they could schedule an initial visit, sometimes asking the caller to accomplish paperwork tasks by coming in-person. These additional steps could pose a potential barrier for consumers seeking to establish care. For a patient looking for treatment, having to make multiple phone calls just to find a provider who is in their network and accepting new patients can be a distinct barrier to access. This may be particularly true for behavioral health, because there may be stigma attached to looking for and getting treatment, according to a 2014 literature review.

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 for the business. In making calls to nearly 500 sampled providers, LFC staff found inaccuracies in the most recent quarterly MCO provider directories. Inaccuracies in provider directories were found in a previous LFC secret shopper survey conducted in 2016. In this most recent secret shopper exercise, LFC found inaccuracies in the provider directories, including:

- One in six providers listed in the directory as accepting new patients were not accepting new patients;
- One in 12 providers had the wrong phone number listed;
- One in four providers were not listed in the provider directories, did not provide a contact number, or were unreachable.

During the survey timeframe, schedulers for PCPs with University of New Mexico, Optum, and Presbyterian Primary Care informed LFC secret shoppers that no PCP in these practices was currently accepting new patients in Albuquerque. For example, Presbyterian primary care schedulers stated no providers in the Albuquerque practice were accepting new adult patients at the time LFC secret shoppers called.

Other states require provider directories be updated regularly to ensure accurate provider information for enrollees. Inaccuracies in MCO directories present a barrier to care access. In many states, including New York, provider directory lists published by MCOs, as well as state marketplaces, are required to be updated regularly. New York requires, through rule, these lists to be updated every 30 days (with the offline directory updated every quarter), while Colorado and Maryland require their marketplace directories to be updated every other week. This allows enrollees to have more up-to-date information regarding provider status that can improve the user experience when trying to find care. MCO contracts stipulate MCOs must maintain an updated provider directory on their websites that shall be updated daily. The draft Turquoise Care contracts stipulate the MCO will conduct an annual provider directory audit to evaluate the accuracy of information. Because LFC found online provider directories were inaccurate, and because the directories are required to be updated more regularly, HSD should consider requiring MCOs to audit provider directories more frequently, potentially every month. If the state implemented this requirement, enrollees would have a more accurate list when needing care, and the state would have better data about the number of providers.

LFC Secret Shopper Survey vs. MCO Secret Shopper Surveys

MCOs are required to conduct secret shopper surveys annually. The LFC reviewed these surveys and included a summary of results in this report. Notably, MCOs are not required to use a standard methodology; each uses a widely varying sample size, ranging from the entire network to a sample size of one provider. In addition, they exclude providers when an appointment cannot be scheduled.

In contrast, the LFC secret shopper survey aimed to replicate a consumer experience with a representative sample of providers. The LFC survey methodology reports providers that could not be reached and providers for which an appointment could not be scheduled.

UNM, Optum, and Presbyterian Primary Care schedulers informed LFC secret shoppers that no PCP was currently accepting new patients in Albuquerque during the LFC survey timeframe.

IPRO conducted an audit of MCO provider directories in Fall 2022 and found inaccuracies with 17 percent of PCPs and 24 percent of specialty provider information located therein.

MCO contract standards are insufficient, and Medicaid enrollees cannot get timely appointments.

MCO contracts evaluate appointment timeliness in two ways: standards for appointment wait times and consumer satisfaction surveys. MCOs must conduct secret shopper surveys to assess appointment wait times within their provider networks. MCOs also conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which measures a variety of metrics, including consumer perception about getting access to care and getting needed care quickly. Both measures suggest accessing timely appointments in New Mexico is a challenge for Medicaid enrollees. New Mexico should improve their appointment timeliness to be closer to the state standards and should work to improve their CAHPS survey scores to align with the national average.

Overall, current ratio standards are set too high, timeliness and patient panel data are not reported consistently, and neither of these measures may be particularly useful as currently reported if patients are unable to access timely care when they need it. To increase access, the state may need stronger ratio standards for primary care.

Figure 3. Standards for Network Adequacy are Generally Met for Primary Care and Urban Areas but not in Rural Communities or for Behavioral Health

Type of Care	Ratios	Distance	Timeliness
Primary Care	✓	✓	✗*
Specialty Care	N/A	✗*	✗
Behavioral Health	N/A	✗	✗

Note: Timeliness based on overall, for routine appointments, primary care is usually able to meet standards.

Source: LFC analysis of MCO and HSD data

Getting needed care and getting timely care is more of a problem in New Mexico than nationally and is exacerbated for children. Findings from the LFC secret shopper survey converge with other national evidence showing issues accessing care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of Medicaid consumers responding to an assessment of providers and the healthcare system on behalf of their MCOs found New Mexico MCO enrollees generally report lower satisfaction than national averages in the areas of getting care and getting needed care quickly. In 2021, getting care quickly was the lowest scoring measure nationally, the 2021 survey had low response rates. The difference between satisfaction for New Mexico MCOs and that for other MCOs is wider for children than for adults, with generally lower percentile rankings for children, regardless of whether the survey is conducted for the general population of children or children with chronic conditions. These low rankings could be related to the relative lack of providers in the state. Consumer ratings could be reflective of the Covid-19 pandemic's impact on the healthcare system, since national trends indicated sharp declines in healthcare utilization, decreases in hospital admissions and preventative services, and increases in use of telemedicine.

Table 6. MCOs for the General Child Population (General) and Children with Chronic Conditions (CCC) Have Lower Satisfaction with Access to Care in New Mexico than the Nation (national percentile ranking, higher is better)

Question		MCO A	MCO B	MCO C
In the last six months when your child needed care right away, how often did you get care as soon as you needed?	General	21st	32th	12th
	CCC	<5th	18th	48th
In the last six months how often did you get an appointment for your child for routine care as soon as you needed?	General	16th	<5th	<5th
	CCC	<5th	<5th	<5th
In the last six months how often did you get an appointment for your child to see a specialist as soon as you needed?	General	<5th	73rd	57th
	CCC	11th	18th	<5th
In the last six months how often was it easy to get the care, tests, or treatment your child needed?	General	50th	25th	17th
	CCC	10th	12th	<5th

Note: Based on responses of always or usually. See Appendix I for the adult CAHPS survey results.

Source: MCO 2021 CAHPS reports

A lack of timely access potentially results in unmet care. All MCOs are required to conduct their own semi-annual secret shopper surveys of both physical and behavioral health providers and report the results to HSD. The MCOs determine whether providers are meeting timeliness standards.

Table 7. Percent of Providers Compliant with HSD Timeliness Standards by Category (of those providers scheduling appointments)

	MCO A	MCO B	MCO C
Primary Care			
Routine Asymptomatic	72%	32%	75%
Routine Symptomatic	61%	53%	
Urgent	22%	11%	83%
Behavioral Health			
Substance Use Routine	50%	100%	38%
Substance Use Urgent	0%*		31%
Practitioner Routine	60%	63%	13%
Practitioner Urgent	16%	0%	0%

Note: Data for MCO C is from 2020 and for MCOs A and B is for 2021.

Source: MCO secret shopper survey reports

Using the most recently provided data, for an urgent primary care appointment, two of the three MCOs reported significant challenges such that only 1-in-5 providers met the standards for MCO A and 1-in-10 providers met the standards for MCO B, however most providers could schedule an urgent appointment for MCO C. For one MCO, the most recent secret shopper survey had the lowest percent of physical health providers meeting timeliness standards since 2017. Furthermore, for substance abuse providers, for the two MCOs with a sample size greater than one, providers met the timeliness standards less than half the time. Delaying care may lead to worse health outcomes and increased disease progression. According to the United States Health and Human Services department, when patients cannot get access to care due to a provider shortage it can lead to delayed care.

As one MCO had a sample size of only one, HSD should require a representative sample be used for any conclusions regarding compliance with standards. The draft Turquoise Care contracts discussed later in the report include this provision. Two MCOs also could not schedule an urgent behavioral health visit and one could not schedule an urgent substance use visit that meets HSD's current timeliness standards.

MCOs only reported data on those providers scheduling appointments; providers not accepting new patients or who stopped taking Medicaid were not included, potentially leading to inflated compliance rates. Additionally, the future Turquoise Care contract should require all MCOs to consistently collect and report the percentage of providers actively accepting and seeing new patients.

Inconsistent reporting may lead to HSD being unable to fully determine network adequacy and provider satisfaction.

HSD receives regular reports from MCOs regarding provider satisfaction and timeliness metrics, however each MCO writes these reports very differently, making it difficult to assess provider satisfaction or timeliness standards for Medicaid overall.

For instance, with the secret shopper survey reports required of MCOs having these data reported in similar ways can allow HSD to determine the level of compliance regarding time to appointment overall, rather than having to do MCO-specific analyses.

Source: LFC analysis of MCO provider

Table 8. Primary Care Provider to Member Ratios by County Type

MCO	County Type	2019	2020	2021
A	Urban	1:133	1:148	1:149
	Rural	1:60	1:62	1:66
	Frontier	1:47	1:46	1:43
	State	1:80	1:85	1:87
B	Urban	1:284	1:262	1:279
	Rural	1:174	1:167	1:171
	Frontier	1:271	1:269	1:276
	State	1:224	1:212	1:220
C	Urban	1:71	1:77	1:59
	Rural	1:44	1:31	1:23
	Frontier	1:29	1:20	1:15
	State	1:52	1:37	1:32

Source: CY19-21 Q4 MCO Geo-Access Reports

MCOs are meeting current contract standards for primary care providers-to-member ratios, but standards are weak. Primary care providers are the foundation of the provider network and are responsible for providing care and coordinating any necessary referrals. Centennial Care 2.0 contracts currently require each MCO have at least one PCP per every 2,000 enrolled members. New Mexico's three MCOs are having no difficulty meeting the weak contractual requirement of one PCP per every 2,000 enrolled MCO members, though there are differences in provider-to-patient ratios among MCO because MCOs serve varying numbers of enrollees and contract with different numbers of providers. Reporting ratio data by MCO may distort the actual ratio of PCPs to Medicaid enrollees as many doctors take more than one MCO.

PCPs include any provider the MCO has designated, including any of an array of physicians (general practice, family practice, internal medicine, gerontology, obstetrics, gynecology and pediatrics), as well as certified nurse practitioners, certified nurse midwives, physician assistants, and, for particularly complex cases, possibly a specialist. PCPs can also be facility-based, such as primary care teams at a teaching facility, or federally qualified health centers (FQHCs), or rural health centers (RHCs). New Medicaid enrollees have 15 days to select their own PCP; if a member does not select a PCP, the MCO will assign one (with the exception of dual-eligible members who have a Medicare PCP).

Physical Health Service Categories That Did Not Meet Provider Access Standards

- Certified Midwives
- Dermatology
- Endocrinology
- ENT
- RHC
- Hematology/Oncology
- I/T/U
- Neurosurgeons
- Rheumatology
- Urology

Note. See Appendix J for a full list of provider service categories and which categories did not meet standards.

Source: CY21 Q4 MCO Geo-Access Reports

Medicaid patients have to travel long distances to access specialty care in rural and frontier areas, a problem that has continued to persist in New Mexico. Multiple specialty service areas previously identified by the LFC as having limited access to Medicaid enrollees remained with limited access in CY21, including certified midwives, dermatology, endocrinology, hematology/oncology, neurology, neurosurgeons, rheumatology, ear, nose, and throat, urology, assisted living facilities, and transportation. Most behavioral health service areas fail to meet provider ratio and distance standards, including psychologists in rural counties. Physical health specialty services and behavioral health areas failing to meet ratio and distance standards should be monitored, and providers should be recruited to increase patient access.

MCO healthcare access reports could over-estimate the actual number of providers for Medicaid enrollees because providers can contract with multiple MCOs but enrollees can only sign up for one MCO. For example, although MCOs are meeting access standards for neurology, if the state has one neurosurgeon in a rural county and this neurosurgeon contracts with each MCO, each MCO can claim access to one neurosurgeon, but in reality each MCO only has access to a part-time neurosurgeon.HSD should develop a comprehensive statewide network adequacy report that takes into account providers who contract with multiple MCOs.

MCOs are meeting contract standards for travel distance to access PCPs. All Centennial Care MCO contracts include minimum requirements for provider networks to ensure enrollees can access a provider in-network within a reasonable distance from their home. For PCPs the standards state that the

maximum distance requirements for at least 90 percent of enrollees should be no more than 30 miles in urban counties, 45 miles in rural counties, and 60 miles in frontier counties. Overall, MCOs are currently meeting these standards for average distance for enrollees to travel to their nearest PCP. On average, enrollees have to travel 1 to 2 miles to their nearest PCP in urban counties and 6 to 7 miles in frontier counties.

Although MCOs are meeting their basic standards for travel distance to primary healthcare for their members, service gaps remain for specialty care and behavioral health services, particularly in rural and frontier counties. HSD should work with MCOs and healthcare providers to monitor service areas failing to meet standards to recruit providers to areas of need. (See Appendix J for a full list of provider service categories and travel distance standards met.)

Despite HSD spending $700 thousand for external quality review of MCOs, the state lacks meaningful quality assurance for network adequacy because standards are too low. IPRO, the state's contracted external quality review organization (EQRO), uses the state's standards rather than national or provider association benchmarks to assess provider adequacy compliance. As such, if the standards are set too low, a state's provider network may be fully compliant, but patients may still have trouble accessing care when needed. IPRO currently reviews MCO compliance against access standards that are too low and do not meaningfully reflect patient access to care. For a New Mexico MCO to have been fully compliant in 2020 (the most recent available public report), the MCO needed to meet standards at least 90 percent of the time. All New Mexico MCOs have been deemed fully compliant for network adequacy since at least 2019. These determinations occurred despite each MCO not meeting a number of specific standards related to timeliness and travel distance.

MCOs are also required to produce an annual plan to improve network adequacy, focused on improving unmet standards. However, the rigor of these plans varies widely and the extent to which MCOs are held accountable to delivering improved network adequacy is unclear.

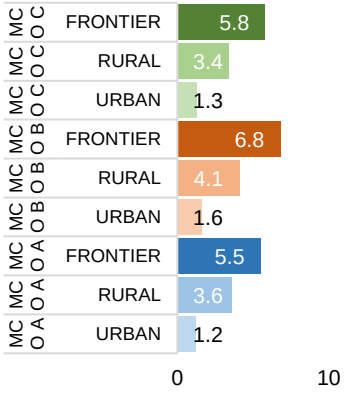
The federal government is proposing tougher standards for the network adequacy review of MCOs, which would require states to complete specific templates regarding network adequacy. This could allow for state-by-state comparisons of the Medicaid network. Another best practice for external quality reviews is to require these organizations to conduct more direct testing. This allows for a potentially more realistic picture of current timeliness to appointments because IPRO, rather than the MCO, would conduct secret shopper surveys and the corresponding analysis. For example, in Ohio when a caller identified themselves as an evaluator, 82 percent of primary care providers had appointment wait times of less than 30 days for a new patient well-check; however, when the external quality review organization conducted the survey this dropped to only 70 percent, highlighting the value of anonymous direct testing. In fall 2022, IPRO conducted direct testing of MCO provider directories and a secret shopper surveys. The results of which corroborated LFC secret shopper findings. Furthermore, using the external quality review organization for direct testing may be cost-effective because the federal government will cover 75 percent of the cost for this service.

Select Behavioral Health Service Categories That Did Not Meet Provider Access Standards

- Psychiatric Hospitals
- Partial Hospital Programs
- Accredited Residential Treatment Centers (ARTC)
- Treatment Foster Care I & II
- Core Service Agencies
- Community Mental Health Centers
- Indian Health Service and Tribal 638s providing BH
- Outpatient Provider Agencies
- Assertive Community Treatment (ACT)
- Multi-Systemic Therapy (MST)
- Intensive Outpatient Services
- Methadone Clinics
- Rural Health Clinics providing BH Services
- Psychologists
- Inpatient Psychiatric Hospitals

Note. See Appendix J for a full list of provider service categories and which categories did not meet standards.
Source: CY21 Q4 MCO Geo-Access Reports

Chart 6. Average Mileage to 1st Primary Care Provider (including Internal Medicine, General Practice, Family Practice) by County Type in CY 2021



Note. Distance Standards 30 miles for urban, 45 miles for rural, and 60 miles for frontier counties
Source: MCO geo-access reports

Recommendations:

Human Services Department should:

- Develop a comprehensive statewide network adequacy report examining provider ratios, distance and timeliness standards that takes into account providers who contract with multiple MCOs and report annually to the Legislature about the adequacy of the state's Medicaid provider network;
- Require MCOs regularly validate their provider directories;
- Strengthen primary care provider ratios in MCO contracts to bring closer to current ratios and consider variation for urban, rural, and frontier geographies;
- Set provider ratios for specialty care with input from a variety of stakeholders informed by external benchmarks;
- Require the external quality review organization continue to conduct direct testing on provider network for access to care and timeliness for an appointment, and provider directory validation; and
- Direct MCOs to review behavioral health provider claims data to identify whether increases in behavioral health utilization is driven by a small percent of enrollees utilizing the majority of services, whether increases in telemedicine or in-person account for trends in behavioral health utilization, whether significantly more individuals are utilizing behavioral health, which diagnoses are driving increases in behavioral health utilization, and whether there are any changes in patient outcomes.

New Mexico's Quality Initiatives and Contracts Need Improvement to Hold MCOs Accountable for Improving Access to Care

To improve access and health outcomes for Medicaid members throughout the state, New Mexico should examine its contracting and quality initiatives. MCOs can examine two programs intended to improve outcomes and utilization of healthcare: care coordination and Centennial Rewards. Determination of best practices and state implementation of these could help with appropriate service utilization, as well as potentially improve health outcomes for those enrolled.

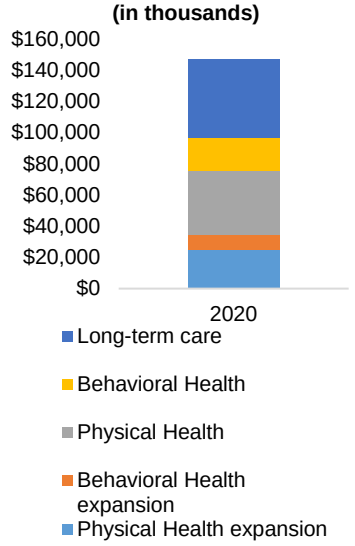
The MCO contracts stipulate the conditions MCOs are required to meet when providing managed care. These include incentives and penalties based on MCO performance. Ensuring the new Turquoise Care contracts have provisions that incentivize MCOs to not only assess but also build their provider networks may help improve access.

Another way to improve accountability for Medicaid in New Mexico is through the Office of Superintendent of Insurance. This agency regulates insurance for New Mexico and can help improve the Medicaid system by providing additional oversight.

Programs designed to improve patient outcomes and address access to care are costly, have indeterminate outcomes, and at times have low participation.

New Mexico's Centennial Care 2.0 demonstration waiver includes the provision of care coordination for all beneficiaries who meet specific criteria and a member-engagement-focused reward program, offered through MCOs to provide incentives for beneficiaries to pursue healthy behaviors, known as Centennial Rewards. These programs carry significant costs, yet their impact on patient access to care and health outcomes is indeterminate. Furthermore, the targeted populations and strategies used in these programs could benefit from consideration of the greatest system need and impact.

Chart 7. Cost of Care Coordination by Enrollee Group, 2020
(in thousands)



Source: MCO Annual Summary Report 2020

Care coordination costs around $147 million annually but serves few enrollees with indeterminate outcomes. HSD promulgated rules on care coordination describe it as being inclusive of coordinating visits with primary care and specialist providers, organizing care, facilitating access to services, and actively managing transitions of care. According to HSD, MCOs employ almost 1,000 care coordinators with a goal of working with enrollees with complex healthcare needs to coordinate their services and ensure they are receiving needed care. Care coordinators serve approximately 6 percent of the Medicaid population in higher-level care coordination. In 2020, Medicaid care coordination cost $147 million, including both administrative and healthcare costs. Care coordination costs were highest for the long-term support services population, at $51 million, and lowest for the behavioral health expansion population, at $9.3 million. While the state requires care coordination in its managed care contracts, the outcomes of the services are uncertain. Previous LFC reports going back to 2015 have been critical of

Table 9. Care Coordination Enrollment 2021

	L1	L2	L3	Total	Refused service
MCO A	171,629	13,391	1,169	186,189	33,312
MCO B	Not reported	5,195	705	5,900	Not reported
MCO C	15,759	3,138	179	19,076	3,106
Total	187,388	21,724	2,053	211,165	36,418

Note: 2021Q2 was used.

Source: MCO quarterly reports

Embedded Case Managers/ Care Coordinators are case managers or care coordinators who work within a primary care practice and provide case management or care coordination to those patients who need this service.

Close Loop Referral Systems allow care coordinators or others in the care team to track whether a patient has engaged with a service to which they were referred as well as helps the care coordinator follow-up regarding that patient's care. These can also include referrals to services that are not health related, such as SNAP.

Sample Centennial Rewards Healthy Activities

- Adult Primary Care Provider annual wellness checkup completed
- Covid-19 vaccine or booster completed
- Child annual dental checkup completed
- Completion of Diabetes HbA1c Test
- Flu Shot received
- 1st Prenatal Care Visit completed in first trimester or within 42 days of enrollment
- Well-baby checkups completed up to age 6
- Antidepressant and schizophrenia medication management
- Follow-up after emergency department visit or hospitalization for mental illness

Source: HSD 1115 Medicaid Waiver Renewal Application

care coordination, calling into question the effectiveness and cost-benefit of this service. A 2020 LFC report recommended establishing benchmarks to increase oversight of care coordination and adopting a set of health outcome measures specifically for care coordination that MCOs are required to track. Similarly, a 2015 LFC report called for HSD to evaluate the benefits of care coordination to determine if benefits are outweighing the costs.

HSD started to collect some outcome metrics for care coordination in 2022. For the past calendar year, HSD has examined care coordination comparing those participating with those who do not, including for dental visits and whether the patient received follow-up after an emergency department visit for mental illness. This examination of outcomes will be continued within the draft Turquoise Care contract because HSD includes four outcome metrics MCOs are required to be measure quarterly. However, the state should also establish targets for these outcomes metrics. Beyond these measures, MCOs will also be required to provide an annual evaluation of its care coordination program, including examining outcomes of its disease management and modifications to its care coordination program to improve disease management for its members. HSD should also conduct a rigorous cost-benefit analysis of care coordination to determine whether the state and the individuals participating in the program are getting positive returns from the large expense of this program.

Best practices for care coordination to reduce costs and improve quality care include embedding managers within primary care and closed-loop referral systems. Case managers embedded within primary care is a component of the network of care the state is looking to move toward through alternative payment models. Research has shown positive impacts from embedded case managers within primary care, including reduced costs and improved quality of healthcare for patients. Within the draft Turquoise Care contract, HSD allows for delegated case management that could take place within a healthcare office or the community. Another best practice includes using technology to aid in care coordination for referral mechanisms. CMS states technology can streamline referrals, which could make the system more efficient. The state is exploring funding a closed loop referral system at approximately $6.3 million.

The state spends $19.5 million on Centennial Rewards programs but has not yet met targets or seen significant health improvements. The Centennial Rewards program was designed to encourage Medicaid members to actively participate in their healthcare and drive improvements in health outcomes. Centennial Care members may participate in the program and receive points for engaging in and completing healthy activities and behaviors, such as completing annual wellness visits or adherence to medication regimens. By doing so, members may redeem points for items. HSD reports roughly 74 percent of members engaged in the program and completed at least one activity. MCOs reported spending $19.5 million on Centennial Rewards in 2021.

The extent the program is driving improved outcomes is unclear, though HSD reports a positive cost benefit. In the state's managed care renewal waiver (1115 waiver), the department reported the program resulted in reduced medical spending, saving an estimated $38.8 million in 2021. Yet, health impacts are not reported. Furthermore, according to the department's first FY23 performance report card, the agency failed to meet many outcome

benchmarks, including activities rewarded through the Centennial Care rewards program. For example, only 29 percent of children in managed care had one or more well-child visits and only 59 percent of mothers of newborns received a prenatal care visit in the first trimester (See Appendix E).

In the Centennial Care 2.0 waiver, HSD added home visiting, an intensive parent education and supports program for new families, as a Medicaid-reimbursable service. In New Mexico, the Early Childhood, Education, and Care Department (ECECD) administers home visiting. However, home visiting participation is not an activity incentivized in the Centennial Rewards program and home visiting participation is not an HSD outcome report card measure. Home visiting may be an appropriate activity to include within Centennial Rewards because evidence strongly supports its positive impact, with benefits lasting through adulthood, and utilization of the program has lagged expectations with only 16 percent uptake reported by ECECD despite a target of 50 percent. Including home visiting in both the Centennial Care rewards program and HSD report cards could help increase utilization and increase accountability to improve outcomes for children in the state. (See Appendix E for the HSD Q1 FY23 report card.)

Because Medicaid serves half the population, the MCOs need to be proactive and held accountable for building a better provider network.

Since Medicaid is such a large proportion of the payer mix, actions MCOs take have a larger effect in New Mexico than it would elsewhere. The way that the state can influence MCOs behavior is largely though the contracts between HSD and the MCOs. The new Turquoise Care contracts provide HSD with the opportunity to strengthen accountability for MCO provider networks, which will have an impact, not only for those on Medicaid, but potentially for the state as a whole. The MCO contracts stipulate required reporting, specifications regarding network adequacy, credentialing partners, and the extent to which the MCOs are allowed to keep profits. Contractual obligations may help ensure adequate healthcare for Medicaid enrollees. Over the next year, HSD will negotiate new contracts for its managed care entities. Therefore, determining how to strengthen accountability and reporting through contracts now will allow for increased accountability in the next contractual cycle. (See Appendix K for a summary of select draft contract changes.)

The standards for network adequacy in the draft Turquoise Care contract are stronger than in the Centennial Care 2.0 contracts, but not strong enough. Actual MCO provider-to-enrollee ratios range from 1:25 to 1:279, yet within the current contract, MCO's targets for primary care provider ratios are 1:2,000 enrollees. These ratio standards are set at a level where each MCO easily meets the standard, and these are significantly weaker than they were prior to Centennial Care. Previous LFC evaluations noted these ratios are so high that they may be meaningless. In the draft Turquoise Care contract, the PCP ratio standard continues to be set significantly above current actual ratios at 1:1,500 enrollees. HSD should set stronger ratios for PCPs based on the current provider network. Previous LFC reports that pointed out provider ratio standards were set at 1:500 in Salud, the state's managed care program prior to Centennial Care. The draft Turquoise Care contract also specifies MCOs should determine ratio standards for specialty providers. While adding standards for specialists is important, the state may benefit from setting these ratios or providing further guidance rather than relying on the MCOs to do so.

Draft Turquoise Care Contract Changes to Timeliness Accountability

- Revises timeliness requirements for a behavioral health crises from two hours to 90 minutes;
- Requires MCOs to conduct secret shopper surveys more frequently (quarterly);
- Specifies who should be surveyed, including primary care, behavioral health, and specialty providers;
- Establishes requirements for the survey sample sizes

Source: HSD

State Primary Care Provider Ratio Comparisons

According to the Commonwealth Fund, a healthcare-focused private foundation, states commonly establish minimum provider ratios in their state Medicaid plans.

Where these standards are adopted, they vary widely. For example, Michigan sets primary care provider ratios at 1:500, while California sets the same standard at 1: 2,000.

In addition, HSD revised some of its timeliness requirements to make them stronger. Increased monitoring of the timeliness standards is important, as it will allow for more information around enrollee need regarding access to care. HSD may also want to require MCOs to fill out an HSD-developed uniform template so all MCOs report their data in the same way. This would allow for direct comparisons across MCOS as well as allow HSD to draw conclusions about timeliness of appointments for Medicaid enrollees as a whole.

HSD did not issue any MCO penalties due to failure to meet network adequacy from 2019-2022 because contracts did not include network adequacy incompliance as a reason for penalties. If HSD does not penalize MCOs for not meeting standards, there is little incentive for the MCO to meet them. In the draft Turquoise Care contract, HSD states MCOs that fail to meet appointment standards can face a penalty of up to 2 percent of their monthly capitation payment. Adding a potential penalty could improve MCO compliance; however, the current language in the draft contract does not specify whether the penalty is only assessed for failure to meet standards for a specific provider type or which specific standard or standards need to be out of compliance to warrant a fine. Including clarifying language could help transparency and improve MCO understanding of expected standards.

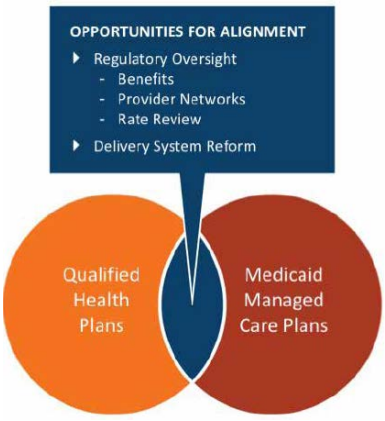
The Office of Superintendent of Insurance (OSI) can partner with HSD to help oversee Medicaid managed care network adequacy.

The Office of Superintendent of Insurance (OSI) can provide additional oversight of Medicaid network adequacy through its role as the state's supervisor of insurance. OSI has two bureaus, funded at $900 thousand with 10 FTE, focused on managed care, including Medicaid, although these bureaus largely examine complaints with managed care for both the public and private insurance systems, rather than a higher-level assessment of the Medicaid system as a whole. Additionally, oversight and review by OSI of how Medicaid is functioning may be called for because Medicaid is the primary insurance for almost half of the state's population.

The Legislature appropriated $300 thousand in FY23 for an external audit of the statewide provider network. Beginning January 1, 2022, OSI implemented more rigorous standards for network adequacy compliance reporting among commercial insurance providers. These updated standards included more accurate provider listings, more specific exception requests, access and secret shopper surveys, provider directory audits, and identifying nonparticipating providers. OSI's requirements for updated provider listings require carriers to remove duplicate listings, better identify providers who serve at multiple locations to indicate primary sites of service, and identify providers available through telemedicine. Beginning in 2022, carriers regulated by OSI must conduct an annual provider directory audit to determine the accuracy of directory information. Also, beginning in 2022, carriers are required to conduct an annual secret shopper survey so that OSI can measure compliance with wait time standards that are based on New Mexico Medicaid's wait time standards. OSI plans to use survey findings to hold carriers accountable through performance improvement plans and other approaches.

In other states, insurance commissioners and Medicaid officials work together to address network adequacy or create common standards between the marketplace and MCOs. OSI oversees the state's health insurance exchange that has similar challenges to MCOs, including similar regulatory oversight components focused around benefits, provider networks, and rate reviews. Other states' Medicaid agencies and offices of insurance have partnered to align these components. For instance, in Washington state the insurance commissioner works with Medicaid offices to help MCOs understand and meet network adequacy standards for the state's marketplace, which highlights common regulatory issues between Medicaid and the healthcare exchange. In Oregon, the Office of Health Reform looked at aligning requirement for MCOs and commercial insurances as part of the state's rate-setting process. This type of transparency can be useful when determining appropriate reimbursement rates. New Mexico may benefit from examining rates and network adequacy across both the MCOs and private insurers. OSI could assist in this analysis, potentially helping to ensure costs and network adequacy standards are aligned across insurance carriers.

Figure 4. Potential Areas of Alignment between MCOs and Private Insurance



Source: Commonwealth Fund

Recommendations:

Human Services Department should

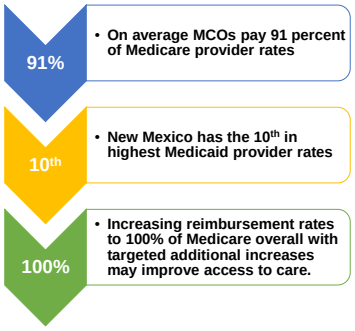
- Conduct a rigorous cost benefit analysis of care coordination;
- Ensure HSD keeps provisions in the Turquoise Care contract requiring quarterly secret shopper surveys with representative samples, specific penalties around network adequacy, and non-emergency medical transportation;
- Establish targets for the care coordination outcomes metrics including within the Turquoise Care contracts;
- Strengthen primary care provider ratios in MCO contracts based on current provider ratios and consider opportunities for variation for urban, rural, and frontier geographies;
- Further clarify how to determine if a MCO is not meeting network adequacy requirements and when they will be penalized; and
- Consider adding Home Visiting participation to Centennial Rewards and track outcomes.

The Office of Superintendent of Insurance should

- Continue to periodically conduct statewide assessments of network adequacy and, in partnership with HSD, develop statewide standards for network adequacy and access that take the state's payer mix into account

Increasing Select Medicaid Payment Rates May Help Address Access to Care

Figure 5. Medicaid Rate Fast Facts



In addition to provider availability impacting access to care, the rate paid to providers can affect access to care by incentivizing providers to accept Medicaid patients. Roughly 83 percent of the state's Medicaid population participates in managed care, and HSD provides a monthly per-member-per-month (PMPM) capitated payment to MCOs for the care of these enrollees. In turn, MCOs contract with individual medical providers, setting payments with these providers and processing billing for care received by enrollees. Both the PMPM rate-setting process led by HSD and the provider-rate-setting process led by MCOs provide opportunities to manage risk, contain costs, and incentivize improved access to quality care. In recent years, HSD leveraged the PMPM rate-setting process to manage risk and contain costs by increasing the medical loss ratio, or ratio of medical care to total MCO expenditures, and setting PMPM rates toward the lower end of the actuarially-sound range. In addition, the Legislature initiated a series of cost-containment measures in 2016, freezing rate increases.

However, MCO PMPM rates increased between 20 and 26 percent between FY19 and FY22, contributing to Medicaid program cost increases. Part of the MCO PMPM rate increases in recent years was intended for provider rate increases, and the Legislature and HSD directed the increase of specific provider rates during this time.

A provider rate study initiated by HSD in 2022 suggests the state's Medicaid fee-for-service equivalent (FFS) rates are 88 percent of Medicare rates in the aggregate but could be improved, with several pockets of low rates. The state's managed care rates are, in the aggregate, 103 percent of the state's FFS rates.

The HSD provider rate study did not compare Medicaid or Medicare rates to private insurance. However, nationally and in New Mexico, Medicaid rates have historically lagged behind private insurance, with a 2019 Congressional Budget Office study suggesting New Mexico's private insurance rates were roughly 125 percent of Medicare. Thus, New Mexico's private insurance rates were roughly 128 percent of Medicaid managed care rates at that time.

Additional rate increases, particularly in targeted areas, may improve access to quality care for enrollees, and national research confirms increasing provider rates can have an effect on access.

Although most Medicaid fee-for-service rates paid to providers are 88 percent of Medicare in the aggregate, increasing provider rates, particularly in targeted areas, could increase access to care.

New Mexico's actuary (Mercer) establishes per-member-per-month capitation payments to MCOs, and HSD establishes the rates the state's Medicaid fee-for-service (FFS) plan will directly pay providers. HSD does not directly set the rates MCOs pay providers when patients in managed care access care; MCOs negotiate rates with providers. However, HSD uses assumptions about provider rates when setting PMPM payments, and HSD issues letters directing MCOs to increase provider rates.The HSD provider rate study concluded fee for service rates are, "consistently lower than corresponding Medicare reimbursement rates", or 88 percent of Medicare-equivalent rates in the

MCO PMPM Rates: HSD pays a per-member-per-month (PMPM) rate to MCOs to cover all healthcare and administration on behalf of an enrollee.

Provider Rates: MCOs individually negotiate rates with providers for services rendered to patients.

HSD may issue letters of direction to MCOs, directing specific provider rate increases.

HSD reports it is difficult to validate the extent to which increases to PMPM MCO rates intended for providers are passed on because individually-negotiated provider rates are proprietary.

Given the significant investment in the Medicaid program, understanding how appropriations translate into MCO PMPM rates is an opportunity for future evaluation and reporting to the Legislature.

aggregate. New Mexico's managed care rates are, in the aggregate, roughly 103 percent of the state's fee-for-service equivalent rates.

National research suggests efforts to bring Medicaid reimbursement rates closer to parity with Medicare can affect the likelihood that providers accept Medicaid, though the resulting impact on utilization is mixed. A 2019 National Bureau of Economic Research (NBER) white paper studied the relationship between increasing state Medicaid reimbursement rates and patient utilization. NBER notes state Medicaid programs have historically paid less than two-thirds of what Medicare and private insurers pay for the same services. The study found increasing Medicaid rates was correlated with a decrease in doctors reporting they are not accepting Medicaid patients and a decrease in parents reporting having trouble finding a doctor for their children.

Table 10. Medicaid-to-Medicare Fee Ratios for Physician Services in Select States, 2019

Location	Medicaid Rate as % of Medicare
Alaska	110%
New Mexico	93%
Vermont	86%
Oregon	83%
District of Columbia	80%
Arkansas	79%
Kentucky	76%
California	73%
West Virginia	71%
Louisiana	69%
Hawaii	62%
New York	57%
Rhode Island	37%

Note: Includes states with Medicaid enrollment greater than 25% of population
Source: Kaiser Family Foundation, State Health Facts and Medicaid.gov

Evidence about Medicaid reimbursement increases resulting in more patients being able to see a provider is mixed, with some promising evidence**.** A study published in the *New England Journal of Medicine* found an increase in appointment availability corresponding to an increase in Medicaid reimbursement rates. However, the study also found the states that required the largest Medicaid rate increases experienced the greatest benefit, and the impact on appointment availability was greatest if the state's rate increased by more than 50 percent. While appointment availability increased, the study also found the Medicaid rate increase had no effect on wait times for appointments. These data suggest, while incremental increases to Medicaid reimbursements appear to increase provider willingness to accept Medicaid, the resulting impact to utilization or timely appointment access may be smaller.

New Mexico has initiated several targeted provider rate increases in recent years, but HSD does not verify if MCO rate increases result in provider rate increases. Several of these rates included "short-term" rate increases to help providers during the pandemic and federally declared public health emergency (PHE). A summary of rate increases for 2019 and 2022 are provided below. In FY22, the legislative appropriations for the Medicaid program included $11 million for hospital provider rate increases associated with the pandemic response and $15 million for managed care rate increases, inflation, and utilization increases in FY23. (See a summary of Centennial Care 2.0 rate increases below, and find further detail in Appendix L.)

Table 11. Summary of Select Centennial Care 2.0 Provider Rate Increases, 2019-2022

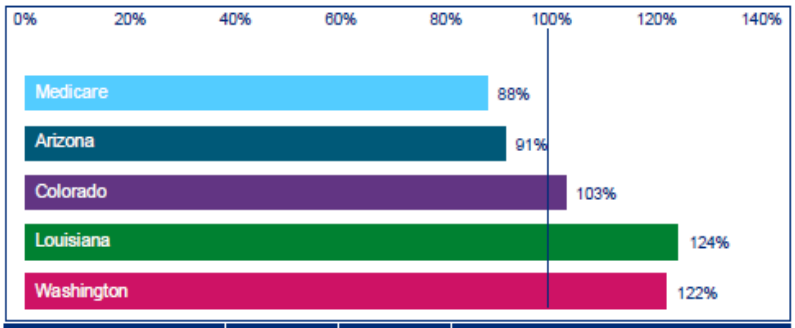
2019	2020	2021	2022
• Increased evaluation and management service rates Increased rates for all dental services Increased behavioral health rates • Increased minimum wage for PCS workers Increased hospital inpatient rates	• Increased rates for LARCs Increased rates for government and non-profit hospitals Increased rates for hospitals who serve a high share of Native American patients • Increased nursing home facility rates Covid-19 temporary increases for: assisted living, behavioral health, dental services, community benefits, and transportation	• Increased rates for trauma hospitals • Increased rates for IHS and tribal 638 providers	• Minimum wage increases Covid-19 temporary rate increases for: hospitals, telehealth, nursing homes, federally qualified health centers (FQHCs), and transportation

Source: HSD Centennial Care 2.0 Letters of Direction

While HSD provides letters of direction about provider rate increases, the extent to which PMPM increases translate to provider rate increases is not clear. HSD does not validate or verify MCOs have passed on rate increases because rates are proprietary and individually negotiated between MCOs and

providers. A September 2022 LFC brief noted MCOs should be more transparent about the way in which funding for rate increases are passed on to providers.

Figure 6. Overall 2021 New Mexico Medicaid FFS Rates Relative to Each Benchmark



Service Area	Medicare	AZ	CO	LA	WA
Total	88%	91%	103%	124%	122%

Source: HSD 2022 Medicaid Provider Rate Study Phase I

The 2022 HSD rate study shows Medicaid rates lag Medicare rates and do not quite meet HSD targets. In 2019, HSD initiated a strategy to bring reimbursement rates to 90 percent of Medicare rates. HSD's Medicaid provider rate study suggests overall New Mexico fee-for-service provider rates are currently 88 percent of Medicare with pockets of lower rates, and managed care rates are roughly 103 percent of the FFS equivalent rates, in the aggregate.

A few sub-service managed care rates, particularly transportation and maternity-related care, appear to lag behind benchmark provider rates. The rate study also examined a few specific sub-services, several of which are listed in Table 12 below. In this sub-service analysis, managed care emergency transportation stands out as 74 percent of the Medicare rate. Nonemergency transportation, which is not covered under Medicare or in Louisiana and Washington Medicaid programs, is considerably lower than the Colorado rate but higher than the Arizona rate. In both cases, New Mexico's managed care rates are, on average, higher than the state's FFS rate, with the nonemergency transport rate more than double FFS.

Table 12. CY2021 Selected Medicaid Rate Benchmarks

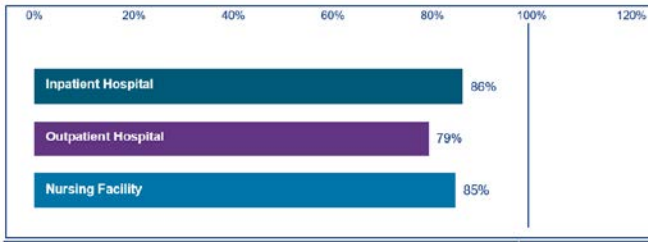
Service Subgroups	NM MC to FFS Rate	NM FFS to Medicare	NM FFS to AZ FFS Rate	NM FFS to CO FFS Rate	NM FFS to LA FFS Rate	NM FFS to WA FFS Rate
Physician and Other Practitioner-Medicine	100%	86%	79%	102%	118%	139%
Emergency Medical Transportation	106%	70%	77%	131%	102%	172%
Non-Emergency Medical Transportation	226%	NA	159%	46%	NA	NA
Maternity-Related Care	87%	93%	80%	101%	139%	112%
Child Health Care	99%	112%	109%	113%	154%	135%
Family Planning	95%	104%	113%	119%	134%	116%
General Behavioral Health	100%	97%	101%	120%	152%	146%

Notes: When a benchmark was unavailable because the service is not covered, NA is listed
MC= Managed Care Rate, FFS= Fee-For-Service Rate
Source: 2022 Medicaid Provider Rate Benchmarking Study

The 2022 rate study also found New Mexico Medicaid FFS rates for in-patient facilities are between 79 and 86 percent of Medicare rates, in the aggregate, and managed care rates are 99 percent of FFS equivalent rates. Overall, Mercer found New Mexico's Medicaid FFS rates were 86 percent of Medicare for inpatient hospitals, 79 percent of Medicare for outpatient hospitals, and 85 percent of Medicare for nursing facilities.

However, the rate study did not include HSD directed payments, which increase total managed care payments by an estimated 14 percent and 46 percent, depending on the facility type (see Appendix R for additional detail about inpatient facility rates).

Figure 7. Overall New Mexico Medicaid FFS Rates Relative to Medicare Rates



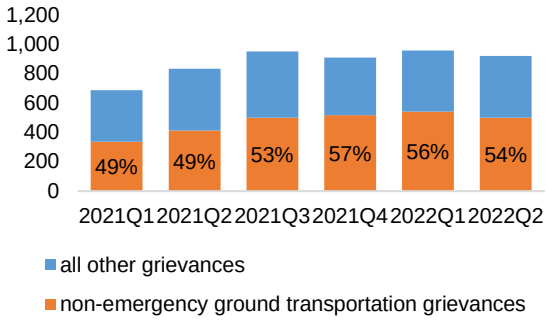
Source: HSD 2022 Mercer Provider Rate Study Phase 2

New Mexico should consider establishing and maintaining rate parity among provider types, such as nurse practitioners and physicians when possible. In addition to the service areas described above, the Mercer rate study noted the fee-for-service payments to physician and nurse practitioners appear to differ for office visit codes. Compared with physicians performing the same services, the Mercer study noted FFS reimbursement for nurse practitioners are lagging, though the study did not find the same lag in managed care rates. Similarly, according to a letter of direction to MCOs, non-physician behavioral health rates are about 90 percent of physician rates, and a 2021 needs assessment of behavioral health provider capacity for children in state custody reported New Mexico has an ongoing struggle to retain behavioral health providers in the state due to reimbursement issues and experience participating in state programs. These study findings suggest targeted rate increases to bring low managed care rates up to a consistent standard should be considered to encourage providers to operate at the top of their scope of practice and improve access to care if and when permitted by CMS regulation.

A recent study from the RAND corporation found that New Mexico hospitals have higher relative prices than many other places, including hospitals in largely rural states The RAND study benchmarked hospitals prices nationwide to Medicare's approved rate, finding the relative price paid by private insurance in New Mexico was 288 percent of the Medicare rate. Results in surrounding states varied, with Oklahoma private insurance paying 199 percent of Medicare, Texas private insurance paying 252 percent, and Arizona paying 291 percent.

Nonemergency transportation accounted for roughly half of the grievance reports in 2021 and 2022, and increasing transportation rates could improve access to care. Nonemergency transportation is an important service to get members to needed medical care. However, over 2021, the number of grievances related to nonemergency transportation increased from 336 to 518 per quarter, making up 56 percent of all grievances in the last quarter of 2021 and the first quarter of 2022. This is a marked increase in the number of grievances from 2020, when transportation only made up 28 percent of all grievances. Additionally, a federal examination of New Mexico's behavioral health system by the Health and Human Services inspector general report found providers noted accessing nonemergency medical transportation for Medicaid to be a challenge for enrollees. These issues could lead to members not being able to get to their appointments timely or safely.

Chart 8. Non-Emergency Transportation Accounts for About Half of All Medicaid Grievances in 2021 and 2022



Source: HSD Centennial Care Waiver Annual Report

According to HSD, MCOs are exploring tribal partnerships and ride sharing, which the Public Regulation Commission may be able to regulate. (See Appendix N for additional transportation strategies.) HSD included penalties for failing to meet performance standards for nonemergency transportation in their draft contract for Turquoise Care. In addition to penalties, increasing provider rates for this service could improve transportation access for members.

Increasing physical health provider rates beyond 100 percent of Medicare may produce diminishing returns. Nationally, a 2021 Medicaid and Children's Health Insurance Program (CHIP) Payment Commission report

In the U.S. 74 percent of physicians accept Medicaid, while in New Mexico an estimated 92 percent of physicians accept Medicaid.

Source: MACPAC

found physicians were less likely to accept new patients insured by Medicaid compared with those with Medicare or private insurance. While the study found a gap in acceptance rates in New Mexico, the gap is smaller than the national average. Despite a large share of physician reports of accepting new Medicaid patients, patients in New Mexico may still be unable to access care if the number of providers does not grow. While nearly all physical health providers accept Medicaid as a form of payment and increasing rates could incentivize providers to take more Medicaid patients, getting timely physical health appointments, regardless of payer source, remains a challenge, and the state needs more primary care providers.

Table 13. Behavioral Health Providers who Report Currently Serving Medicaid Patients

Behavioral Health Provider Type	% Serving Medicaid Patients
Prescribers	80%
Independently Licensed Psychotherapy Providers	75%
Non-Independently Licensed Psychotherapy Providers	75%
Substance Use Treatment Providers	60%
Total	**75%**

Source: 2022 New Mexico Health Care Workforce Report

With an estimated 25 percent of the state's behavioral health providers reporting they do not accept Medicaid, targeted rate increases in this area could increase provider willingness to accept Medicaid patients. Over the last few years, the state has increasingly relied on telemedicine, and HSD reports seeing more Medicaid behavioral health encounters than ever. Yet, several recent reports suggest behavioral health access remains a concern. Even though the Mercer rate study found New Mexico's Medicaid behavioral health provider rates are comparable with Medicare and exceed Medicaid FFS rates in other states, many providers in New Mexico report they do not accept Medicaid patients and access remains a challenge. The *2022 Annual New Mexico Healthcare Workforce* report found 25 percent of the state's behavioral health providers are not currently seeing Medicaid patients. Similarly, a 2021 behavioral health provider capacity assessment initiated by the Children, Youth and Families Department and HSD, which included a survey of 387 behavioral healthcare providers in the state, found a quarter of those surveyed were either enrolled to accept Medicaid but not currently billing (20 percent) or not enrolled Medicaid providers (6 percent). Additionally, 30 percent of surveyed respondents reported waiting lists for children and youth, and 13 percent of respondents reported wait times for appointments exceeded two weeks. Surveyed providers reported low reimbursement rates, a lack of reimbursement or incentives for start-up costs and training, and cumbersome credentialing and reimbursement processes as reasons for not accepting Medicaid.

A lack of behavioral health providers accepting Medicaid has been an issue for several years, as a 2019 report issued by the U.S. Health and Human Services Department Office of the Inspector General (HHS-OIG) similarly noted. This report also noted 62 percent of the state's behavioral health providers work in behavioral health organizations (BHOs). Among BHOs, the report found more than 40 percent were unable to meet New Mexico's behavioral health standards, which state providers must be available within 24 hours for urgent conditions and 14 days for routine behavioral healthcare. Additionally, the report used a benchmark of two behavioral health providers per one thousand Medicaid enrollees and found nearly all rural and frontier counties fail to meet this benchmark. The 2019 HHS-OIG report recommended New Mexico take a variety of actions to improve behavioral health access for Medicaid patients, including expanding the state's behavioral health workforce, periodically reviewing and streamlining licensure requirements and reimbursement procedures, and directly reaching out to providers.

The Legislature should consider appropriations to increase Medicaid rates to 100 percent of Medicare, with additional targeted increases for services including primary care, behavioral health, and maternal child health. The

legislature should also consider additional funding to ensure behavioral health services covered by Medicare but not Medicaid should similarly be increased. The FY24 HSD budget request includes $1.2 million for behavioral health rate parity for services not covered by Medicaid. Finally, HSD and OSI should evaluate the impact of provider rate increases on network adequacy and access to care for both public and private payers and report back to the Legislature about these outcomes.

The state should be able to validate that the MCO PMPM rate setting process is appropriately managing risks and costs

HSD does not directly set managed care provider rates. Instead, HSD establishes PMPM rates paid to MCOs to provide all patient care. When HSD aims to direct a provider rate increase, they issue a letter of direction to MCOs and the MCOs make adjustments, based on actuarial projections. PMPM rates are set in a way that intends to manage risk, incentivize quality care, and assume a reasonable profit margin.

New Mexico increased MCO per-member-per-month capitation rates in recent years, intending increases to translate into higher provider rates and offset inflation. Capitated PMPM payments to MCOs increased between 20 percent and 26 percent between FY19 and FY22, depending on the Medicaid population. According to the U.S. Bureau of Labor Statistics, cumulative healthcare inflation during this period was roughly 21 percent.

These capitation rate increases followed a period of cost-containment measures. HSD lowered and froze capitation rates amidst a challenging budgetary context in the state but increased PMPM rates between FY19 and FY22.

A 2020 LFC evaluation of Centennial Care 2.0 found PMPM rate increases in 2020 led to $70 million in additional general fund spending, and MCO PMPM rate increases were driven by provider and hospital rate increases, minimum wage adjustments, health insurance exchange fees, and other nonmedical changes to Centennial Care 2.0. MCO PMPM rate increases between 2020 and 2022 are also attributed, in part, to provider rate increases, hospital rate increases, minimum wage adjustments, health insurance exchange fees, and other nonmedical changes to the Centennial Care 2.0 plan. Additionally, the health care quality surcharge and increases to the health insurance premium surtax partially drove PMPM rate increases.

Table 14. Weighted Average Medicaid MCO PMPM Rates

Group	FY19	FY20	FY21	FY22	% Change FY19 to FY22
Physical Health	$307	$343	$357	$367	20%
Long-Term Services and Supports	$1,789	$1,913	$2,088	$2,185	22%
Medicaid Expansion Population	$447	$494	$526	$538	20%
Behavioral Health	$58	$67	$71	$73	26%

Source: HSD Monthly Projection Reports

This report was unable to validate assumptions in the MCO PMPM rate setting process, including client utilization and rate placement. Previous LFC evaluations noted HSD should better negotiate payments rates with MCOs, setting rates closer to the lower bound of the actuarially sound range. A 2015 LFC evaluation found HSD was setting PMPM rates at the midpoint

Underwriting gain is the excess of premiums collected less claims costs and other expenses, and an underwriting gain occurs when premium revenue is greater than expenses. Underwriting gain provides the MCO with compensation for the risks assumed when receiving capitation payments for patient care and is commonly viewed as the expected MCO net income or profit. It is similar to profit.

The Medical Loss Ratio (MLR) refers to the portion of consumer premium dollars spent on administrative costs, profits, and overhead costs, compared to medical care. An MLR of 80 percent would suggest an insurance company spent 80 percent of revenue collected from premiums on medical care and quality improvement and 20 percent on administrative costs.

Examples of MCO Risk-Sharing Arrangements

Arizona limits MCO underwriting gain to 6 percent, allowing MCOs to keep all profits up to 6 percent.

Nebraska limits MCO underwriting gain to 3 percent in the first year of the state managed care contract and 2.5 percent in each subsequent year. The state makes an additional payment to the MCO if the company incurs a loss greater than 3 percent.

Washington allows MCOs to keep all underwriting gain up to 3 percent. The MCO must equally share any gain between 3 percent and 5 percent. The state recovers all gain in excess of 5 percent.

A 1% increase in medical loss ratios translates to roughly $47.6 million more spent on medical care in 2021

Source: LFC analysis of MCO Report 29 data

Table 15. MCO 2021 Medical Loss Ratios

	2021
MCO A	80.9%
MCO B	89.7%
MCO C	90.1%

Source: MCO Report 29 data

Table 16. MCO Net Underwriting Gain/ Loss (in thousands)

	Net Underwriting Gain (Loss)	% of Net Capitation Revenue
MCO A	-$71,923	-14%
MCO B	$151,096	4%
MCO C	$13,810	2%

Source: MCO Report 26 data

of the actuarially sound range, which could have translated to $24 million in savings in 2014. While this evaluation could not determine where in the actuarial range PMPM rates are currently set, HSD reports beginning in 2023, the department will set PMPM rates between the minimum and 25th percentile of the range. In addition, HSD reports because utilization has been lower than projected in 2022, the department reduced 2022 PMPM rates by 1.5 percent in July 2022, as allowed by CMS regulation. The department estimates this reduction will result in savings of $95 million in PMPM payments to MCOs this calendar year.

This report was also unable to verify all of the assumptions currently used to establish MCO PMPM rates, including assumptions about patient utilization trends. Given the significant investment in the Medicaid program, understanding how appropriations translate into MCO PMPM rates is an area for future evaluation and reporting to the Legislature.

New Mexico aims to balance MCO risk and profit through MCO contracts. When setting MCO PMPM rates, the state makes an assumption about underwriting gain and administrative costs that reflect contractual limits about how much MCOs should spend on administration by establishing medical loss ratios (MLR), the ratio of revenue spent on medical services versus administration. States may incentivize and limit MCOs from incurring risk and profit by setting limits around MCO underwriting gain (profit) or loss. Federal regulations (42 CFR 438.6(a)) require states to document in MCO contracts and rate certification documents any risk-sharing mechanisms, including details about the methodology to limit or share underwriting gains or losses between the MCO and the state Medicaid agency. A 2021 report from the consulting firm Health Management Associates suggests, when states limit MCO underwriting gain, these limits tend to range between 1 percent and 8 percent. New Mexico's Centennial Care 2.0 contracts permit MCOs to retain 100 percent of underwriting gain up to 3 percent of capitation revenue. New Mexico's MCO contracts stipulate the MCO shall share with HSD 50 percent of any underwriting gain in excess of 3 percent. Mercer and HSD report the the state assume underwriting gain between 1.5 percent and 2.25 percent when setting MCO PMPM rates.

New Mexico's current Centennial Care 2.0 MCO contracts require an MLR that dedicates 3 percent more spending to medical services than required in federal regulation. In this respect, the state is improving on federal best practice. The Affordable Care Act requires health insurers to submit data on their MLR and issue rebates if the MLR percentage does not meet minimum standards. 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.

New Mexico's current Centennial Care 2.0 contracts and amendments specify the MCO shall spend no less than 88 percent of net capitation revenue on direct medical expenses, including activities that improve healthcare quality and fraud prevention, on an annual basis. Establishing an MLR higher than the CMS standard requires MCOs in New Mexico to spend an even greater share of capitation revenue on medical care, as compared with administrative costs.

In 2021, only two MCOs met the MLR standard in MCO contracts, though the extent to which they report profits in excess of 3 percent varies by MCO. In 2021, MCO reports suggest one MCO exceeded the 88 percent MLR threshold and will be subject to payment remittance of $108.5 million. In 2021, one MCO reported underwriting gain in excess of 3 percent, while one MCO reported a net underwriting loss.

HSD's draft Turquoise Care contract notes the new program design will further improve by increasing the MLR to 90 percent. The new Turquoise Care contracts will go into effect January 1, 2024 and include new provisions about MLR and underwriting gain. Failing to meet this minimum MLR may result in MCO remittances. The former Centennial Care contracts allowed MCOs to keep 100 percent of the underwriting gain up to 3 percent under and then required MCOs to share underwriting gain beyond 3 percent with HSD. The new contracts address underwriting gain at two thresholds: below 3 percent and above 3 percent. For underwriting gain up to 3 percent, MCOs will be allowed to keep 95 percent and then will be required to reinvest the other 5 percent in the community. Above 3 percent, the MCO and HSD will share any additional underwriting gain (profit). Community reinvestment can help grow provider networks or create other needed services or capital in communities.

In the Turquoise Care contracts, HSD stipulates this community reinvestment should be focused on efforts to develop, expand, and retain in-state behavioral health residential providers to reduce the unnecessary utilization of inpatient, emergency room, and out-of-state services. While more behavioral health providers are needed within New Mexico, residential providers may not be the best providers to exclusively focus on; the state also needs community behavioral health providers to deal with less acute need. Beyond reinvesting these dollars in the community, MCOs will also be required to submit an annual community reinvestment plan to HSD. This plan is supposed to highlight the MCOs activities and strategies, as well as the anticipated period to see outcomes with the subsequent plan reports highlighting the impact of the prior year's investment. Given the MLR and underwriting gain and losses reported by MCOs in 2021, these contractual changes may not significantly impact MCO profits or administrative costs but could result in some positive change to the community and maintenance of enhanced risk-management standards.

HSD should continue placing the PMPM rate at the lower end of the actuarial range and implement the increased MLR and underwriting gain provisions in the draft Turquoise Care contracts.

Recommendations:

The Legislature should

- Consider funding the Medicaid program for provider rate increases to bring Medicaid rates to parity with Medicare and provide additional targeted increases for services, including primary care, behavioral health, and maternal and child health and consider funding for non-medicaid eligible behavioral health rate increases.

The Human Services Department should

- Through letters of direction, direct MCOs to enact targeted provider rate increases described above;

- In partnership with OSI, should monitor outcomes associated with these rate increases, including changes to the Medicaid provider network, access, and utilization, and impacts to patients with other insurance and report these outcomes to the Legislature;
- Verify, either directly or through the EQRO process, that provider rate increases directed by the Legislature translate to provider rate increases and report about their findings;
- Provide the LFC with information that allows the Legislature to verify the assumptions in the MCO PMPM rate setting process that impact Medicaid projections, including utilization and placement within the actuarial range;
- Ensure potential changes in MLR and underwriting gain are reflected in FY24 appropriations for the Medicaid program and are adjusted for prior-year MLR remittances;
- Continue to work with other state entities and MCOs to allow for Medicaid reimbursement for nonemergency medical transportation and other services;
- Implement and enforce the draft changes to MLR and underwriting gain in Turquoise Care contracts; and
- Continue to set PMPM rates toward the lower end of the actuarially-sound range.

To improve timely access to care, the state needs to invest in provider recruitment and retention strategies

The state does not have enough providers for some specialty types or communities and forecasts expect the state to lose more providers due to an aging workforce. A lack of healthcare providers hinders access to healthcare for all New Mexicans. Furthermore, the state is likely to face a number of providers retiring, just as the state's population ages and stresses the healthcare system. According to a 2020 research article, New Mexico will need an additional 2,118 physicians by 2030 to maintain its provider network from 2017 due to provider retirements and an aging population. Beyond increasing provider rates, a variety of policy strategies could further encourage providers to come to New Mexico and remain in practice.

As New Mexico needs more providers and the MCOs are responsible for care for roughly half of New Mexicans, these MCOs should be proactive in trying to bring more providers to New Mexico and in creating incentives for providers to serve Medicaid clients.

In addition to MCOs, a variety of state agencies play a role in producing studies and recommendations related to state healthcare workforce needs, including the Behavioral Health Services Division, Higher Education Department, Children, Youth and Families Department, and Early Childhood Education and Care Department. Most of these agencies meet their obligations through including the healthcare workforce within their strategic plan or other planning documents. In addition, as a result of the Health Care Work Force Data Collection Analysis and Act, the University of New Mexico annually convenes the New Mexico Healthcare Workforce Committee to provide detailed data about the state's healthcare workforce and to make recommendations about areas for improvement. Finally, the Legislature also created the Health Policy Commission in statute to annually perform needs assessments about health personnel and health education and make recommendations about training, recruitment, and retention of health professionals in underserved areas, but this commission has not been active for at least a decade.

MCOs should be an active partner in improving the overall network.

The state's MCOs should be an active participant in building the healthcare workforce in New Mexico as they are responsible for managing care for almost half of the population in the state. This necessitates ensuring these individuals can see a provider when needed. Current contracts require MCOs to annually report to HSD on how they plan to develop the provider network, but these reports have not led to care being more available for enrollees. HSD and the MCOs should do more to incentivize providers accepting multiple MCOs, to ease the burden of credentialing, and to help build up the healthcare workforce.

Requiring MCOs to contract with all major provider networks may help ease access burdens for some enrollees. Current MCO contracts require MCOs to make concerted efforts to contract with many specific provider types, including federal qualified health centers (FQHCs) and certified community behavioral health clinics (CCBHCs), when those clinics are created. However,

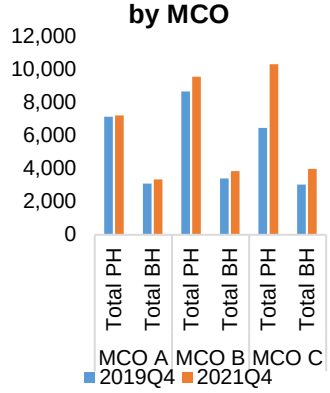
DOH has an office of Primary Care and Rural Health housed within the Public Health Division.

This office houses three types of programs: primary care programs, rural hospital and health programs, and health workforce development programs. The primary care programs include recruitment and retention of providers as well as financial support for the operations of community-based primary health clinics. The health workforce development program oversees the state's health service corps as well as the J-1 visa program.

This office also administers the New Mexico Rural Health Care Practitioner Tax Credit Program, which almost 4 thousand providers have claimed since its inception. Of those claiming this credit, over 60 percent have claimed it for three or more years.

This office also runs the HRSA Loan Repayment program and can continue to promote this program amongst others to increase retention of health care

Chart 9. Medicaid Provider Increases From 2019 to 2021 by MCO



Note: Providers may contract with multiple MCOs, likely duplicating total counts

Source: MCO quarterly Report 3

One MCO spent $16 million from 2019 to 2021 on grants to providers to help establish buy telemedicine infrastructure which can assist providers in serving clients through telehealth.

the contracts do not require each MCO to contract with all major hospitals or hospital provider networks. As of 2020, Washington D.C. requires all acute hospitals and their provider networks, among other provider types, to contract with all MCOs, which should result in better access to care for Medicaid members. Increasing the provider network should lead to increased access to care as well as less confusion for members as to where they can and cannot receive care. New Mexico MCOs vary as to the number of physical health providers they contract with. For example, MCO A contracted with roughly 3,000 fewer physical health providers than MCO C in 2021.

Table 17: Centennial Care Provider Counts, Fourth Quarter 2021

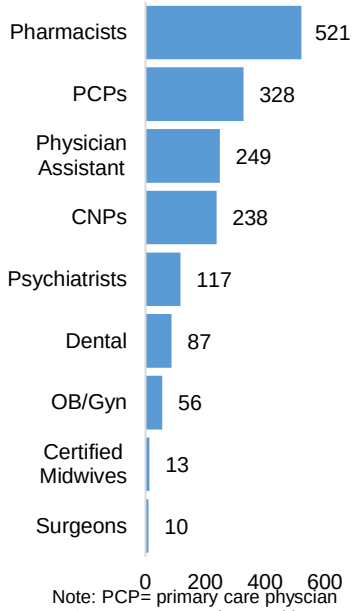
	MCO A	MCO B	MCO C
PCP	2,145	3,959	3,369
PH	7,364	9,574	10,338
BH	3,441	3,869	3,988
LTC	208	328	216
FQHC	2,145	3,959	3,369

Note: PCP= primary care provider, PH=physical health including PCP, BH=behavioral health, LTC=long term care, FQHC= federally qualified health center.
Source: IPRO 2020 network adequacy report

Currently each MCO has its own credentialing process for providers, increasing the amount of work providers have to complete to accept each MCO; however, HSD intends to take a larger role in this process, similar to other states. When North Carolina moved from a fee-for-service structure to a managed care structure, it established centralized credentialing for providers to ease the administrative burden for MCOs. Ohio summarizes the benefits of centralized credentialing to providers by pointing out, because it has five MCOs, providers would have to go through the credentialing process five times without centralized credentialing.

The number of providers varies significantly by MCO, and stakeholders reported to LFC the credentialing process is cumbersome. However, if the credentialing process did not need to be repeated when becoming approved by another MCO, more providers may opt to serve additional MCO networks. Within the Turquoise Care contract, HSD stipulates it plans to establish centralized credentialing to all MCOs during the term of Turquoise Care (2024-2028). The draft contract also states the MCOs shall help HSD with this transition and comply with the new credentialing requirements. This addition could ease provider burden, but HSD may want to specify timeframes to help ensure a centralized credentialing process is implemented.

Chart 10. Overall Number of Providers Needed to Meet National Benchmarks for New Mexico Population



Note: PCP= primary care physcian
Source: New Mexico Healthcare Workforce Committee Report, 2021

While both the overall number of physical and behavioral health providers in the state and the number of providers serving Medicaid increased since 2019, it is unclear to what extent the MCOs played a role in this increase. The state should assess MCO annual development plan reports to determine if these activities lead to more providers. As a provision of the Centennial Care 2.0 contracts, MCOs are required to submit annual development plan reports. These highlight how the MCO plans to increase its provider network. Some of the reports also include information on the number of providers needed to better serve their enrolled members. However, the current contract does not include how HSD uses these reports. HSD could provide oversight of whether the MCO's activities have led to additional providers where needed. In addition to the provider network plan reports, the community reinvestment requirement included within the draft Turquoise Care contracts may assist with increasing healthcare providers, however this will also need to be evaluated, as well as included within the draft contract.

To allow for timely access to care when needed, the state needs more medical providers including psychiatrists, nurse practitioners, and primary care physicians.

The state's Medicaid network does not currently allow many enrollees timely access to care. The percentage of primary care providers in the Medicaid managed care network who report accepting new patients has decreased, Medicaid enrollee satisfaction lags behind national averages, and data indicates access to timely appointments is a challenge for the state. Overall, the state needs more medical providers.

Within the state's overall healthcare provider network, the number of providers who accept Medicaid is a smaller proportion of providers, as not all providers take Medicaid, which is especially true for behavioral health. When examining the state's healthcare provider network overall, physician provider shortages, particularly in primary care and psychiatry, persist. According to the annual New Mexico Health Care Workforce Committee report, in 2021 only eight counties reached benchmarks for primary care, seven were at benchmark for psychiatrists, and 10 were at benchmark for nurse practitioners. However, even when a county is at the benchmark overall, the county might not have enough providers to serve the patients seeking care in that area because people from other counties may receive care in the counties with larger provider networks. Overall, the state needs at least 149 more primary care physicians, 30 more psychiatrists, and 119 more nurse practitioners or, absent a redistribution of providers, 334 more primary care physicians, 119 more psychiatrists, and 227 more nurse practitioners. These provider totals for each of these groups increased since 2019 but additional providers are needed to meet national benchmarks.

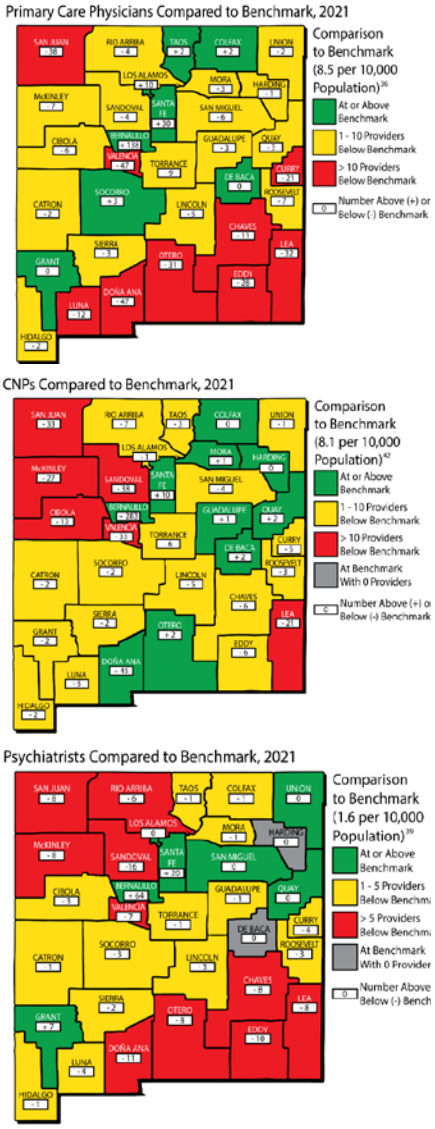
New Mexico's has had a persistent shortage of behavioral health providers

In a 2018 report from the American Journal of Preventive Medicine, New Mexico's Health Care Workforce Committee data was highlighted to show the state's behavioral health workforce needs, which were then and continue to be some of the highest in the country. Furthermore, the state's behavioral health workforce is not reflective of the population, except for non-independently licensed psychotherapy providers.

However, New Mexico is not the only state facing a shortage; nationally, two-thirds of primary care physicians report difficulties accessing behavioral health care. The state will need to recruit and retain more behavioral health providers, especially in rural areas to improve access to care.

Source: American Journal of Preventive Medicine

Figure 8. For the Majority of Counties, New Mexico has a Shortage of Primary Care and Psychiatric Providers



Source: 2022 New Mexico Healthcare Workforce Report.

New Mexico should aim to recruit, train, and retain mid-level providers, such as nurse practitioners, to increase access to care.

Mid-level providers can fill a critical gap by providing skilled caregivers across the state who can enter the workforce more quickly. Additionally, practices with more mid-level providers are more likely to accept Medicaid patients. New Mexico's Nursing Practice Act (Chapter 61, Article 3 NMSA 1978) lays out the requirements for each level of nursing, including scope of practice and minimum educational requirements. The Nursing Practice Act outlines the scope of practice for advanced practice nurses (APRNs), who are nurses with graduate degrees who perform more specialized and advanced care, including certified nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists. These positions

Table 18. Legislative Appropriations to UNM in 2022

Purpose	Amount (thousands)
Nurse expansion	$951.6
Graduate Nurse Education	$1,653.1
Physician Assistants and Nurse Practitioners	$2,000
Total	**$4,604.7**

Source: HB002 2022

Table 19. UNM College of Nursing Graduates by Program Concentration

Program	Academic Year 21	Academic Year 24
Total Master's of Science in Nursing	***44***	***46***
Adult Gerontology -Acute Care NP	6	10
Family Nurse Practitioner	14	23
Nurse-Midwifery	6	6
Pediatric Nurse Practitioner	1	0
Psych/Mental Health Nurse Practitioner	4	7
Nurse Administration	13	0
Total Post-Master's Doctor of Nursing Practice	***13***	***8***
Clinical	5	0
Nurse Executive Organizational Leadership	8	8

Note: MSN does not include nurse education degrees. AY24 graduates are projected.

Source: UNM

typically require at least a master's degree in nursing and licensure as a registered nurse. As previous LFC evaluations have noted, New Mexico's Nursing Practice Act is one of the most expansive nationally, and APRNs perform many procedures independently, allowing them to operate as providers with expansive scopes.

Practices with more mid-level providers, such as nurse practitioners, are more likely to accept Medicaid patients. In a 2021 analysis, New Mexico was one of seven states in which Medicaid and the CHIP Payment and Access Commission found the presence of more mid-level providers in a practice led to increased Medicaid acceptance rates. Therefore, one potential way to likely increase Medicaid acceptance rates in New Mexico may be to increase the number of mid-level providers within the state and individual practices. Beyond creating additional access opportunities for Medicaid enrollees, one in four nurse practitioners provide services in rural communities, which would be particularly helpful in the state. To do this, New Mexico will need to train more advance practice level nurses, recruit more from other states, or retain current practicing mid-level providers within the state.

Critical programs including UNM's MSN program are essential to the health practitioner pipeline. The Legislature appropriated $2.6 million to UNM for graduate nurse education and $2 million solely for nurse practitioners and physician assistants. The master's program graduated practicing nurses who can see patients and expand the healthcare workforce quickly and leads to Advanced Practice Registered Nurse (APRN) licensure. Last year, UNM graduated 38 clinical master's level nurses and five clinical doctoral level nurses.

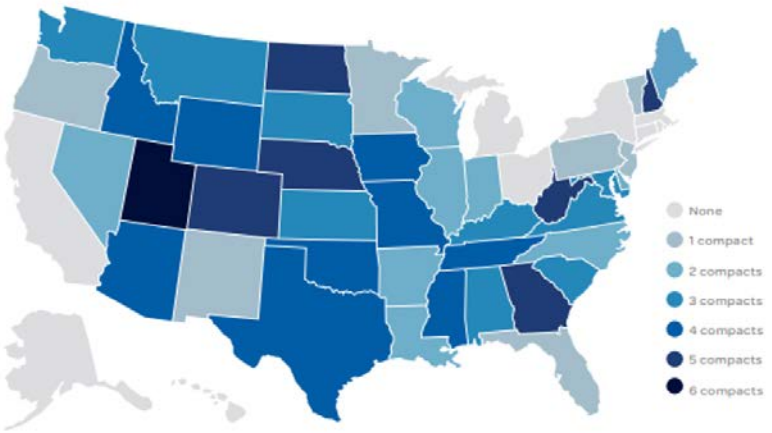
While the American Association of Colleges of Nursing in 2004 voted that the doctorate in nurse practice was the most appropriate degree for APRNs, a master's degree is still the dominant choice for APRN entry to practice, and is useful when the state and nation is experiencing shortages of healthcare providers. According to the New Mexico Healthcare Workforce report, the state needs approximately 227 more nurse practitioners if current practicing nurses are not redistributed. Furthermore, a 2020 LFC nursing evaluation stated, due to the projected growth in nurse practitioners, additional pathways into master's degree and APRN nursing may be warranted. Therefore, the state likely benefits from UNM having a master's level nursing program because it leads to more nurse practitioners in the clinical setting.

The state has focused on increasing the workforce by streamlining licensure and expanding graduate medical education.

HSD and other stakeholders are working to improve provider shortages. In the past three years, two workgroups were established in statute to address the workforce, resulting in strategic plans to grow medical residencies and improve primary care access through alternative payment models. Beyond these workgroups, the state has allocated funds to expanding advance practice nurses, which can help reduce the current provider shortages experienced throughout New Mexico. Research suggests practices with more mid-level providers are more likely to accept Medicaid patients.

New Mexico only participates in one out of 10 healthcare licensing compacts, which may be contributing to fewer healthcare providers coming to the state. New Mexico only participates in the Nurse Licensure Compact (NLC). Compacts are available for healthcare professions that New Mexico has a shortage of, including physicians, psychologists, advanced practice registered nurses, social workers, counselors, and occupational therapists. While New Mexico adopted the Nursing Licensure Compact in the 2018 session, proposed legislation introducing the physical therapy compact (SB60 in 2021 regular session) and the Interstate Medical Licensure Compact (SB97 in the 2019 session) have not passed. Advancing the recognition of cross-state licensure could increase provider access to communities with more in-person and telehealth appointment availability statewide while drawing more healthcare practitioners to the state.

Figure 9. Occupational Licensure Compact Membership



Source: The Council of State Governments

Potential interstate compacts the state could prioritize include medical, occupational and physical therapy, psychology, counseling, and social work. Occupational and physical therapy compacts would increase access to long-term and aging populations, potentially keeping elderly individuals physically functional for longer, reducing the need for assisted living services. Expanding access to psychologists, counselors, and social workers should be a priority because psychotherapy is one of the most billed procedures in the state and secret shopper surveys have identified this as an area of need.

Compacts Established for Healthcare Licensure

- Interstate Medical Licensure Compact (IMLC)
- Nurse Licensure Compact (NLC)
- Advanced -Practice Registered Nurse Compact (APRN Compact)
- Recognition of Emergency Medical Services Personnel Licensure Compact (The EMS Compact)
- The Physical Therapy Compact (PT Compact)
- The Psychology Interjurisdictional Compact (PSYPACT)
- Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC)
- The Occupational Therapy Licensure Compact (OT Compact)
- The Counseling Compact
- Social Work Compact

Source: National Center for Interstate Compacts

New Mexico's J-1 Visa Waiver (State 30) program brings foreign physicians to the state. The Department of Health administers these waivers, which connect foreign doctors to health care facilities that accept Medicaid and are within federally designated health professional shortage areas. These visas also have a higher retention of doctors in rural areas than a visa waiver program. According to DOH, of those immigrants who moved to New Mexico on a J-1 Visa from 2009-2013, two thirds of them are still in New Mexico.

Other states also administer this program because it can lead to a large increase in the state's healthcare workforce. For instance, according to a 2021 article roughly 25 percent of Nevada's doctors and 37 percent of their nurses are immigrants.

Source: High Country News, DOH

Peer Support Workers can play a role in BH Treatment

- NM has a program for certified peer support workers through Behavioral Health Services Division funded at $260 thousand in FY23.
- A peer support worker is someone with lived experience of a mental health condition, substance use disorder, or both.
- They provide support to others experiencing similar challenges.
- Peer support improves engagement in self-care, wellness, and social support and functioning.
- The role complements, but does not duplicate or replace, the roles of therapists, case managers, and other members of a treatment team.
- Because the role is not duplicative of therapists, the state still needs to recruit and retain behavioral health workers.

Source: SAMSHA

The state has outlined a plan to increase primary care medical residencies from 2019 to 2025 by 86 percent, a significant acceleration of the growth in residency slots that occurred from 2012 to 2022. According to a report published in the *Journal of Graduate Medical Education*, residents are likely to practice where they complete residency, and residents who spend at least 50 percent of their residency in a rural communities are more likely to practice in a rural community. Informed by this research, New Mexico has invested in expanding primary care and rural residency programs. The University of New Mexico (UNM) grew its first-year primary care residency slots from approximately 50 in 2012 to approximately 100 in 2022, doubling the number over 10 years.

To continue to expand residency slots, the state has funded approximately 25 slots using general fund revenue (at roughly $2 million) while continuing to have most slots funded by Medicare and Medicaid. In addition to this funding, the state also established the graduate medical education (GME) expansion advisory group in 2019, through legislation, to focus on increasing GME opportunities in New Mexico. The group's updated five-year plan, published by HSD, projects to add 61 family medicine, 20 general pediatric, and 16 general internal medicine residency slots between 2020 and 2025. In addition to these residency slots, it will also add 25 psychiatry residencies, for a total of 122 slots, or a 86 percent increase since 2019. These new slots should lead to 34 new graduating residents per year, of which roughly half, or 17, per year are expected to stay in New Mexico. Increasing the number of doctors in the state will help improve the shortage of physicians and the state should continue to use this group to make coordinated GME expansion decisions.

Table 20. 5-year Timeline of new or Expanded Primary Care Graduate Medical Education Program in New Mexico
(Updated 2022)

Program	Number of First Year Residents						Total New Residents	New Graduating Residents Per Year
	2020	2021	2022	2023	2024	2025		
Family Medicine	3	9	11	12	14	12	61	14
General Psychiatry	0	0	0	5	10	10	25	10
General Pediatrics	0	5	5	5	5	0	20	5
General Internal Medicine	2	2	2	0	5	5	16	5
Total Residents per Year	5	16	18	22	34	27	122	34

Source: HSD

Additionally, the state is partnering with the Western Interstate Commission for Higher Education to bring more clinical psychologists to the state for pre-doctoral internships. This program, in its first year, can bring two students per site (Indian Health Service in Shiprock, the Behavioral Health Institute in Las Vegas, and Hidalgo Medical Services in Silver City) to the state, for six slots, and is funded at $50 thousand. Additionally, the Behavioral Health Services Division will provide a state agency with $50 thousand to provide a post-doctoral year to clinical psychology students; however, no agency requested this funding during the first year the program was established.

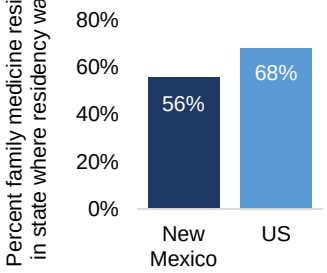
The Primary Care Council, established through statute, focuses on increasing primary care access through several mechanisms, including alternative payment models. The Primary Care Council Act passed in 2021 established the council to focus on analyzing and creating policy recommendations around primary care, requiring the council to present annually to the Legislative Finance and the Health and Human Services committees. (See Appendix P for a summary of five-year plan published in 2022.) One strategy that has been incorporated into MCO contracts is using an alternative payment structure to support a multidisciplinary team approach to

primary care. These teams are not incentivized under the current reimbursement rate structure because they may provide services that are not directly billable. The American Medical Association highlights alternative payment models as a best practice to decrease costs while maintaining or increasing quality care. The Primary Care Council will provide budget recommendations to the Medicaid program on the development of alternative payment models and needed provider technical assistance by March 2023. As these alternative payment model pilots progress, the state should monitor outcomes from these and report to the legislature.

Ensuring New Mexico's healthcare workforce stays in state could help improve network adequacy and improve access to care.

While the state has focused on recruitment and creation of the healthcare workforce, establishing retention strategies may also be necessary. Currently, fewer medical residents stay in New Mexico on completion of residency than the national average**.** Nationally, 68 percent of family medicine residents stay in the state where they train but only 56 percent of New Mexico family medicine residents stay in state. Additionally, national research shows approximately 57 percent of individuals who complete residency stay in the state they did their training. For New Mexico, this number is lower, with 21 percent of doctors who completed only their residency at UNM licensed to practice medicine in New Mexico and 54 percent of those who completed both their residency and medical school practicing in New Mexico, according to the University of New Mexico's location reports.[2] In 2020, the overall retention rate for UNM was only 38 percent. Furthermore, a spring 2022 survey of UNM's current residents found 46 percent of residents originally planned to stay in New Mexico post residency. However, only 20 percent of those residents who originally planned to stay still intend to do so.

Chart 11. Fewer Family Medicine Residents Stay in New Mexico Upon Completing Residency than Nationally



Source: HSD GME 5 year strategic plan

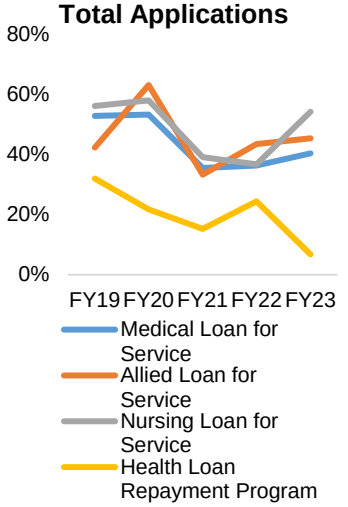
Increasing residency slots may increase the number of doctors in the state, but this increase will likely be lower than it would be in other states due to retention challenges. Research points to financial incentives as a potential lever to help retain providers; however, other factors, such as family satisfaction, may also need to be addressed.

New Mexico has loan repayment and loan-for-service programs that may help retain healthcare workers in rural areas if expanded. Loan repayment and loan-for-service programs have been shown to retain healthcare workers, with those who enter a rural loan for service program more likely to stay in a rural community. Colorado examined three loan-for-service programs, concluding, while these programs may enroll some individuals who are already interested in serving rural communities, they have a limited but important influence on retaining rural providers. Another study found doctors were 3.2 times less likely to leave a rural area if they were fulfilling a service obligation than if there was no obligation.

New Mexico has five loan repayment or loan-for-service programs for healthcare workers operated in conjunction with the Higher Education Department and a federally funded program run by DOH. In total, the HSD programs in FY23 expended approximately $2.1 million to 111 students. Four

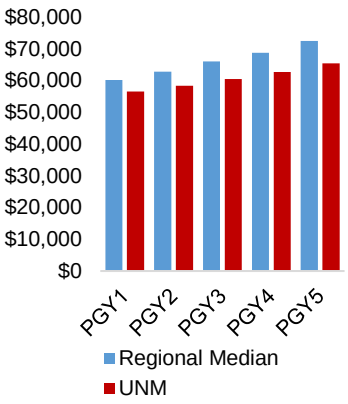
[2]Based off the 2019, 2020, and 2021 location reports, which had 21 percent, 21 percent, and 20 percent of residents becoming licensed in the state.

Chart 12. Percent of Loan Awards by Total Applications



Source: HED

Chart 13. UNM Resident Salaries Are Below the Regional Average Each Year



Note: PGY is the program year. Residencies last between 3-7 years.
Source: CIR/SEIU Letter

of these loan-for-service programs can provide up to 100 percent loan reimbursement—a portion of the loan is forgiven for every year of service—while the health professional makes a two-year service commitment to practice full-time in a medical shortage area within the state under the Health Professional Repayment Program. As stated in a 2021 LFC memo, the state may want to consider lengthening the number of years for which an individual can receive an award to help keep healthcare professionals working in rural areas for a longer time. In FY23, of the 787 total students who applied overall, only 111, or 14 percent, were awarded a loan. Furthermore, in its annual report, HED states these loans are a competitive process where some applicants will not get an award. When looking at the loans individually, the acceptance rate ranged from 7 percent to 87 percent, with the program with the largest applicant pool awarding the lowest proportion of applicants. Because loan repayment and loan-for-service programs have been shown to retain healthcare professionals in rural areas, the state should look at expanding these programs, particularly the Health Professional Repayment program, to more individuals to ensure that all qualified applicants receive loan repayment in some form.

University of New Mexico's resident salaries are below the regional average, one factor reportedly leading residents to relocate post-residency. The average salaries for medical residents at UNM are between $4,000 and $7,000 lower than the regional average. Medical resident salaries increase over the three to seven years a doctor is in residency. The average first year resident salary at UNM is $56.6 thousand, roughly $4,000 lower than the regional median of $60.3 thousand. The gap between salaries is larger for those in their fifth year of residency, when UNM pays approximately $65.5 thousand and the regional median is $72.6 thousand. A recent survey of residents at UNM cited residents being excluded from recent pay increases and the relatively inadequate salary offers as reasons to relocate from New Mexico. The Committee of Interns and Residents at UNM has asked the Legislative Finance Committee to provide an 8 percent pay increase for medical residents at the University as well as providing a one-time $1,500 bonus for current residents, with an estimated cost of $4.5 million.

New Mexico's medical malpractice limitations are higher than two out of three neighboring states. Research is mixed on the impact of tort reform on physician supply, with many articles showing a correlation between high medical malpractice and reduced physician supply. However, studies of states that implemented tort reform have not seen increases in physicians. New Mexico recently changed its medical malpractice laws, allowing for claims up to $4 million from hospitals and outpatient facilities. This cap will increase to $6 million in 2026. Meanwhile Colorado, Texas, and other states have lower caps on medical malpractice, while Arizona has no limitations. To understand better the impacts of increasing medical malpractice in the state, HSD with the Center for Health Policy should conduct research on the effects of increasing medical malpractice on provider recruitment and retentions as well as patient health outcomes and report to the legislature the findings of this research.

Table 21. Medical Malpractice Laws in New Mexico and Neighboring States

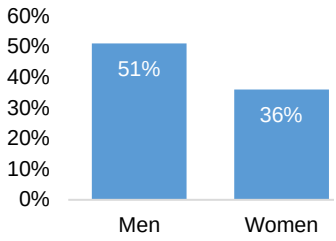
State	Limitations	Statute
AZ	No limitations.	Ariz. Const. Art. 2, §31 Ariz. Const. Art. 18, §6
CO	noneconomic capped at $300,000 total damages capped at $1 million	Colo. Rev. Stat. §13-64-302
TX	$250,000 limit per claimant for noneconomic damages against physician or provider.	Tex. Civil Practice & Remedies Code Ann. §41.008 Tex. Civil Practice & Remedies Code Ann. §74.301 Tex. Civil Practice & Remedies Code Ann. §74.303
NM	Except for punitive damages and past and future medical care and benefits cap set at $750 thousand for independent providers. In 2022, the cap is $4 million for claims brought against a hospital or outpatient care facility. This increases to $4.5 million in 2023, $5 million in 2024, $5.5 million in 2025 and $6 million in 2026. Beginning in 2027 rates will be set annually and indexed to CPI. The value of accrued medical care and related benefits have no limitations. A healthcare personal liability is limited to $250 thousand.	N.M. Stat. Ann. §41-5-6

Source: NCSL

Providing spousal employment or help finding employment may improve retention of healthcare professionals in rural areas. Research shows spousal satisfaction regarding living in a rural area as a major factor when recruiting and retaining healthcare practitioners. In a peer-reviewed article focused on rural healthcare in Idaho, spousal satisfaction with job location was rated as very important by 91 percent of survey respondents. Additionally, spousal satisfaction was the most frequently reported barrier to practicing in a rural community. These respondents specified that inadequate employment and cultural opportunities were the main factors in spousal dissatisfaction.

Some universities and national laboratories, particularly in rural area, provide dual-career services for new hires to help find employment for the spouse, either at the same location or within the community based on the spouse's qualifications. These programs help the spouse look for jobs within the university or community, generally for a specific time. Similarly, Los Alamos National Laboratory in 2015 established a dual-career program to help keep employees. This program has two tiers, providing "hands-on help" for critical positions or for which there may be retention problems or providing general assistance for all employees. These types of programs would be particularly useful for rural hospitals because approximately 51 percent of male doctors and 36 percent of female doctors are married to a doctor or individual in the healthcare field. As universities may provide dual-career services for academic or executive hires, it would be beneficial for New Mexico's medical institutions to have these services available for medical residents and their spouses.

Chart 14. Percent of Doctors Married to Someone in the Healthcare Field



Source: AMA

Case Study of Dual Career Hiring at University of Rhode Island

Spouses looking for employment in the community may seek services from the university, who is responsible for using their formal & informal contacts to assist the partner in identifying, applying for, and interviewing for appropriate off campus employment. A facilitator is appointed who is responsible for ensuring strong communication between the university and community connections.

For an individual seeking employment at the university, the candidates chair will collect the spouse's resume and qualifications and communicate with target deans or provost as appropriate.

Source: CSUSB Dual Career report

Recommendations:

The Legislature should consider

- Enacting legislation to allow New Mexico to enter multi-state licensing compacts, including medical, psychology, counseling, and social work compacts.

The Human Services Department should

- Require MCOs to contract with all major provider networks;
- Provide evaluation of MCO annual provider network development plan reports;

- Work with the Center for Health Policy to examine the effects of increasing medical malpractice and report to the legislature the findings of this research; and
- Track outcomes regarding alternative payment models, including provider uptake, cost per patient, and health outcomes and report to the Legislature.

The University of New Mexico should consider

- Raising pay for medical residents;
- Facilitate medical resident spouse's access to and utilization of the university's career services; and
- Continue to offer its master's of nursing science graduate program.

The Higher Education Department should

- Expand loan repayment and loan-for-service programs to allow for longer lengths of services, potentially up to five years, and to allow more qualified applicants to receive awards.

The Regulation and Licensing Department and the Nursing Board should

- Measure the average time to issue licenses and create a set of performance measures in regard to licensure issuance.

Agency Response

HUMAN SERVICES DEPARTMENT
Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary
Nicole Comeaux, J.D., M.P.H., Director

December 12, 2022

Mr. Jon Courtney
Deputy Director for Program Evaluation
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Mr. Courtney:

The New Mexico Human Services Department (HSD) appreciates the opportunity to review and respond to the Legislative Finance Committee's (LFC) evaluation report of Network Adequacy and Utilization in the Medicaid Program.

There is a 1500 year old parable about four blind men who have never encountered an elephant before. They each feel one part of the elephant (tusk, trunk, leg, side) and then report their description of the animal. Of course, they wildly disagree, based on the limited assessment they have taken of the animal.

The point of the parable is that the various parts of the elephant provide only a limited picture, and that, in the end, one must come to grips with the "whole elephant" to understand it. In our view, this LFC Program evaluation attempts to identify the limitations caused by a statewide shortage of almost all types of providers (the elephant) by examining one important part of it: Medicaid (let's say, a leg). The danger of this approach is that it could create an impression that the changes that are needed to improve access to a wide variety of providers can be simply executed within the Medicaid program. While there are certainly important interventions that Medicaid can make that will help, such as provider rate increases, the "fix" that is needed to improve access to healthcare in New Mexico should be squarely centered in public policy and legislative action. Interventions that have proven effective in other states, such as expansion of health profession loan repayment funding, expanding pipeline capacity in training institutions such as medical and nursing schools, expanding primary care and behavioral health training in particular, addressing rising malpractice cost issues, and focusing on the support and preservation of rural healthcare are all examples of things that Medicaid can *help with* (the elephant's leg), but that should be driven by a broader legislative agenda designed to make New Mexico a place where providers come to practice and desire to stay here for the rest of their careers (the whole elephant).

So, while you will read below that we concur with most, but not all, of the recommendations in the report, we want to stress that any attempt on the part of our Medicaid program to make New Mexico more "provider friendly" is not likely to succeed without the enactment of a much broader public policy umbrella that includes the Office of the Superintendent of Insurance, health professional training

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institutions, providers themselves, and every community that desires to improve access to healthcare. Not just the Medicaid program.

In response to the key recommendations made by the LFC within its report, HSD provides the following responses. We apologize for the duplicate responses but we have done this to directly correspond to the duplicate recommendations in the LFC report itself:

1. **LFC Recommendation – HSD should develop a comprehensive statewide network adequacy assessment and report to the Legislature annually about adequacy of the state's Medicaid provider network.**
   Concur. The network adequacy assessment is limited to Medicaid providers only. However, HSD would welcome completing this effort in coordination with the Office of the Superintendent of Insurance (OSI) as the adequacy of the statewide network is a critical factor in the feasibility of establishing an adequate Medicaid network.

   The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

2. **LFC Recommendation – HSD should direct MCOs to enact targeted provider rate increases, monitor MCO rates to ensure intended provider rate increases are passed on, evaluate and report outcomes and impact to the Legislature.**
   Concur. HSD currently directs MCOs to enact targeted provider rate increases, monitors rates to ensure intended provider rate increases are passed on where appropriate. The development of an outcomes report for directed payments will aid the legislature and the state in evaluating the impact of our investments.

3. **LFC Recommendation – HSD should ensure it keeps provisions in the Turquoise Care contract requiring quarterly secret shopper surveys with representative samples, specific penalties around network adequacy and non-emergency medical transportation.**
   Concur. HSD intends to maintain provisions and appreciates the LFC's acknowledgment of the Department's oversight efforts in the upcoming contract.

   The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

4. **LFC Recommendation – Strengthen primary care provider ratios in MCO contracts to bring closer to current ratios and consider variation for urban, rural, and frontier geographies.**
   Disagree. HSD disagrees with this recommendation as it does not align with national evidenced based ratios. However, HSD will engage in additional research and consider targeted ratios in rural and frontier areas.

Additionally, based upon subsequent recommendations made by the LFC throughout this report, HSD provides the following responses.

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1. **LFC Recommendation – HSD should develop a comprehensive statewide network adequacy report examining provider ratios, distance and timeliness standards that takes into account providers who contract with multiple MCOs and report annually to the Legislature about the adequacy of the state's Medicaid provider network.**
   Concur. The network adequacy assessment is limited to Medicaid providers only. However, HSD would welcome completing this effort in coordination with the Office of the Superintendent of Insurance (OSI) as the adequacy of the statewide network is a critical factor in the feasibility of establishing an adequate Medicaid network.

   The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

2. **LFC Recommendation – HSD should require MCOs regularly validate their provider directories.**
   Concur. HSD currently requires MCOs to update their online provider directories daily. However, HSD will include a requirement for quarterly provider directory validation and will add independent validation of the directories to the contract requirements for the External Quality Review Organization (EQRO). With the implementation of the Medicaid Management Information System Replacement (MMISR - HHS 2020) Medicaid will have a single provider director that combines listings from all MCOs and will interface directly with MCO systems for nightly batch updates of information. This automation should improve accuracy.

   The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

3. **LFC Recommendation – Strengthen primary care provider ratios in MCO contracts to bring closer to current ratios and consider variation for urban, rural, and frontier geographies.**
   Disagree. HSD disagrees with this recommendation as it does not align with national evidenced based ratios. However, HSD will engage in additional research and consider targeted ratios in rural and frontier areas.

4. **LFC Recommendation – HSD should set provider ratios for specialty care with input from a variety of stakeholders informed by external benchmarks.**
   Disagree. HSD disagrees with this recommendation because specialists are not assigned members like they are to PCPs. It is difficult to establish ratios for specialty care. Except for chronic conditions members do not typically see a specialist for on-going care and treatment. For example, an orthopedic surgeon after a knee injury. HSD will research other best practices for measuring adequacy of specialists and the EQRO will continue to conduct validations of provider network adequacy for access and timeliness annually.

5. **LFC Recommendation – HSD should require the external quality review organization continue to conduct direct testing on provider network for access to care and timeliness for an appointment, and provider directory validation.**

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Concur. HSD agrees with this recommendation and has executed a contract amendment with the EQRO to include conducting independent secret shopper survey of each MCO's network providers and an audit of provider directories on a semi-annual basis. HSD will begin work on the inclusion of additional provider types and specialties as well as behavioral health providers in calendar year 2023. HSD will include any additional EQRO costs in the SFY25 budget request.

The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

6. **LFC Recommendation – HSD should direct MCOs to review behavioral health provider claims data to identify whether increases in behavioral health utilization is driven by a small percent of enrollees utilizing the majority of services, whether increases in telemedicine or in-person account for trends in behavioral health utilization, whether significantly more individuals are utilizing behavioral health, which diagnoses are driving increases in behavioral health utilization, and whether there are any changes in patient outcomes.**
   Concur with condition. HSD agrees with the concept of measuring network performance, with the full involvement of the MCOs, based on quality metrics included here. The sole area of concern is a focus on whether "increases in utilization is driven by a small percent of enrollees." It has long been understood that individuals with Serious Mental Illness and co-occurring chronic physical health conditions require a disproportionate share of overall healthcare spending, including behavioral health spending. While there is no disagreement with monitoring this, the danger of increasing stigmatization of those neighbors should lead to caution about an overemphasis on that aspect of spending. *This reality would also benefit from monitoring effective implementation of integrated physical and behavioral healthcare.*

7. **LFC Recommendation – HSD should conduct a rigorous cost benefit analysis of care coordination.**
   Concur with condition. HSD agrees that a rigorous cost benefit analysis of care coordination should be conducted. However, the 2019-2023 contract period would yield an inadequate study as a result of the COVID-19 Pandemic interruption where for almost half of the study period care coordination was prohibited from happening in person. HSD will review this recommendation and develop a proposal for this study. It is our impression that the study would require analysis of levels of care, MCO staffing, clients affected, programmatic costs, and review of client benefits. We anticipate the benefit side of the study will be challenging and will need to be outlined prior to beginning of study so can be tracked.

8. **LFC Recommendation – HSD should ensure it keeps provisions in the Turquoise Care contract requiring quarterly secret shopper surveys with representative samples, specific penalties around network adequacy and non-emergency medical transportation.**
   Concur. HSD intends to maintain provisions and appreciates the LFC's acknowledgment of the Department's oversight efforts in the upcoming contract.

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The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

9. **LFC Recommendation – HSD should establish targets for the care coordination outcomes metrics including within the Turquoise Care contracts.**
   Concur with condition. HSD agrees and will establish these targets and look at issuing direction in CY2023 as a measurement year. Due to the nature of the pending procurement of Turquoise Care, we are not able to discuss new initiatives and recommendations related to Turquoise Care at this time.

10. **LFC Recommendation – HSD should set primary care provider ratios in MCO contracts at 1:500 or lower and consider opportunities for variation for urban, rural, and frontier geographies.**
    Disagree. HSD disagrees with this recommendation as it does not align with national evidenced based ratios. However, HSD will engage in additional research and consider targeted ratios in rural and frontier areas.

11. **LFC Recommendations – HSD should further clarify how to determine if a MCO is not meeting network adequacy requirements and when they will be penalized.**
    Concur. HSD agrees with this recommendation and will convene a workgroup in CY2023 to revise distance standards for provider types and services and clarify penalties where appropriate with consideration for feasibility given statewide provider shortages acknowledged in the LFC Evaluation. HSD will also implement the CFR 'exception' provision in CY2023 via a Letter of Direction.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

12. **LFC Recommendation – HSD should consider adding home visiting participation to Centennial Rewards and track outcomes.**
    Concur with condition. There are 16 initiatives currently outlined for Centennial Rewards CY2023, but HSD will evaluate budget feasibility of CY2023 implementation. If not feasible will include in FY2025 budget for implementation.

13. **LFC Recommendation – HSD should through letters of direction, direct MCOs to enact targeted provider rate increases.**
    Concur. HSD currently issues and will continue to issue directed payments within the requirements outlined in Medicaid managed care regulations at 42 C.F.R. § 438. CMS requires that directed payments be tied to utilization and delivery of services under the managed care contract, be distributed equally to specified providers under the managed care contract, advance at least one goal in the state's managed care quality strategy, and not be conditioned on provider participation in intergovernmental transfer (IGT) agreements (42 CFR §438.6(c)). To enforce these requirements, CMS required states to seek prior approval of all directed payment arrangements. HSD also uses other mechanisms such as a minimum fee schedules, Medical Loss

Ratios (MLR), and underwriting gain caps to ensure the vast majority of appropriated state general fund dollars are spent on direct member care.

14. **LFC Recommendation – HSD should in partnership with OSI, monitor outcomes associated with these rate increases, including changes to the Medicaid provider network, access, and utilization, and impacts to patients with other insurance and report these outcomes to the Legislature.**
Concur with condition. The OSI does not have oversight authority over HSD or HSD's Medicaid program. HSD is by federal and state law the single state agency designated to administer the Medicaid program (42 CFR 431.10; NMSA 1978 § 27-2-12, et seq.). The Patient Protection Act in the Insurance Code states that it applies to Medicaid (NMSA 1978 § 59A-57-10) but only very limitedly so and expressly not in any way to limit the authority of HSD over the Medicaid program: "Nothing in the Patient Protection Act shall be construed to limit the authority of the human services department to administer the Medicaid program, as required by law." Suggestions that the OSI has "oversight" (or equivalent) over HSD, or the Medicaid program are contrary to this express statutory provision. Medicaid is and should remain under the authority of the only agency with the expertise to oversee what is probably the most complex health care program in the U.S., which includes many covered services and provider types that are not included in commercial plans. That said, we are supportive of collaboration between the OSI and HSD in furtherance of all New Mexicans' needs to have access to affordable, quality health care.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

15. **LFC Recommendation – HSD should verify, either directly or through the EQRO process, that provider rate increases directed by the Legislature translate to provider rate increases and report about their findings.**
Concur. HSD, where appropriate, requires detailed reporting on the implementation of directed payments appropriated by the legislature. HSD will consider how we may evaluate outcomes associated with specific directed payments and how we may report on them. Many directed payments from 2019-2022 were directed at hospitals so evaluations of cost reports and salaries may provide insight into how these payments were used and impacted New Mexican providers and Medicaid members.

16. **LFC Recommendation – HSD should provide the LFC with information that allows the Legislature to verify the assumptions in the MCO PMPM rate setting process that impact Medicaid projections, including utilization and placement within the actuarial range.**
Concur. It is the goal of HSD to promote transparency and enhance the public trust. Keeping in the spirit of that goal, HSD has provided the LFC with the actuarial rate certification reports and statewide rate averages for the last four calendar year rating periods (CY2019 through CY022) and will continue to do so. These reports include assumptions made in the rate setting process and utilization trends. Additionally, and as part of the development of this report, HSD and Mercer staff met with the LFC to discuss how capitation rates are developed. HSD posts publicly on its website utilization statistics and dashboards reflecting medical and non-medical

costs, as well as enrollment and utilization trends quarterly. HSD presents this information publicly at the quarterly Medicaid Advisory Committee Meetings which LFC staff regularly attend, and at interim LFC budget hearings. HSD has made a good faith effort and will continue to work with LFC to provide any and all information that would not impede on HSD's ability to negotiate rates with the MCOs protected by state regulations.

17. **LFC Recommendation – HSD should ensure potential changes in MLR and underwriting gain are reflected in FY24 appropriations for the Medicaid program and are adjusted for prior-year MLR remittances.**
Concur. HSD agrees with the recommendation to provide an analysis of MCO profitability (MLR/UWG) as reflected in SFY24. HSD will review this proposal with our actuary.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of applicable health insurance, rather than limiting to Medicaid.

18. **LFC Recommendation – HSD should continue to work with other state entities and MCOs to allow for Medicaid reimbursement for non-emergency medical transportation and other services.**
Concur. The PRC regulates transportation services, and the CFR has stringent requirements for Medicaid non-emergency medical transportation (NEMT). HSD is in favor of allowing other transportation entities such as Uber and Lyft to provide and augment existing NEMT services. HSD and our MCOs have been working with these entities and the PRC to obtain licensure so HSD can enroll them as Medicaid providers. Additionally, our MCOs have been working in partnership with ambulance entities to augment existing networks. HSD recommends and appropriation to increase rates here as well to that reimbursement and pay will be competitive and allow us to build in adequate network.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

19. **LFC Recommendation – HSD should implement and enforce the draft changes to MLR and underwriting gain in Turquoise Care contracts.**
Concur. HSD intends to maintain provisions and appreciates the LFC's acknowledgment of the Department's oversight efforts in the upcoming contract.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

20. **LFC Recommendation – HSD should continue to set PMPM rates toward the lower end of the actuarially-sound range.**
Disagree. Since 2019, HSD has considered and maintained the MCOs' bid position submitted in the Centennial Care 2.0 Cost Proposal when selecting final MCO payment percentiles from the minimum and maximum range developed by Mercer. In reviewing final rates and medical trends, as well as to support various budget objectives, HSD has elected to adjust the position of the MCOs' payment percentile within the minimum and maximum range for CY2023. The

adjustment will move the MCOs' payment percentile to the minimum of each MCO's Centennial Care 2.0 Cost Proposal bid position and the twenty-fifth percentile for each rate cohort. Any contracted rate that was previously below the twenty-fifth percentile will remain unchanged. This approach considers historic policy decisions around the MCO's bid position as well as the current budgetary environment. HSD expects the capitation revenues associated with the MCO payment rates will continue to support successful delivery of Medicaid services in an ever-changing environment, but HSD must consider all factors in each rate setting period and cannot commit to this recommendation. HSD does commit to always striving to set rates that allow for successful operation of the program and fiscal conservatism in the expenditure of state general funds and federal funds.

21. **LFC Recommendation – HSD should require MCOs to contract with all major provider networks.**
Disagree. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid enrollee. Under the managed care model, the state pays a managed care plan a capitation rate—a fixed dollar amount per member per month—to cover a defined set of services for each person enrolled in the plan. In turn, the plan pays providers for all the Medicaid services an enrollee may require that are included in the plan's contract with the state. MCOs are at financial risk if spending on services and administration exceeds payments; conversely, they are permitted to retain any portion of payments not expended for covered services and other contractually required activities. Managed care plans can establish their own provider network qualifications, contract terms, and payment rates (within parameters required by the terms of the contract with the state). Requiring MCOs to contract with all providers can inhibit their ability to negotiate rates, control costs, and design value-based payment arrangements. HSD does agree that networks need to be adequate and as committed to elsewhere in these responses, HSD is committed to continued efforts to strengthen guidance, oversight, and enforcement of network adequacy requirements.

22. **LFC Recommendation – HSD should provide evaluation of MCO annual provider network development plan reports.**
Concur with condition. HSD reviews several reports related to network adequacy including the Geo Access, Network Adequacy, Grievance and Appeals, and the Provider Network Development Plan reports on a quarterly and annual basis and provides detailed feedback to the MCOs. HSD would like to work with LFC to understand what kind of evaluation is being requested and requirements for its submission.

    The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

23. **LFC Recommendation – HSD should work with the Center for Health Policy to examine the effects of increasing medical malpractice and report to the legislature the findings of this research.**
Concur with condition. HSD can engage with the Center for Health Policy to understand what a statement of work might look like to support this recommendation and if there would be an

associated cost. HSD will work with LFC to determine options available to us in alignment with this recommendation.

The most effective strategy for New Mexico would be to implement this recommendation for all forms of health insurance, rather than limiting to Medicaid.

24. **LFC Recommendation – HSD should track outcomes regarding alternative payment models including provider uptake, cost per patient, and health outcomes and report to the Legislature.**
Concur. There are several alternative payment model initiatives underway. The new payment model for Medicaid primary care will go live in CY2024 and HSD can report to the Legislature when data becomes available. HSD is also currently developing a Value Based Purchasing framework for administering quality related payments to hospitals and nursing facilities in coordination with our provider partners. HSD will be working to expand this framework to other providers and will include legislative reports on these efforts.

Sincerely,

David R. Scrase, M.D.

David R. Scrase, M.D.
Secretary

cc: Angela Medrano, Deputy Cabinet Secretary
Kari Armijo, Deputy Cabinet Secretary
Nicole Comeaux, Medicaid Director, Medical Assistance Division
Neal Bowen, Director, Behavioral Health Services Division

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Appendix A: Evaluation Scope and Methodology

Evaluation Objectives.

- Assess the adequacy of the New Mexico Medicaid provider network and identify potential gaps;
- Determine potential barriers to service access by Medicaid enrollees including uptake of Medicaid patients and time to treatment;
- Analyze Medicaid utilization rates and examine how these relate to program funding and capitation rates; and
- Identify primary cost drivers contributing to Medicaid expenses.

Scope and Methodology.

- Interviewed HSD and MCO employees;
- Reviewed state and federal laws, regulations, and policies – goals and objectives of the program;
- Reviewed department reports, Medicaid plans, waivers, CMS reports and EQRO reports;
- Reviewed public and private research and evaluations of managed care, Medicaid managed care and costs of health care in general;
- Collected financial and other aggregate utilization data from the department for FY19-FY21, and projected FY23 for Medicaid managed care as a whole and for each individual MCO;
- Reviewed recent policy or programmatic changes related to Centennial Care 2.0 intended to address network adequacy, standards, or rate changes;
- Reviewed draft Turquoise Care contracts;
- Reviewed reports from HSD's actuary including rate studies;
- Reviewed changes in cohort enrollment and costs from FY19-FY23 (projection);
- Reviewed summary contract compliance reports from the department, selected network development plans from MCOs, and contract documents; and
- Reviewed program goals.

Evaluation Team.

Ryan Tolman, Ph.D., Lead Program Evaluator
Rachel Mercer Garcia, Program Evaluator
Sarah Dinces, Ph.D., Program Evaluator
Ginger Anderson, Fiscal Analyst

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with the Human Services Department Secretary, Medicaid Director, and staff on December 8, 2022.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Jon Courtney, Ph.D.
Deputy Director for Program Evaluation

Appendix B: HEDIS Metrics on Which New Mexico Ranks in the Bottom Quartile

Table 22. HEDIS Metrics on Which New Mexico Ranks in the Bottom Quartile

Domain	Rate Definition	NM Rate	National Median
Primary Care Access and Prevention	Percentage who had 1 or More Well-Child Visits with a Primary Care Practitioner: Ages 3 to 6	55.4	70.4
Primary Care Access and Prevention	Percentage of Women Screened for Cervical Cancer: Ages 21 to 64	43.7	56.7
Primary Care Access and Prevention	Counseling for Physical Activity: Ages 3 to 17	48.3	58.5
Primary Care Access and Prevention	Counseling for Nutrition: Ages 3 to 17	53.1	63.1
Primary Care Access and Prevention	Percentage of Women who had a Mammogram to Screen for Breast Cancer: Ages 50 to 64	46.6	54.7
Behavioral Health	Percentage Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 18 to 64	36.6	54.7
Behavioral Health	Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6 to 12	42.4	57.4
Behavioral Health	Percentage Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 6 to 17	53	66
Behavioral Health	Percentage with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Age 18 and older	52.4	62.5
Behavioral Health	Percentage Current Smokers and Tobacco Users Advised to Quit: Ages 18 to 64 Years	70.1	76.7
Behavioral Health	Percentage of Current Smokers and Tobacco Users Discussing Cessation Medications: Ages 18 to 64 Years	42.5	53.7
Care of Acute and Chronic Conditions	Percentage who had a Diagnosis of Hypertension and Whose Blood Pressure was Adequately Controlled: Ages 18 to 64	47.9	59.2

Source: 2020 CMS Healthcare quality measures

Appendix C: Medicaid Eligibility Groups Covered Under Centennial Care 2.0

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Figure 10. Medicaid Eligibility Groups Covered Under Centennial Care 2.0

Population Group	Populations
TANF and Related	Newborns, infants, and children CHIP children (Medicaid expansion) Foster children Adopted children Pregnant women Low income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI
HCBS	Individuals receiving Community Benefit HCBS services under "217-like" group

The following populations are excluded from Centennial Care 2.0:

- Qualified Medicare Beneficiaries;
- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only;
- Mi Via 1915(c) waiver participants for HCBS;
- Supports 1915(c) waiver participants for HCBS; and
- Individuals eligible for the Optional COVID-19 Group.

Source: Draft Section 1115 Medicaid Demonstration Waiver Renewal Request

Appendix D: Medicaid Utilization Metrics

Physical Health Utilization Metrics

Category	Unit Description	CY17 (AS)	CY18 (AS)	CY19 (AS)	CY20 (Q4)	CY21 (Q4)	% Change CY20 to CY21	5 Year Trend
Inpatient Hospital - Acute	Days	158,949	165,871	181,032	155,844	141,514	-9.2%	
Inpatient Hospital - Acute	Admits	34,015	35,719	43,026	40,217	31,649	-21.3%	
Inpatient - Specialty Hospital	Days	6,337	4,711	10,158	7,889	6,736	-14.6%	
Inpatient - Specialty Hospital	Admits	460	379	638	485	379	-21.9%	
Non-Acute LTC/SNF/Respite	Days	16,171	8,445	19,437	14,916	12,106	-18.8%	
Non-Acute LTC/SNF/Respite	Admits	692	477	1,109	866	776	-10.4%	
Ambulatory Surgery Centers - Outpatient Surgeries	Visits	4,018	3,988	4,424	3,642	4,744	30.3%	
Outpatient Hospital - Emergency Room	Visits	203,363	181,954	219,487	157,190	174,627	11.1%	
Outpatient Hospital - Urgent Care	Visits	27,891	22,804	23,443	15,838	19,973	26.1%	
Ambulance - Ground	s - One Way	-	-	0	15,148	-	-100.0%	
Non-Emergent Transportation - Non-Capitated	s - One Way	83,906	58,518	42,794	29,683	22,119	-25.5%	
Prescribed Drugs - Brand Name	Scripts	254,442	243,473	256,410	215,448	265,344	23.2%	
Prescribed Drugs - Generic	Scripts	1,800,748	1,803,500	1,830,195	1,461,891	1,644,644	12.5%	
Prescribed Drugs - Other	Scripts	3,833	2,417	140	141	97,685	69180.1%	

Source: MCO financial reports, report 3

Physical Health Expansion Group Utilization Metrics

Category	Unit Description	CY17 (AS)	CY18 (AS)	CY19 (AS)	CY20 (Q4)	CY21 (Q4)	% Change CY20 to CY21	5 Year Trend
Inpatient Hospital - Acute	Days	96,797	99,624	105,947	104,895	114,776	9.4%	
Inpatient Hospital - Acute	Admits	18,885	19,284	21,744	21,029	17,983	-14.5%	
Inpatient - Specialty Hospital	Days	10,405	10,219	31,003	13,930	13,553	-2.7%	
Inpatient - Specialty Hospital	Admits	733	833	1,218	919	764	-16.9%	
Non-Acute LTC/SNF/Respite	Days	43,824	65,977	60,580	61,753	63,757	3.2%	
Non-Acute LTC/SNF/Respite	Admits	2,186	2,609	3,390	3,313	3,562	7.5%	
Ambulatory Surgery Centers - Outpatient Surgeries	Visits	6,945	6,214	6,042	4,724	5,639	19.4%	
Outpatient Hospital - Emergency Room	Visits	162,650	138,302	165,334	141,111	143,325	1.6%	
Outpatient Hospital - Urgent Care	Visits	11,332	9,017	10,186	8,469	8,869	4.7%	
Ambulance - Ground	s - One Way	-	-	0	-	-	#DIV/0!	
Non-Emergent Transportation - Non-Capitated	s - One Way	148,135	113,761	55,777	37,872	29,755	-21.4%	
Prescribed Drugs - Brand Name	Scripts	301,593	299,807	315,988	902,084	324,653	-64.0%	
Prescribed Drugs - Generic	Scripts	2,088,752	2,020,412	2,020,163	1,985,172	1,809,905	-8.8%	
Prescribed Drugs - Other	Scripts	15,967	2,367	235	278	45,952	16429.5%	

Source: MCO financial reports, report 3

Behavioral Health Utilization Metrics

Category	t Descriptio	CY17 (AS)	CY18 (AS)	CY19 (AS)	CY20 (Q4)	CY21 (Q4)	% Change CY20 to CY21	5 Year Trend
Residential Treatment Center, ARTC and Group Homes	Days	124,069	113,764	93,882	93,916	58,850	-37.3%	
Foster Care Therapeutic (TFC I & II) < 21	ay / Per Diem	118,401	111,447	97,734	82,619	69,531	-15.8%	
Hospital Inpatient Facility (Psychiatric Hospitalization S	Days	37,593	37,397	30,099	27,382	26,349	-3.8%	
Hospital Inpatient Facility (Psychiatric Hospitalization S	Admits	4,867	3,768	4,565	4,704	3,767	-19.9%	
BH Pharmaceuticals - Brand Name	Scripts	53,918	51,521	52,870	224,290	47,814	-78.7%	
BH Pharmaceuticals - Generic	Scripts	590,976	538,797	559,925	553,664	532,130	-3.9%	
BH Pharmaceuticals - Other	Scripts	497	1,604	0	-	40,802	#DIV/0!	
Federally Qualified Health Centers (FQHC's)	e TCN Count	113,647	140,097	124,386	75,633	71,309	-5.7%	
Methadone Treatment	Visits	97,237	168,208	283,931	330,110	333,090	0.9%	

Source: MCO financial reports, report 3

Behavioral Health Expansion Group Utilization Metrics

Category	t Descriptio	CY17 (AS)	CY18 (AS)	CY19 (AS)	CY20 (Q4)	CY21 (Q4)	% Change CY20 to CY21	5 Year Trend
Residential Treatment Center, ARTC and Group Homes	Days	210	49	162	120	-	-100.0%	
Foster Care Therapeutic (TFC I & II) < 21	ay / Per Diem	-	-	1,271	-	-	#DIV/0!	
Hospital Inpatient Facility (Psychiatric Hospitalization S	Days	20,096	23,217	17,984	18,276	16,081	-12.0%	
Hospital Inpatient Facility (Psychiatric Hospitalization S	Admits	3,095	2,986	3,435	3,504	2,356	-32.8%	
BH Pharmaceuticals - Brand Name	Scripts	49,917	49,520	47,331	222,927	47,405	-78.7%	
BH Pharmaceuticals - Generic	Scripts	558,705	499,697	507,014	585,984	538,601	-8.1%	
BH Pharmaceuticals - Other	Scripts	89	4,239	446	-	12,342	#DIV/0!	
Federally Qualified Health Centers (FQHC's)	e TCN Count	72,711	79,606	74,706	53,208	45,039	-15.4%	
Methadone Treatment	Visits	162,394	271,011	462,150	541,549	525,286	-3.0%	

Source: MCO financial reports, report 3

Long Term Services and Supports Utilization Metrics

Category	Unit Description	CY17 (AS)	CY18 (AS)	CY19 (AS)	CY20 (Q4)	CY21 (Q4)	% Change CY20 to CY21	5 Year Trend
Nursing Facility State Owned - High Level of Care	Days	4,887	3,658	2,599	3,606	3,167	-12.2%	
Nursing Facility State Owned - Low Level of Care	Days	88,183	75,924	48,167	67,137	57,748	-14.0%	
Nursing Facility Private - High Level of Care	Days	99,587	51,859	29,044	31,687	22,257	-29.8%	
Nursing Facility Private - Low Level of Care	Days	1,087,075	1,110,585	1,067,928	1,002,860	810,780	-19.2%	
Hospital Swing Bed - High Level of Care	Days	-	-	30	-	-	#DIV/0!	
Hospital Swing Bed - Low Level of Care	Days	-	27	84	44	-	-100.0%	
Community Benefit - Respite	Unit = 15 Min	135,079	133,576	248,413	502,886	565,364	12.4%	
Community Benefit - Adult Day Health	Unit = Day	195,213	214,592	163,132	38,966	40,606	4.2%	
Community Benefit - Assisted Living	Unit = Day	130,609	161,007	144,740	147,868	128,893	-12.8%	
Community Benefit - Environmental Modifications	Modification	2,395	1,667	1,273	1,149	1,654	44.0%	
Community Benefit - Private Duty Nursing	Unit = 15 Min	3,196	3,151	1,568	969	457	-52.8%	
Personal Care Option - T1019	Unit = 15 Min	44,192,339	46,241,772	34,405,588	35,276,424	33,638,017	-4.6%	
Personal Care Option - 99509	Unit = 1 Hour	6,697,438	7,512,848	8,061,744	9,062,924	8,661,409	-4.4%	
Inpatient Hospital - Acute	Days	53,363	56,770	59,930	50,352	50,637	0.6%	
Inpatient Hospital - Acute	Admits	8,936	9,688	10,499	8,876	6,606	-25.6%	
Inpatient - Specialty Hospital	Days	4,839	3,905	10,609	6,462	5,211	-19.4%	
Inpatient - Specialty Hospital	Admits	212	235	387	309	264	-14.6%	
Ambulatory Surgery Centers - Outpatient Surgeries	Visits	2,711	2,676	2,863	1,969	2,492	26.6%	
Outpatient Hospital - Emergency Room	Visits	42,199	36,838	44,530	38,339	36,711	-4.2%	
Outpatient Hospital - Urgent Care	Visits	1,280	1,003	1,227	867	832	-4.0%	
Ambulance - Ground	s - One Way	21,944	20,367	13,727	12,977	12,196	-6.0%	
Non-Emergent Transportation - Non-Capitated	s - One Way	243,321	184,124	108,297	72,620	61,703	-15.0%	
Prescribed Drugs - Brand Name	Scripts	64,111	55,905	69,600	253,589	53,841	-78.8%	
Prescribed Drugs - Generic	Scripts	398,578	382,235	445,471	448,071	374,230	-16.5%	
Prescribed Drugs - Other	Scripts	36,048	1,104	52	50	31,431	62762.0%	

Source: MCO financial reports, report 3

Appendix E: HSD Performance Report Card, Q1 FY23

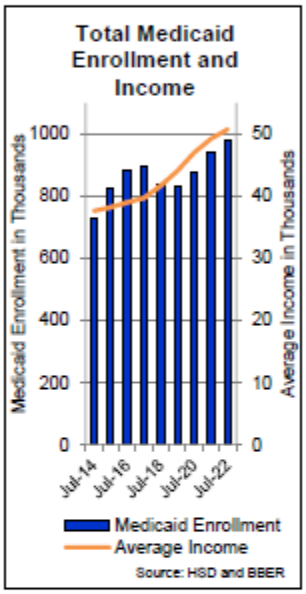
NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

PERFORMANCE REPORT CARD
Human Services Department
First Quarter, Fiscal Year 2023

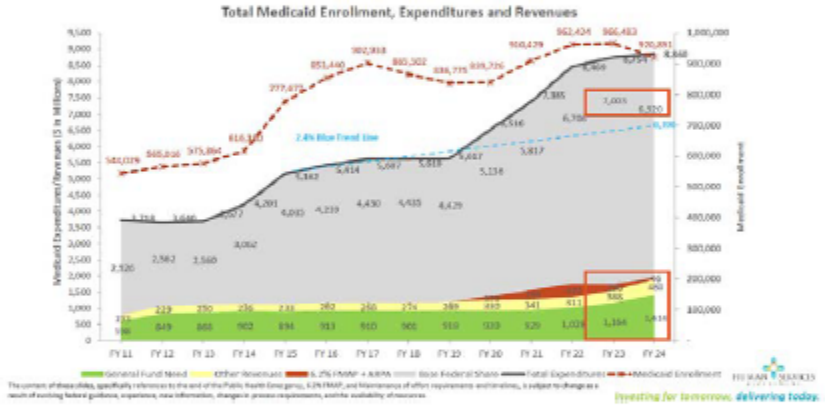
ACTION PLAN

Submitted by agency?	Yes
Timeline assigned?	No
Responsibility assigned?	No

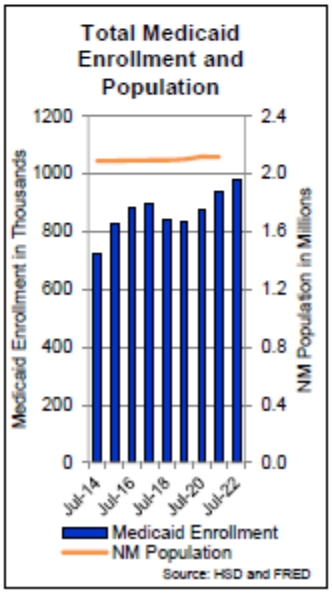
The Human Services Department's Medicaid Program enrolls almost 50 percent of New Mexicans, making it the largest per capita Medicaid Program in the country. The Medicaid Program also represents approximately 14 percent of the state's general fund spending. The Medicaid program reported data for all performance measures for the first quarter of FY23. However, much of Medicaid's performance appears to be lagging behind the targets. HSD reports performance is improving on certain Medicaid performance measures when compared with the same time period last year.



Medicaid managed care organizations (MCOs) receive per-member per-month (PMPM) payments for most Medicaid enrollees regardless if they access services. Notably, utilization rates appear well below the projected levels on which the PMPM rates were built, resulting in MCO recoupments. Network adequacy must be ensured to enable Medicaid clients to have access to services funded through the MCOs.



Source: HSD



Labor force participation is needed at all levels in the state. However, the Income Support Division's (ISD) Temporary Assistance for Needy Families (TANF) Program reported 1.6 percent out of a targeted 37 percent of TANF recipients earned sufficient income to impact their eligibility to receive cash assistance. This is an indication almost all TANF recipients are unemployed or underemployed. The Workforce Solutions Department is tasked with assisting TANF participants with workforce and educational opportunities. ISD and the Child Support Enforcement Division's performance both lagged behind targeted levels for FY23.

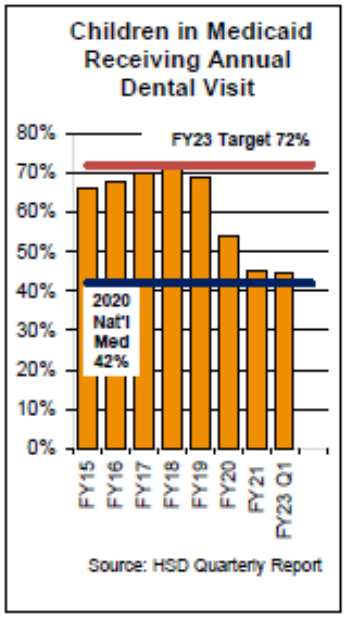
Pandemic-Related Enrollment and Funds. The public health emergency (PHE), federal policy, and workforce participation greatly impact the Medicaid program's enrollment, utilization, costs, and outcomes. In 2020, the Families First Coronavirus Response Act included a 6.2 percent increase in the federal Medicaid matching rate. States receiving the increase are required to continue Medicaid eligibility for any individuals enrolled during the public health emergency that likely will be extended through June 2023, unless the individual voluntarily terminates eligibility or is no longer a resident of the state. During the PHE between March 2020 and March 2022, Medicaid enrolled over 160 thousand new members, for a total approaching 985 thousand. Over 18 thousand people living out-of-state were incorrectly enrolled in Medicaid and the program is in the process of recouping PMPM funds from MCOs for these members.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

PERFORMANCE REPORT CARD
Human Services Department
First Quarter, Fiscal Year 2023

The Medicaid caseload in August 2022 was 975,093 individuals, a 3.8 percent increase over a year ago. The count of Medicaid recipients increased by 3,600, or 0.4 percent, over July 2022.

In August 2022, 386,023 children were on Medicaid, an increase of 3,545 children, or 11.7 percent, over August 2021. However, the number of children on Medicaid decreased by 36 members, from August 2022 to July 2022.



The Office of Superintendent of Insurance (OSI) implemented network adequacy compliance reporting requirements for commercial health insurance beginning January 1, 2022. OSI also implemented more rigorous standards for existing network adequacy compliance reporting.

Medicaid MCOs should be required to comply with OSI regulations for network adequacy and reporting.

Medical Assistance Division

The Medicaid Program reported data for all performance measures in the first quarter. However, performance did not meet targeted levels.

For the first quarter, a reported 28.7 percent out of a targeted 88 percent of children received one or more well-child primary care visits. HSD reports this rate is based on Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications, which applies a member's continuous enrollment specification for the measurement year and does not align with the state fiscal year quarterly reporting. 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 the Centennial Home Visiting program (CHV) remains low despite federal and Medicaid funding for the program. CHV, established in 2020, provides in-home services to young children, children with special healthcare needs, and parents and primary caregivers. CHV's goals are to improve maternal and child health, promote child development and school readiness, encourage positive parenting, and connect families to support in their communities. MAD could leverage the Centennial Rewards program to incentivize CHV participation.

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

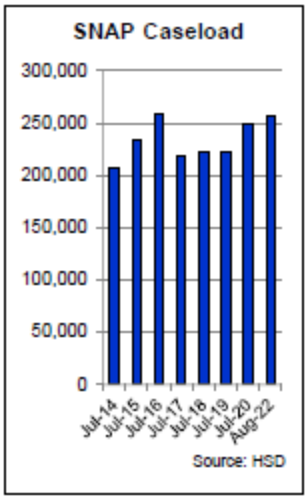
	FY21 Actual	FY22 Actual	FY23 Target	FY23 Q1	Rating
Infants in Medicaid managed care who had six or more well-child visits with a primary care physician during their first 15 months*	51%	49.6%	N/A	55%	Y
Children and youth in Medicaid managed care who had one or more well-child visits with a primary care physician during the measurement year*	39.3%	16.7%	67%	28.7%	R
Children ages 2 to 21 enrolled in Medicaid managed care who had at least one dental visit during the measurement year	56%	37.7%	72%	44.7%	R
Hospital readmissions for children ages 2 to 17 within 30 days of discharge	6.7%	6.8%	<5%	7.3%	R
Hospital readmissions for adults 18 and over within 30 days of discharge	8.9%	11%	<8%	11.2%	R
Emergency room use categorized as nonemergent per one thousand Medicaid member months	50%	53%	45%	53%	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%	59.3%	83%	59.4%	R
Medicaid managed care members ages 18 through 75 with diabetes, types 1 and 2, whose HbA1c was >9 percent during the measurement year*	53%	77.4%	86%	72.8%	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 includes the last quarters of FY22. The data for HEDIS measures is preliminary and will be finalized in June 2022.

Income Support Division

The Supplemental Nutrition Assistance Program (SNAP) caseload in August 2022 was 257,176, a 7.2 percent decrease from a year ago and an increase of 6,517 cases, or 2.6 percent, over July. SNAP caseloads have increased 10 percent since the start of the pandemic.

The Temporary Assistance for Needy Families (TANF) caseload was 10,803 in August 2022, a decrease of 10.3 percent from a year ago and a decrease of 84 cases, or 0.8 percent, below July.



The Income Support Division's (ISD) Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) caseloads rose over the previous year but began declining at the end of FY22. The performance measure "TANF recipient's ineligible for cash assistance due to work-related income" reflects adults whose new employment income exceeded TANF guidelines. Despite unemployment substantially declining in New Mexico, less than 2 percent of TANF recipients were ineligible for cash assistance due to work-related income.

The Workforce Solutions Department (WSD) is partnering with ISD to establish employment placements for TANF Career Link Program and Wage Subsidy Program participants. WSD started a campaign called "Ready NM" with access to training, education, and employment resources that can assist TANF participants.

HSD reports WSD implemented an internal case management process to utilize its employment services staff and workforce connection online system (WCOS) to directly connect TANF participants to available employment and training opportunities throughout the state. TANF participants identified as job ready are referred to employment services staff who assist in WCOS registration, résumé writing, interview preparation and applying for jobs via WCOS. TANF participants who are working with WSD also have direct access to programs offered by the Division of Vocational Rehabilitation, Higher Education Department, and other local community partners, enhancing opportunities for employment and education for TANF participants.

Budget: $1,086,913.5 **FTE:** 1,134

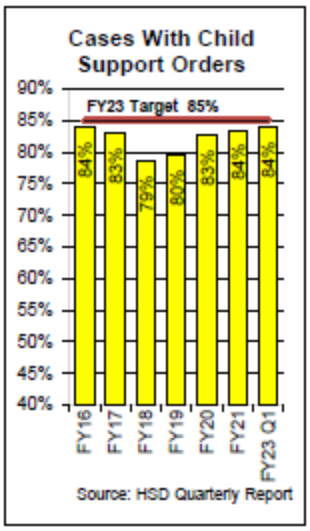
	FY21 Actual	FY22 Actual	FY23 Target	FY23 Q1	Rating
Regular Supplemental Nutrition Assistance Program cases meeting the federally required measure of timeliness of 30 days	98.6%	89%	98%	38.5%	R
Expedited Supplemental Nutrition Assistance Program cases meeting federally required measure of timeliness of seven days	98.5%	75.5%	98%	62.5%	R
Temporary Assistance for Needy Families recipients ineligible for cash assistance due to work-related income	7.6%	0.8%	37%	1.6%	R
Two-parent recipients of Temporary Assistance for Needy Families meeting federally required work requirements	3.5%	2.9%	52%	10.6%	R
All families receiving Temporary Assistance for Needy Families meeting federally required work requirements	4.2%	2.8%	37%	6.4%	R
Program Rating	Y	R			R

Child Support Enforcement Division

The Child Support Enforcement Division (CSED) is engaged in modernizing the program to set accurate child support obligations based on the noncustodial parent's ability to pay; increasing consistent, on-time payments to families; moving nonpaying cases to paying status; improving child support collections; and incorporating technological advances and evidence-based standards that support good customer

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

PERFORMANCE REPORT CARD
Human Services Department
First Quarter, Fiscal Year 2023



HSD's partnership with the Workforce Solutions Department (WSD) does not yet appear to be positively affecting performance outcomes for work program case management services for mandatory TANF participants. WSD is slated to assist TANF participants with gaining skills, experience, and resources to improve the family's financial stability, find employment, and earn living wages.

WSD previously reported staffing issues. However, at the end of FY22, WSD's TANF program reported a vacancy rate of only 8 percent. With caseloads declining, low unemployment, and more staff, hopefully the outcomes of the TANF program will return to pre-pandemic levels.

service and cost-effective management practices. These modernization efforts were tested in pilot offices and were implemented statewide beginning in February 2022. CSED expected performance to improve with these efforts; however, performance for all FY22 CSED performance metrics fell short of targeted levels.

CSED reported child support collections totaled $28.7 million and may meet the FY23 target of $145 million for the year. A decrease in collections began in September 2021, when many noncustodial parents lost unemployment benefits, which were collected as withholdings from the Workforce Solutions Department (WSD). CSED is focusing on assisting unemployed or underemployed noncustodial parents through the Supporting, Training, and Employing Parents Up Program (STEPUp!). The program is in collaboration with WSD to develop job opportunities to assist noncustodial parents with meeting their child support obligations. During the 2021 legislative session, statutory changes were made to assist CSED with setting orders based on new guidelines and reviewing cases for possible modifications for right-sized court orders that the noncustodial parents can pay on a more consistent basis. Implementation of those changes began in July 2021 and early data is showing promise for FY23 performance.

Total dollars collected per dollars expended is a federal fiscal year performance measure and no data was yet reported at the close of FY22. CSED expected to see a drop in this measure due to several IT expenditures for modernization projects, the largest of which is the mainframe platform project, implemented in February 2022.

Budget: $35,995.4 FTE: 370

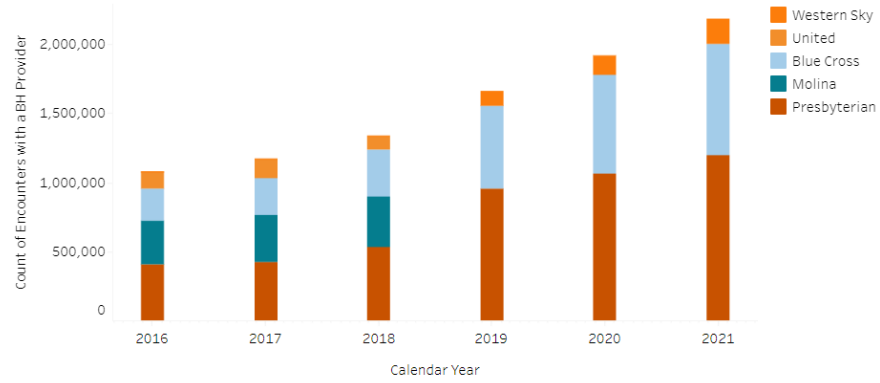
	FY21 Actual	FY22 Actual	FY23 Target	FY23 Q1	Rating
Noncustodial parents paying support per total cases with support orders	55.7%	52.4%	58%	50.1%	R
Total child support enforcement collections, in millions	$147.4	$130.3	$145	$28.7	Y
Child support owed that is collected	60.9%	57.6%	60%	56.8%	R
Cases with support orders	83.5%	83.1%	85%	83.9%	Y
Total dollars collected per dollars expended	$2.90	No Report	$4.00	No Report	R
Average child support collected per child	NEW	$127.92	N/A	$116.07	Y
Program Rating	R	R			Y

Note: Children with paternity acknowledged or adjudicated are reported in the federal fiscal year.

Appendix F: HSD Behavioral Health Encounter Data

Figure 11. HSD Behavioral Health Encounter Trends

How good is my Managed Care Organization (MCO) at working with providers to ensure I have a behavioral health (BH) visit with a BH provider?



Last updated: 4/17/2022

Description: The number of BH encounters provided by BH professionals. Non-BH providers include primary care providers, nurse practitioners, etc.
Target: Increase BH provider visits. 2014-2020: improve each year by 2%; 2020-2023: expected to be at or above 75%.
Results: The five-year trend, since 2016, has shown that all MCOs have seen a steady growth in both members with a BH diagnosis and the BH encounters from the providers. Just in the last calendar year, (CY21) preliminary data shows that there has been almost a 10 percent (9.4%) increase in the number of BH encounters delivered as compared to (CY20.) A related factor driving this increase in services is the corresponding growth in BH members. For example, all the MCOs notably exceeded their CY21 targets (18%) for increasing the percent of unique Medicaid Managed Care members receiving outpatient BH services with a BH practitioner.

Appendix G: Standards for Provider Ratios, Distance, and Timeliness

Access Standards

	Ratios
Primary Care Providers	1:2000
Specialty Providers	Adequate Access with no specific ratio

Distance Standards- All state 90% of members should not travel further than….

	Urban	Rural	Frontier
PCP	30 miles	45 miles	60 miles
Behavioral Health and Specialty Providers	30 miles	60 miles	90 miles

Note: for behavioral health and specialty providers in rural and frontier counties states this distance standard holds unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

Timeliness Requirements

Healthcare Service	Appointment Characteristics	Standard
Primary Care	Routine asymptomatic, member-initiated outpatient primary care	No more than 30 calendar days, unless the member requests a later time
	Routine symptomatic, member-initiated outpatient primary care	No more than 14 calendar days, unless the member requests a later time
	Outpatient appointments for urgent medical conditions	Within 24 hours
Behavioral Healthcare	Outpatient appointments for non-urgent conditions	No more than 14 calendar days, unless the member requests a later time
	Outpatient appointments for urgent conditions	Within 24 hours
	Face-to-face crisis services	Within two hours
Specialty Care	Outpatient referral and consultation	Consistent with clinical urgency but no more than 21 calendar days, unless the member requests a later time
Diagnostic laboratory, diagnostic imaging, and other testing	Routine outpatient appointments	Consistent with clinical urgency but no more than 14 calendar days, unless the member requests a later time
	Walk-in instead of an appointment system	Member wait time shall be consistent with the severity of the clinical need
	Urgent outpatient appointments	Consistent with clinical urgency, but no longer than 48 hours
Dental Care	Routine asymptomatic appointments	No more than 60 calendar days, unless the member requests a later time
	Routine, symptomatic, member-initiated outpatient appointments for non-urgent care	No more than 14 calendar days, unless the member requests a later time
	Urgent outpatient appointments	Within 24 hours
Prescription Fill Time	In-person fill time	No longer than 40 minutes
	Practitioner phone-in fill time	No longer than 90 minutes
Follow-up Visits	Outpatient follow-up visits	Consistent with clinical need

Source: HSD and PHP Report 49

Appendix H. LFC PCP and Behavioral Health Provider Phone Survey Methodology

The methodology for the LFC survey was adapted from methodology previously used by the HHS OIG 2014 survey of Medicaid managed care providers nationwide. For the current survey, LFC staff targeted providers from counties that were previously surveyed, having been identified as among counties with the greatest increases in Medicaid enrollment. The targeted counties selected included three urban counties (Bernalillo, Dona Ana, and Santa Fe), three rural counties (Chaves, McKinley, and San Juan), and one frontier county (Mora).

LFC staff then worked to identify Centennial Care 2.0 primary care providers (PCPs) and behavioral health providers in these counties. PCP is not a stand-alone provider type or specialty; the Centennial Care contracts specify that each MCO may designate any provider from the following types: a medical doctor (MD or DO) who is in general practice, family practice, internal medicine, gerontology, obstetrics, gynecology or pediatrics, as well as certified nurse practitioners, certified nurse midwives, and physician assistants. Specialists may serve as PCPs when appropriate for patients with chronic or complex health issues. MCOs may also designate primary care teams, FQHCs, RHCs, and I/T/Us as PCPs. However, this survey included individual providers only.

LFC staff targeted behavioral health (BH) providers if they were licensed clinical social workers (LCSW), licensed professional clinical counselors (LPCC), or psychologists. These behavioral health specialties were targeted since they were assumed, like PCPs, to be front-line behavioral health providers for general care that does not require a referral or specialize in specific treatments.

PCPs and BH providers were identified by the most recently available (CY22 Q1) MCO network adequacy reports provided by HSD. Because many providers participate in more than one MCO plan, an unduplicated list of both PCPs and BH providers was created based on name and NPI number. The MCO network adequacy reports list which providers are designated as PCPs and were selected for surveying.

LFC staff identified an unduplicated list of 3,353 PCPs and 1,827 BH providers within the selected counties and specialty in the case of BH providers. Please note that number differs from the number of PCPs reported in the MCO geographic access and network adequacy reports, since providers can partner with multiple MCOs. LFC staff utilized online survey sample size calculators to determine that a sample of 251 PCPs and 236 BH providers would be an appropriate sample with a 90 percent confidence interval and 5 percent margin of error.

LFC staff randomized the list of targeted PCPs and BH providers. Since providers could partner with multiple MCOs, providers were randomly assigned an MCO. Current PCP and BH provider contact information was drawn from the online MCO directories. In the event accurate contact information could not be found in the directory, LFC staff used a Google search to attempt to find a functioning phone number. The online directories are designed for individual patients to search for nearby providers based on specialty. Phone calls were then made to each PCP and BH provider's office. Three survey questions confirmed whether the provider was (or was not) at the listed contact number; the provider was (or was not) participating in a specific Centennial Care 2.0 plan; and the provider was (or was not) accepting new patients. If the answer to the first three questions were all 'yes,' then the caller asked for the next available new patient appointment. If the respondent suggested another provider with greater availability, that provider was added to the pool for replacing excluded providers. No appointments were actually made. Calls were completed between October 31 and November 28, 2022.

LFC staff eventually contacted 252 PCPs and 236 BH providers. Results of the survey calls were then coded into one of 11 categories based on consumer experience, ranging from not being able to locate a number for the provider to being offered an appointment date. Please see Table XX for coding categories.

Coding Categories of Consumer Experience for LFC Secret Shopper Survey

0. Provider number not listed or unable to locate provider
1. Determined provider was inappropriate for primary care
2. Could not get through to provider
3. Left voicemail, call not returned
4. Left voicemail, call was returned but unable to connect
5. Provider no longer with office
6. Provider did not accept Medicaid
7. Provider not accepting new patients at this time
8. Put on waitlist
9. Might be able to schedule an appointment after submitting paperwork or initial in-person visit
10. Appointment offered

LFC Secret Shopper Survey Results Primary Care Physicians (PCPs)

Survey Result	Count	Percent
1. Provider number not listed or unable to locate provider	54	21%
2. Determined provider was inappropriate for primary care	26	10%
3. Could not get through to provider	35	14%
4. Left voicemail, call not returned	20	8%
5. Left voicemail, call was returned but unable to connect	0	0%
6. Provider no longer with office	20	8%
7. Provider did not accept Medicaid	1	0%
8. Provider not accepting new patients at this time	47	19%
9. Put on waitlist	3	1%
10. Might be able to schedule an appointment after submitting paperwork or initial in-person visit	8	3%
11. Appointment offered	38	15%

Source: LFC Secret Shopper Survey

LFC Secret Shopper Survey Results of Behavioral Health Providers

Survey Result	Count	Percent
1. Provider number not listed or unable to locate provider	24	10%
2. Determined provider was inappropriate for primary care	18	8%
3. Could not get through to provider	15	6%
4. Left voicemail, call not returned	59	25%
5. Left voicemail, call was returned but unable to connect	10	4%
6. Provider no longer with office	19	8%
7. Provider did not accept Medicaid	2	1%
8. Provider not accepting new patients at this time	38	16%
9. Put on waitlist	19	8%
10. Might be able to schedule an appointment after submitting paperwork or initial in-person visit	9	4%
11. Appointment offered	23	10%

Source: LFC Secret Shopper Survey

Appendix I: Adult CAHPS Survey Result Summary

New Mexico MCOs Rank Below the Nation for Consumer Satisfaction with Access to Care (national percentile rankings, higher is better)

Question	MCO A	MCO B	MCO C
In the last six months when you needed care right away, how often did you get care as soon as you needed?	28th	36th	<5th
In the last six months how often did you get an appointment for routine care as soon as you needed?	17th	37th	47th
In the last six months how often did you get an appointment to see a specialist as soon as you needed?	19th	39th	40th
In the last six months how often was it easy to get the care, tests, or treatment you needed?	46th	30th	15th

Note: Based on responses of always or usually.

Source: MCO 2021 CAHPS reports

Appendix J: Medicaid MCO Performance on Distance Standards and Metrics

Number of MCOs (Out of Three) that Meet Physical Health Access Standards

Physical Health Service Type - Standard 1	Urban	Rural	Frontier
PCP including Internal Medicine, General Practice, Family Practice	3	3	3
Pharmacies	3	3	3
FQHC - PCP Only	3	3	3
Physical Health Service Type - Standard 2			
Cardiology	3	3	3
Certified Nurse Practitioner	3	3	3
Certified Midwives	3	2	3
Dermatology	3	0	1
Dental	3	3	3
Endocrinology	3	0	1
ENT	3	2	2
FQHC	3	3	3
RHC	0	0	2
Hematology/Oncology	3	3	2
I/T/U	0	0	0
Neurology	3	3	3
Neurosurgeons	2	0	0
OB/Gyn	3	3	3
Orthopedics	3	3	3
Pediatrics	3	3	3
Physician Assistant	3	3	3
Podiatry	3	3	3
Rheumatology	1	0	0
Surgeons	3	3	3
Urology	3	1	1
Long-term Care Service Type - Standard 2			
Assisted Living Facilities	0	0	1
Personal Care Service Agencies	3	3	3
Nursing Facilities	3	3	3
General Hospitals	3	3	3
Transportation	3	2	3

Note. Access is defined as the percentage of members who can access each service type. Above 90 percent is considered meeting standard.

Source: MCO geo access report CY21 Q4

Table 33. Number of MCOs (Out of Three) that Meet Behavioral Health Access Standards

Behavioral Health Service Type	Urban	Rural	Frontier
Freestanding Psychiatric Hospitals	2	0	0
General Hospitals with psychiatric units	2	0	0
Partial Hospital Programs	0	0	0
Accredited Residential Treatment Centers (ARTC)	1	0	0
Non-Accredited Residential Treatment Center & Group Homes	0	0	0
Treatment Foster Care I & II	0	0	0
Core Service Agencies	2	2	2
Community Mental Health Centers	1	2	2
Indian Health Service and Tribal 638s providing BH	0	0	0
Outpatient Provider Agencies	3	2	3
Behavioral Management Services (BMS)	3	1	1
Day Treatment Services	0	0	0
Assertive Community Treatment (ACT)	1	0	0
Multi-Systemic Therapy (MST)	3	0	0
Intensive Outpatient Services	3	1	3
Methadone Clinics	3	0	0
FQHCs providing BH services	3	3	3
Rural Health Clinics providing BH Services	0	0	1
Psychiatrists	3	3	3
Psychologists	3	2	3
Suboxone certified MDs	3	3	3
Other Licensed Independent BH Practitioners	3	3	3
Inpatient Psychiatric Hospitals	3	0	1

Note. Access is defined as the percentage of members who can access each service type. Above 90 percent is considered meeting standard.

Source: MCO geo access report CY21 Q4

Number of MCOs (Out of Three) that Meet Distance Standards for Average Distance to Travel for Behavioral Health Services

Provider / Service Category	URBAN			RURAL			FRONTIER		
	1st Provider	2nd Provider	3rd Provider	1st Provider	2nd Provider	3rd Provider	1st Provider	2nd Provider	3rd Provider
Freestanding Psychiatric Hospitals	3	2	2	0	0	0	3	2	1
General Hospitals with psychiatric units	2	0	0	2	0	0	3	1	0
Partial Hospital Programs	1	0	0	0	0	0	0	0	0
Accredited Residential Treatment Centers (ARTC)	3	1	0	3	1	0	3	3	1
Non-Accredited Residential Treatment Center & Group Homes	0	0	0	1	0	0	2	0	0
Treatment Foster Care I & II	3	2	2	3	0	0	3	2	1
Core Service Agencies	3	2	2	3	2	2	3	3	2
Community Mental Health Centers	3	2	2	2	2	2	3	2	2
Indian Health Service and Tribal 638s providing BH	1	0	0	1	0	0	3	3	2
Outpatient Provider Agencies	3	3	3	3	3	3	3	3	3
Behavioral Management Services (BMS)	3	3	3	2	2	1	3	3	3
Day Treatment Services	0	0	0	0	0	0	0	0	0
Assertive Community Treatment (ACT)	3	1	0	0	0	0	1	1	0
Multi-Systemic Therapy (MST)	3	2	1	2	0	0	3	2	1
Intensive Outpatient Services	3	3	3	3	3	2	3	3	3
Methadone Clinics	3	1	0	2	0	0	3	2	0
FQHCs providing BH services	3	3	3	3	3	3	3	3	3
Rural Health Clinics providing BH Services	0	0	0	1	1	1	1	1	1
Psychiatrists	3	3	3	3	3	3	3	3	3
Psychologists	3	3	3	3	3	3	3	3	3
Suboxone certified MDs	3	3	3	3	3	3	3	3	3
Other Licensed Independent BH Practitioners	3	3	3	3	3	3	3	3	3
Inpatient Psychiatric Hospitals	3	3	3	1	0	0	3	3	3

Source: MCO geo access report CY21 Q4

Appendix K: Turquoise Care Contracts

Select Changes from Centennial Care 2.0 to Turquoise Care that may Increase Accountability

	Centennial Care 2.0	Turquoise Care
Network Adequacy	-Provider Ratio for PCP is set at 1:2,000 enrollees - 2 hours to respond to a behavioral health crisis -Semi-Annual secret shopper surveys, no specification regarding who to survey -Distance -No mention of ratios for specialty providers -No minimum survey size	-Provider Ratio for PCP set at 1:1,500 -90 minutes to respond to a behavioral health crisis -Quarterly secret shopper surveys for primary care, behavioral health, and specialties -Reduced distance standards -Have MCOs set ratio standards for specialty providers -A minimum of 30 providers and must be statistically significant
Credentialing	-suggests MCOs work together to streamline credentialing	-HSD plans to implement a centralized credentialing and re-credentialing process for all MCOs during the term of the agreement as part of MMIS-R -Contractor shall assist HSD with the transition and implementation and comply with all requirements
External Quality Review	-Has 3 areas for the external quality review to assess each MCO including:	-Has 4 areas for the external quality review to assess each MCO including:
Population health	-Not included in Centennial Care 2.0	
Penalties	- No specific penalties for network adequacy or non-emergency medical transport	-Added monetary penalty for not meeting appointment standards -Added monetary penalty for not meeting non-emergency medical transport quality standards
Underwriting Gain and Community Reinvestment	-MCO allowed to keep 100 percent of underwriting gain up to 3 percent. -50:50 profit sharing above 3 percent underwriting gain	-MCO allowed to keep 95 percent of underwriting gain up to 3 percent -5 percent of underwriting gain needs to be allocated for community reinvestment
MLR	-set at 88 percent	-set at 90 percent
Care Coordination	Process centered rules regarding care coordination including number of visits and process focused performance metrics	Shift towards outcomes based accountability of care coordination including annual and quarterly reports with outcome metrics.

Source: HSD Centennial Care 2.0 and draft Turquoise Care contracts

Appendix L: Centennial Care 2.0 Rate Increases

Centennial Care 2.0 Provider Rate Increases, 2019-2022

2019	2020	2021	2022
Increase of Evaluation and Management Codes to minimum 90% of Medicare	Directed increase of ~100% in payment rates for LARCs	Extended a uniform contracted rate increase for trauma hospitals	Directed minimum wage increases up to $12/ hour by 2023
2% increase for all dental services	Increase in governmental and investor-owned hospitals by 2%	Directed MCOs to increase reimbursement rates for IHS facilities and 638 providers to all-inclusive rate published in the federal register	Directed pharmacist reimbursement parity, regardless of whether prescription issued through a point of sale, office, or facility
Increase in dispensing fees for community-based pharmacies	Increased to hospitals serving a high share of Native American members by 13%	EPSDT directed payment July 1, 2022	*Temporary: Directed MCOs implement a temporary 15% reimbursement increase for Home and Community Based Services, including private duty nursing and PCS services May 2021- June 2022. Reduced to 10% July 2022-December 2022*
Increase of reimbursement rates for agency-based community benefits Personal Care Service (PCS) providers by minimum of 50 cents per hour.	Increased the minimum wage for Personal Care Services (PCS) to between $9.00 and 12.80 per hour	Updated increase to hospitals serving a high share of Native American members by 13% and 33% for provider classes	*Covid-19 temporary through the PHE: Allowed providers to bill for telehealth services at the same rates as in-person services. Retroactive to 2020.*
Increase reimbursement rates to Assisted Living Facilities by 5%	250% increase to the payment rate for instrument-based ocular screenings Increased ambulance air reimbursement and justice-involved transportation		*Covid-19 temporary through the PHE: increased hospital reimbursement.*
Increase to payments for outpatient behavioral health rates to a minimum of 90% of Medicare	NM HB42: pharmacists with prescriptive authority increases		*Covid-19 temporary through June 2022: increased nursing home rates by 8.1%, increased FQHC encounter rates by $15, increased non-emergency medical transportation by 6.8%*
Increase in the base rate for FQHCs and established new FQHC dental FFS rate	Increased nursing facility per diem rate increase and a market basket increase for all facilities. Additional adjustments in 2021 and 2022 Directed a value-based purchasing agreement for nursing facilities		
3.8% increase in non-profit community hospitals	Increased ABA rate		
Increased hospital inpatient and outpatient rate between 5% and 14%	*COVID-19 Temporary Through PHE: Increased assisted living facility rates by 5%*		
Increases for outpatient reimbursement 18-25%	*Covid-19 Temporary through PHE: Increased rate for rehabilitation hospitals by 12.4%*		
	Covid-19 Temporary: increased provider rates~6.8% through the PHE for behavioral health, evaluation and management services, dental services, self-direct community benefits, personal care services, emergency and non-emergency transportation		

Source: HSD Centennial Care 2.0 Letters of Direction

Appendix M: States with Highest Medicaid-to-Medicare Fee Ratios for Physician Services, 2019

States with Highest Medicaid-to-Medicare Fee Ratios for Physician Services, 2019

Location	Medicaid FFS Rate as % of Medicare Rate
Delaware	118%
Montana	111%
Alaska	110%
Nebraska	105%
North Dakota	100%
South Carolina	98%
Nevada	96%
Wyoming	96%
Oklahoma	94%
Idaho	93%
New Mexico	93%

Source: Kaiser Family Foundation, State Health Facts

Appendix N: Select Strategies to Improve Transportation

While New Mexico has implemented some strategies to overcome transportation barriers, more may need to be done to improve access to facilitate healthcare access for Medicaid recipients. According to work from the University of Chicago, there are a number of ways to improve transportation in rural communities by improving access, overcoming barriers, or improving safety or infrastructure. While the state has implemented a number of the strategies, some may need to be expanded to become reimbursable for Medicaid or new programs may need to be introduced to reduce transportation barriers. For instance, it could potentially expand mobile clinics and ride sharing, both of which are done in some areas, and are best practices, but are not available statewide. HSD states in their 2021 Medicaid Centennial Care 2.0 Demonstration Annual report that MCOs are currently looking for potential accessible transportation options including tribal partnerships and ride shares. One potential solution would be for the state to expand Medicaid reimbursable services to cover services already operational in the state. This could reduce state general fund spending and increase visibility of services to Medicaid enrollees.

Transportation Solutions for Rural Areas

Goal of Model	Model Name	In New Mexico?
Improve Access to Transportation 	Public Transportation (Fixed or Flex Bus Routes)	Yes
	Volunteer	?
	Voucher	?
	Coordinated Services	?
	Mobility on Demand	?
	Ridesharing	Yes
	Connector Services	Yes
	Mobility Management	?
Overcome Transportation Barriers 	Mobile Clinics	Yes
	School/Work Based Health	Yes
	Home Visiting Programs	Yes
	Telehealth	Yes
Models to Improve Safety/Infrastructure 	Active Transportation Models	?
	Models to Increase Public Transportation	?
	Road Safety Models	?

Note: Home visiting is available for prenatal and postnatal families.

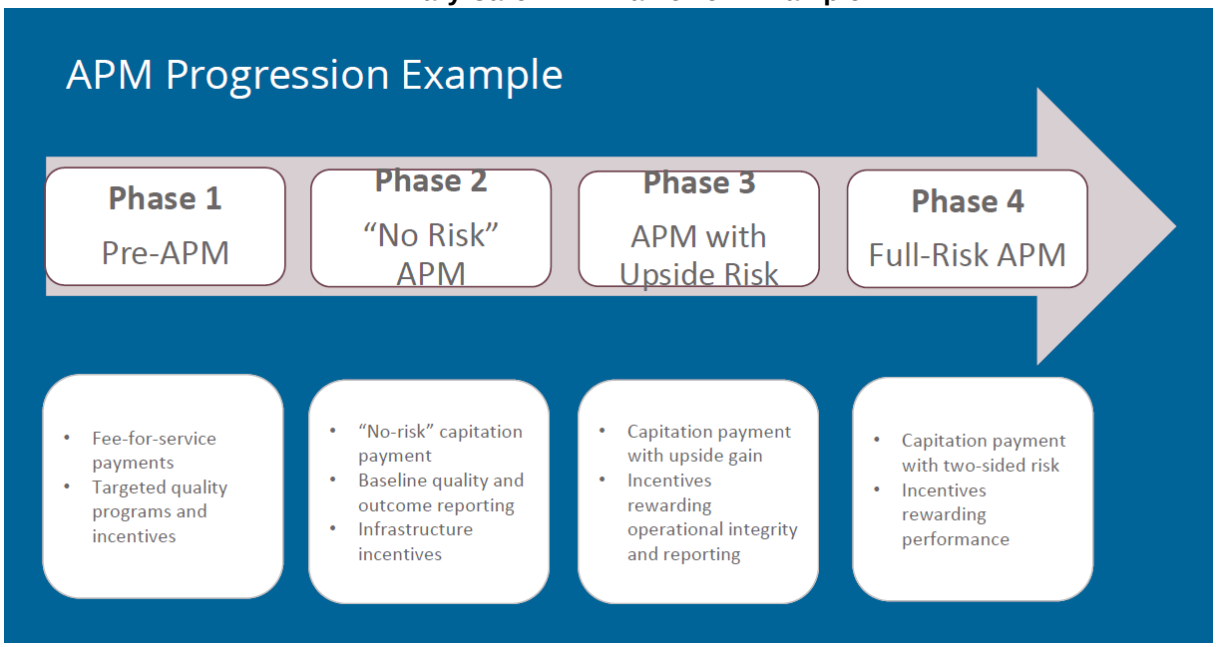
Source: University of Chicago

The Non-metropolitan Area Agency on Aging (NMAAA) and the North Central Economic Development Division (NCEDD) are preparing to pilot volunteer ride sharing, with a goal of having this service be reimbursable by Medicaid. NCEDD received two grants from the national aging and disability transportation center totaling $90 thousand ($20 thousand for planning and $70 thousand for implementation), one for planning and one from implementation of the ride-sharing pilot. The pilot is scheduled to be established by May 2023 and will coordinate and reimburse volunteers who will provide rides for seniors and individuals with a disability. NMAAA and NCEDD have discussed with Medicaid how to make this service reimbursable and will need to work with MCOs to become a credentialed provider. Other states have successfully created these volunteer driver programs, including Missouri and Minnesota, and these programs are used as models upon which to build the New Mexico volunteer ride-sharing pilot. The state should review outcomes from this pilot and expand it if it leads to improved access to healthcare for enrollees.

Appendix O: Alternative Payment Models

The alternative payment models (APM) proposed for New Mexico include multiple phases starting at fee-for-service and moving towards capitation with incentives. The PCC is currently exploring an alternative payment model patterned after models from National Academy of Sciences, Engineering, and Medicine and the Health Care Payment Learning and Action Network. The APM could offer participating providers a phased-in approach ranging from fee-for-service models to incentives rewarding performance and capitation payments with two-sided risk. Potential benefits to patients could include improved outcomes as incentives align with quality of care, access to additional non-medical service providers, increased access to comprehensive and flexible services based on patient needs, incentives for more preventive care. In 2022, the PCC has been engaging stakeholders by meeting with the PCC Payment Strategies and Health Data Equity Workgroups monthly, conducting discussions the New Mexico Medical Society conducted four focus groups in October and November, 2022, with small and medium practices, hospitals, FQHCS, and inter-professional teams. In addition, they are in the process of conducting a provider readiness survey. Current concerns expressed by providers includes difficulties for smaller primary care providers in New Mexico, not having enough financial resources to hire additional staff needed for a team-based approach to care, not having adequate IT resources, focus on process measures, and increasing administrative burden. As the direct impact of this type of alternative payment model is unknown, the state could pilot the model while measuring provider and client outcomes.

Primary Care APM Framework Example



Source. Primary Care Council Meeting Presentation November 9, 2022.

Appendix P. Additional Data from MCO Secret Shopper Surveys

Percent of Providers Taking New Patients			
	MCO A	**MCO B**	**MCO C**
Primary Care			
Routine Asymptomatic	68%	Not reported	Not reported
Routine Symptomatic	63%	Not reported	Not reported
Urgent	68%	Not reported	Not reported
Behavioral Health			
Substance Use Routine	55%	Not reported	Not reported
Substance Use Urgent	45%	Not reported	Not reported
Practitioner/MH Routine	51%	Not reported	Not reported
Practitioner/MH Urgent	49%	Not reported	Not reported

Note: All MCO data is from the most recent report available, MCO A and MCO B use 2022 data, MCO C uses 2020 for PH and 2021 for BH. N size varies considerably for each MCO. No data from MCO C, however not taking new patients was a top reason for not being able to schedule an appointment.

Source: MCO secret shopper survey reports

One MCO reported the percent of providers taking new patients for both physical and behavioral health, with roughly two thirds of physical health providers accepting new patients while only about half of behavioral health providers are accepting new patients. These percentages are lower than what was reported by MCOs in a 2016 LFC report, when between 84 percent and 91 percent were accepting new patients.

Appendix Q: Comparison Medicaid PMPM Rates to Private Insurance Premiums

How do Medicaid PMPM rates compare to private insurance rates?

The chart below compares the weighted-average PMPM annual rate the state pays to the MCOs to the annual cost of the state employee HMO plan (annual premium cost + deductible cost). The state is, on average, paying a lower PMPM rate to MCOs than the annual cost to the state and employee for the state's HMO plan. These costs are still lower than what the Kaiser Family Foundation reports as the average annual cost of an HMO plan in the western region of the United States (premium + deductible).

	Medicaid PH Expansion Adults Annualized PMPM Cost	State Employee HMO Monthly Premium + Deductible Annual Cost + 20% for Deficit Plug	Average Western Region HMO Premium + Deductible Annual Cost
Adult	$ 7,368	$ 7,492	$ 9,150
Two Adults	$ 14,736	$ 16,838	$ 18,300
Family (Two Adults + 1 Child)	$ 17,283	$ 22,118	$ 25,244
Family (Two Adults + 2 Children)	$ 19,830	$ 22,118	$ 25,244

Source: HSD Medicaid June 2022 Capitation Rates, Kaiser Family Foundation, State Employee HMO

Appendix R: CY2021 Selected Medicaid Rate Benchmarks in Mercer Study

Table X. CY2021 Selected Medicaid Rate Benchmarks

Service Subgroups	NM MC to FFS Rate	NM FFS to Medicare	NM FFS to AZ FFS Rate	NM FFS to CO FFS Rate	NM FFS to LA FFS Rate	NM FFS to WA FFS Rate
Skilled Maintenance Therapies (Ex. Physical Therapy, Occupational Therapy)	124%	88%	90%	98%	142%	145%
Physician and Other Practitioner-Medicine	100%	86%	79%	102%	118%	139%
Radiology/ Laboratory	100%	94%	88%	110%	102%	120%
Emergency Medical Transportation	106%	70%	77%	131%	102%	172%
Non-Emergency Medical Transportation	226%	NA	159%	46%	NA	NA
Physician Administered Drugs	101%	100%	99%	103%	97%	101%
Maternity-Related Care	87%	93%	80%	101%	139%	112%
Child Health Care	99%	112%	109%	113%	154%	135%
Newborn Care	104%	95%	103%	101%	140%	110%
Family Planning	95%	104%	113%	119%	134%	116%
General Behavioral Health	100%	97%	101%	120%	152%	146%
Opioid Treatment Program	99%	NA	NA	116%	105%	109%
Applied Behavioral Analysis	98%	NA	NA	73%	172%	161%
Diagnostic/ Preventive/Other Dental	96%	NA	NA	80%	88%	109%
Orthodontics	94%	NA	NA	145%	90%	166%

Notes: When a benchmark was unavailable because the service is not covered, NA is listed
MC= Managed Care Rate, FFS= Fee-For-Service Rate
Source: 2022 Medicaid Provider Rate Benchmarking Study

The table below shows the comparison of the managed care expenditures to the fee-for-service equivalent (FFSE) (in aggregate and by service), in addition to the comparison of New Mexico's FFS rates to the available Medicare benchmarks.[4]

Table 1: Overview of New Mexico Benchmarking Results by Service Area ($ in Millions)

		CY2019		CY2021
Phase 2 Service Area	**Service Subgroups**	**Total Medicaid Expenditures[1]**	**Managed Care Percent of FFSE[2]**	**NM FFS Percent of Medicare[3]**
ALL	**ALL**	**$1,991.2**	**99%**	**N/A**
Inpatient Hospital	General Acute Hospitals	$708.1	117%	72%
	Critical Access Hospitals	$15.8	125%	77%
	Psychiatric Hospitals	$46.2	54%	164%
	Rehabilitation Hospitals	$81.9	67%	154%
Outpatient Hospital	General Acute Hospitals	$513.8	81%	89%
	Critical Access Hospitals	$50.4	132%	66%
	Psychiatric Hospitals	$3.2	70%	268%
	Rehabilitation Hospitals	$8.1	98%	142%
Nursing Facility/	Private - Low Level of Care	$214.7	111%	84%
	State - Low Level of Care	$30.0	99%	91%
Hospice	Private - High Level of Care	$21.2	114%	82%
	State - High Level of Care	$1.9	97%	161%
	Hospice	$22.9	92%	N/A
Residential Treatment Centers	ARTC Psychiatric	$25.9	114%	N/A
	RTC - Youth	$4.4	153%	N/A
	Group Home	$0.6	116%	N/A
	ARTC Chemical Dependency	$0.1	89%	N/A
	RTC - Other	$17.3	N/A	N/A
Other Institutional	Dialysis	$18.2	262%	N/A
	Home Health Agency	$10.0	107%	N/A
	Nursing Agency, Private Duty	$7.1	N/A	N/A
	Ambulatory Surgical Centers	$2.2	164%	64%
	Intermediate Care Facility	$0.8	N/A	N/A
Excluded Services	Indian Health Services	$177.1	N/A	N/A
	PACE	$9.2	N/A	N/A

1. CY2019 Total Medicaid Expenditures includes managed care encounters and FFS claims after exclusions. See Data Sources and Time Period for the impact and list of exclusions applied to the claims data. Totals differ due to rounding.
2. Includes services with available managed care expenditures and FFSE amounts.
3. Medicare rates were not available for all Service Subgroups. In some cases, the service is not a covered benefit, such as residential treatment centers, in other cases, such as dialysis services, Mercer did not have available claims detail required to calculate Medicare rates. Mercer calculated a reasonable estimate for Medicare payments based on available information for critical access hospital (CAHs), psychiatric and rehabilitation services. For nursing facilities, Mercer compared the NM Medicaid FFS payments to the estimated facility costs (based on facility costs reported in Medicare cost reports). See the Results section for each service area for additional details.

Source: HSD and Mercer Rate Studies, Phases I and II

[4] The FFSE amounts in this report reflect Mercer's best proxy of the FFS reimbursement that is most comparable for each service included in Phase 2.

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