Health Notes

Program Evaluation Unit
Legislative Finance Committee
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Medicaid Managed Care Provider Networks and Access to Care

AT A GLANCE

Over 850,000 people, or about 40 percent of New Mexicans, are now enrolled in the state's Centennial Care Medicaid program, at a cost of over five billion dollars. Expanding Medicaid coverage, however, is of limited value unless we can confirm that there is meaningful access to care for all of these people. New Mexico is unlikely to see improved health outcomes without establishing and maintaining a strong foundation of provider networks through which patients can access healthcare to begin with.

The Human Services Department (HSD) monitors the adequacy of the Medicaid provider network by reviewing numerous reports from the state's four Centennial Care managed care organizations (MCOs). According to the reports, the MCOs are meeting their contractual requirements for geographic access to primary care providers (PCPs), as well as most physical health, long-term care, and behavioral health providers. At the same time, the reports show some notable gaps in provider networks. There are shortages for a handful of physical health specialists such as dermatologists, neurologists, and rheumatologists, and there are significant behavioral health network gaps, particularly in the areas of access to various intensive outpatient therapies. In addition, the reports are not always accurate or timely; to date, HSD has assessed MCO sanctions totaling over $5.5 million, the bulk of which were for problems with reports.

The Centennial Care contracts also include requirements regarding appointment timeliness standards. Simply having a healthcare provider located within a reasonable distance from a prospective patient's home is not a guarantee that the patient will be able to access services when needed. MCO reports provide an unclear picture of their compliance with this aspect of access to care, and HSD does not appear to be monitoring the issue. HSD reports steadily increasing use of hospital emergency rooms. A persistent portion of this use is for routine urgent care conditions, which may be an indicator that some Medicaid recipients are turning to the ER because they cannot get a timely appointment with their PCP.

The LFC conducted its own survey of PCPs in seven New Mexico counties, intending to gather data on wait times for routine new patient appointments. The LFC survey found average wait times for the surveyed counties ranged from three weeks to nearly two months. The survey also found significantly fewer PCPs accepting new Medicaid patients than has been reported by the MCOs. The LFC's review of Centennial Care MCO reports, combined with results from the LFC survey, lead to concerns that some Medicaid recipients in New Mexico may face barriers when they attempt to access the healthcare system.

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Policy Context for Network Adequacy and Access to Care

Federal focus on access to care is increasing. Federal regulations require that Medicaid managed care organizations have provider networks sufficient to ensure that all services covered under the state plan, including primary, preventive and specialty services, are available and accessible to enrollees.

In 2011, the Center for Medicare and Medicaid Services (CMS) noted that state budget-cutting efforts were potentially putting access to care at risk, and a new federal rule to address the problem went into effect on January 4, 2016. The new rule applies to fee-for-service Medicaid only; CMS has proposed a similar rule for managed care Medicaid. The rule requires states to develop an access monitoring review plan that considers factors such as the extent to which beneficiary needs are met, availability of care and providers, and provider payment rates. HSD reports that its access monitoring review plan is being developed and will be available for public review and comment in May, 2016. In addition to regular monitoring of access to specific categories of services (primary care, physician specialist, behavioral health, pre-and-post-natal obstetric services, and home health services), states must review access for other services whenever there are rate changes for those services, and if there are unusually high levels of complaints about access to a service.

CMS specifically rejected the idea of setting national access standards because there currently are no standardized methods for demonstrating access to care. The intent is that best practices will evolve as states are given the flexibility to develop their own measures of access.

Table 1: Centennial Care Contract MCO Provider Network Adequacy Requirements

Provider type	Provider to member ratio	Maximum distance requirements for at least 90% of enrollees	Appointment standards, in calendar days
Primary care (pharmacies have same geographic access standards)	2,000 members per provider per MCO	Urban: 30 miles Rural: 45 miles Frontier: 60 miles	Routine, asymptomatic out-patient: no more than 30 days Routine, symptomatic out-patient: no more than 14 days Urgent condition: within 24 hours
Specialty provider	"Adequate" to be determined by MCO	Urban: 30 miles Rural: 60 miles Frontier: 90 miles	Referral and consultation: consistent with clinical urgency, no more than 21 days
Dentist		Urban: 30 miles Rural: 60 miles Frontier: 90 miles	Routine, asymptomatic: no more than 60 days Routine, symptomatic: no more than 14 days Urgent condition: within 24 hours
Behavioral health		Urban: 30 miles Rural: 60 miles Frontier: 90 miles	Non-urgent: 14 days Urgent condition: within 24 hours Crisis services: within 2 hours
Long term care service agencies and facilities		Urban: 30 miles Rural: 60 miles Frontier: 90 miles	
Diagnostic testing			Routine out-patient: no more than 14 days Urgent: consistent with clinical urgency, no more than 48 hours

Note: Primary care includes general practice, family practice, internal medicine, gerontology, obstetrics, gynecologist and pediatrics, certified nurse practitioners, certified nurse midwives, and physician assistants.
Source: HSD MCO contracts

In New Mexico, Medicaid MCO contracts establish provider network adequacy and access standards. All Centennial Care MCO contracts include minimum requirements for provider networks to ensure that enrollees can access a provider in their network within a reasonable distance from their home and obtain an appointment within a reasonable amount of time. These requirements are also codified in the New Mexico Administrative Code (8.308.2.11 NMAC). Table 1, left, summarizes the requirements.

HSD monitors MCO compliance with these requirements through many quarterly and annual MCO reports. For this brief, HSD provided the LFC with nearly two years' worth of MCO geographic access reports, network adequacy reports, PCP reports, grievances and appeals reports, and provider network development plans, among other requested documents. Because each report gathers different information, and because they are often completed in different ways by the four MCOs, the reports do not, by themselves, offer a clear, unified view of how well the MCOs are meeting their contractual requirements related to access to care. This brief attempts to pull together as much information as possible from the various reports into a comprehensive overview of access to care within the Centennial Care program.

According to a study conducted by the US Health and Human Services Department's (HHS) Office of Inspector General (OIG) in early 2013, state standards for Medicaid managed care access vary widely. Of the 33 states surveyed, New Mexico was one of 32 states that limited the time or distance an individual has to travel to see a primary care provider, and was one of three states with the longest allowable distance, 60 miles for frontier areas. Thirty-one states required that appointments be scheduled within a certain timeframe; New Mexico was among the 26 states that have an upper time frame of 30 days or less.

Lastly, the OIG report found that only 20 states established a minimum provider-to-enrollee ratio. Of these, New Mexico's 1:2,000 requirement is higher than the requirements in twelve other states, and it is the same or lower than the requirements in seven other states.

Primary Care in New Mexico

New Mexico has a documented shortage of primary care providers. The federal Health Resources and Services Administration (HRSA) has designated 32 of New Mexico's 33 counties as full or partial federally designated Health Professional Shortage Areas (HPSAs) for primary medical care. The New Mexico Health Care Workforce Committee uses slightly different methodology and more detailed information from a growing amount of health professional licensing survey data. The Committee's 2015 Annual Report found 25 counties with shortages of primary care providers. Previous LFC evaluations have also analyzed the workforce situation and confirmed existing shortages.

Centennial Care MCOs

Blue Cross Blue Shield of New Mexico (BCBS)

Molina Healthcare of New Mexico (MHNM)

Presbyterian Health Plan (PHP)

United Healthcare Community Plan (UHC)

Table 2: Medicaid primary care provider to enrollee requirements by state, ranked highest to lowest (2013)

State	Number of enrollees per primary care provider
Maryland	3,500: 2,000 adult, 1,500 under 21
Delaware, Tennessee	2,500
California, Colorado, Illinois, New Jersey	2,000
New Mexico	1,500 – increased to 2,000 in 2014 with Centennial Care
Florida, Kentucky, Nevada, New York, Rhode Island, Virginia	1,500
Pennsylvania	1,000
Michigan	750
West Virginia	500
Hawaii	300
Massachusetts	200
Wisconsin	100

Source: HHS OIG Report, 9/14

Each of these sources, it should be noted, base their categorization on national benchmarks for how many providers there should be for a given population. Just like the Centennial Care geographic access requirements, these are relatively static standards that count how many providers practice within a certain area. They are not designed to take into account factors such as the actual healthcare needs of an area or population, or the workload preferences of providers, and therefore do not directly measure access to care.

Complicating the issue of provider shortages is the fact that there are concentrations of providers in major urban areas, and often too few providers in more rural areas. This dilemma is especially acute for specialists, but applies to primary care providers as well.

Table 3: Top Ten New Mexico Counties Ranked by Change in Medicaid Enrollment

County	Oct 2013 total	Feb 2016 total	Increase	Percent growth
Bernalillo	149,019	246,615	97,596	66%
Dona Ana	70,801	108,081	37,280	53%
San Juan	37,004	56,594	19,590	53%
Santa Fe	24,935	43,182	18,247	73%
Sandoval	27,804	45,579	17,775	64%
McKinley	29,932	44,133	14,201	47%
Valencia	20,676	32,476	11,800	57%
Otero	12,027	21,955	9,928	83%
Lea	17,331	27,146	9,815	57%
Chaves	21,295	30,886	9,591	45%

Source: HSD monthly statistical report July 2013 – Jan 2014; HSD Medicaid eligibility report by county, February 2016

Growth in Medicaid enrollment has been uneven across New Mexico's counties. Every New Mexico county has experienced significant growth in the number of residents enrolled in Medicaid, in the base group as well as the expansion population. Between October 2013, just prior to the first open enrollment period for the Affordable Care Act, and February 2016, Bernalillo County has had the largest increase in enrollment, over 97 thousand or approximately 66 percent. Harding County has seen the fewest number of new enrollees, 71, but that small county also experienced the highest rate of growth in its Medicaid population, 127 percent. Table 3 shows the ten New Mexico counties where the impact of Medicaid expansion has been greatest. (See Appendix A for Medicaid growth for all counties.)

Despite these challenges, New Mexican Medicaid recipients are generally satisfied with the healthcare they receive. Consumer satisfaction with Centennial Care MCOs is generally above the national average. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, a program of the US Agency for Healthcare Research and Quality, is required annually from all Medicaid health plans. There are three versions of the survey: adult, children, and children with chronic conditions. The full surveys include over 60 questions that cover a wide array of health care and customer service topics.

For adults, New Mexico's MCOs received relatively high marks on patient satisfaction measures, as well as for timeliness of urgent care appointments. However, the picture is more mixed on measures for routine appointment times, where all four MCOs are below the national average. See Table 4, right.

New Mexico's MCOs received relatively higher marks for children than for adults on almost all measures. The highest scores were for timely access to urgent care and timely appointments for routine care, and most overall satisfaction measures also exceeded the national average. The lowest scores were for access to, and satisfaction with, specialists. See Table 5, right.

Table 4: 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adults

Question	Measure	BCBS	MHNM	PHP	UHC	2014 NCQA national average
How would you rate all your health care in the last six months?	Percent scoring 8, 9 or 10	75%	76%	71%	73%	71%
How would you rate your personal doctor?	Percent scoring 8, 9 or 10	83%	80%	80%	85%	79%
How would you rate the specialist you saw most often in the last six months?	Percent scoring 8, 9 or 10	80%	82%	78%	77%	80%
How would you rate your health plan?	Percent scoring 8, 9 or 10	78%	77%	76%	77%	75%
In the last six months when you needed care right away, how often did you get care as soon as you needed?	Percent answering 'usually'/always'	86%	84%	83%	87%	83%
In the last six months how often did you get an appointment for routine care as soon as you needed?	Percent answering 'usually/always'	73%	74%	72%	77%	79%
In the last six months how often did you get an appointment to see a specialist as soon as you needed? *	Percent answering 'usually/always'	75%	77%	71%	80%	79%
In the last six months how often was it easy to get the care, tests or treatment you needed?	Percent answering 'usually/always'	88%	82%	83%	80%	83%

Note: Specialist does not include dental or hospital inpatient
Source: CC MCO 2015 Medicaid CAHPS Reports

In Tables 4 and 5, shaded cells indicate the highest scores.

Table 5: 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) General Child Population (General) and Children with Chronic Conditions (CCC)

Question	Measure	Population	BCBS	MHNM	PHP	UHC	2014 NCQA national average
How would you rate all your child's health care in the last six months?	Percent scoring 8, 9 or 10	General	87%	85%	86%	83%	85%
		CCC	80%	81%	84%	77%	83%
How would you rate your child's personal doctor?	Percent scoring 8, 9 or 10	General	87%	90%	85%	87%	88%
		CCC	88%	86%	88%	83%	87%
How would you rate the specialist your child saw most often in the last six months?	Percent scoring 8, 9 or 10	General	83%	79%	82%	82%	85%
		CCC	76%	81%	90%	77%	85%
How would you rate your child's health plan?	Percent scoring 8, 9 or 10	General	87%	87%	88%	81%	85%
		CCC	80%	82%	85%	73%	81%
In the last six months when your child needed care right away, how often did you get care as soon as needed?	Percent answering 'usually'/always'	General	94%	94%	92%	89%	91%
		CCC	93%	92%	90%	93%	94%
In the last six months how often did you get an appointment for your child for routine care as soon as needed?	Percent answering 'usually/always'	General	85%	90%	86%	86%	88%
		CCC	92%	90%	86%	85%	91%
In the last six months how often did you get an appointment for your child to see a specialist as soon as needed? *	Percent answering 'usually/always'	General	81%	77%	75%	80%	82%
		CCC	83%	83%	83%	83%	83%
In the last six months how often was it easy to get the care, tests or treatment your child needed?	Percent answering 'usually/always'	General	93%	89%	91%	84%	90%
		CCC	90%	86%	90%	85%	91%

Note: Specialist does not include dental or hospital inpatient
Source: CC MCO 2015 Medicaid CAHPS Reports

Access to Primary Healthcare

Centennial Care MCO reports offer a somewhat more detailed look at access to care in New Mexico. The Centennial Care MCO reports are primarily a reflection of how many healthcare providers there are and where they are located. There is more limited reporting regarding how many providers are accepting new patients and how long patients have to wait for an appointment to see a provider. Ultimately, whether a patient can access the specific healthcare she or he needs precisely when she or he needs it is often dependent on a determination of medical necessity, something too individually-specific to be addressed by bulk MCO reports or this brief.

Table 6: Primary Care Provider to Member Ratios by County
Third Quarter CY15

	BCBS	MHNM	PHP	UHC
Urban counties				
Bernalillo	1:56	1:87	1:229	1:12
Dona Ana	1:50	1:319	1:210	1:46
Los Alamos	1:20	1:13	1:27	1:8
Santa Fe	1:37	1:46	1:275	1:33
Rural Counties				
Chaves	1:88	1:295	1:147	1:44
Curry	1:57	1:153	1:156	1:16
Eddy	1:64	1:325	1:154	1:45
Grant	1:58	1:111	1:105	1:30
Lea	1:31	1:289	1:147	1:78
Luna	1:41	1:286	1:392	1:61
McKinley	1:189	1:23	1:27	1:32
Otero	1:67	1:141	1:146	1:37
Rio Arriba	1:40	1:23	1:95	1:25
Roosevelt	1:73	1:185	1:111	1:50
San Juan	1:122	1:100	1:85	1:43
Sandoval	1:64	1:39	1:81	1:12
Taos	1:70	1:61	1:122	1:31
Valencia	1:46	1:128	1:218	1:16
Frontier counties				
Catron	1:55	1:61	1:136	1:12
Cibola	1:123	1:35	1:150	1:23
Colfax	1:41	1:66	1:172	1:36
De Baca	1:43	1:127	1:202	1:26
Guadalupe	1:25	1:85	1:77	1:36
Harding	1:13	1:16	1:40	1:31
Hidalgo	1:106	1:145	1:205	1:14
Lincoln	1:22	1:26	1:108	1:13
Mora	1:136	1:336	1:261	1:259
Quay	1:20	1:44	1:134	1:6
San Miguel	1:63	1:85	1:282	1:84
Sierra	1:20	1:170	1:193	1:38
Socorro	1:29	1:61	1:168	1:19
Torrance	1:54	1:186	1:271	1:35
Union	1:117	1:45	1:48	1:43

Note: The LFC was unable to verify the high number of PCPs reported by UHC prior to the date of this brief.
Source: CY15 Q3 MCO Geo-Access Reports, except MHNM, which is CY15 Q2

Reported Provider Network Adequacy and Access: Primary Care. Primary care provider, as defined by Centennial Care contracts, is not limited to physicians. The term primary care provider (PCP) includes any provider the MCO has designated, including any of an array of physicians (general practice, family practice, internal medicine, gerontology, obstetrics, gynecologist 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 FQHCs, RHCs or I/T/Us.

The primary care providers are the foundation of the provider network, and are responsible for providing care and coordinating any necessary referrals. Every new Medicaid enrollee has 15 days to select their own PCP; if a member does not select a PCP, the MCO will assign them one (with the exception of dual-eligible members, who have a Medicare PCP).

Centennial Care contracts require that each MCO shall have at least one PCP per every 2,000 enrolled members, referred to as the PCP-to-member ratio. The geographic access requirements and appointment time standards for PCPs are also somewhat stricter than for other provider types, as Table 1 shows.

New Mexico's four Centennial Care MCOs are having no difficulty meeting the contractual requirement of one PCP per every 2,000 enrolled MCO members, and in fact are so far below the maximum that it is not clear why HSD decided to increase the ratio to 1:2,000 from the 1:1,500 standard that existed before Centennial Care.

UHC reports that it has more PCPs than any other MCO, even though it has the smallest Centennial Care enrollment. The result is a very low PCP-to-member ratio. The LFC was not able to fully resolve this apparent inconsistency during discussions with HSD and cannot confirm that the UHC data presented in Tables 6 and 7 is correct.

As Table 7 shows, at the end of the third quarter of 2015, the MCOs reported PCP to member ratios from 1:17 to 1:109. PCPs that are contracted

with more than one MCO may have individual ratios that are somewhat higher than the average. They nonetheless do not seem likely to begin to approach the contractual maximum.

Centennial Care MCOs are also meeting contractual requirements for geographic access to PCPs. HSD and the MCOs calculate the PCP to member ratio as the total number of non-dual members per PCP; another way to present the situation is on a county by county basis. As Table 6 shows, county-level ratios vary from a low of 1:6 to a high of 1:392. Geographic access is based on distance from member to provider, not on county lines, and no MCO failed to meet the geographic access requirements for PCPs.

This calculation of county-level PCP to member ratios is based on total Medicaid enrollment per county. However, some Medicaid enrollees are also eligible for Medicare and have a PCP through the Medicare program. Additionally, some PCPs have practice locations in more than one county. The MCO PCP reports, summarized in Table 7, control for both these factors and therefore have more accurate PCP to member ratios, albeit only at the statewide level.

Table 7: Statewide PCP to Member Ratios and Open PCP Panels
Third Quarter CY2015

	BCBS	MHNM	PHP	UHC
Total number of non-dual MCO members	113,528	224,703	200,682	65,028
Total number of PCPs	1,924	2,059	2,370	3,871
PCP to member ratio	1:59	1:109	1:85	1:17
Percent of PCPs accepting new members	88.7%	90.7%	83.5%	98.8%

Note: The LFC was unable to verify the high number of PCPs reported by UHC prior to the date of this brief.
Source: CY15 Q3 MCO PCP Reports

The PCP reports also provide information for another measure of access: the percentage of PCPs who are accepting new patients, referred to as 'open panels.' During the third quarter of 2015, open panels reportedly ranged from a low of 83.5 percent to a high of 98.8 percent.

MCO Member Grievance reports do not show a significant number of access related complaints. From January through September, 2015, the four MCOs reported a total of 2,498 member grievances. Detailed review of the reports shows that only 33 of the complaints were related to problems with network adequacy for healthcare providers. Of these, five were about problems obtaining or changing a PCP, five were about providers who were no longer in the MCO network, and five were about long appointment waits for the only vision care provider in the Roswell area.

Meaningful, up to date information about appointment wait times is not available from HSD. Geographic access is universally recognized as a valid measurement for access to services. On the other hand, simply having a healthcare provider located within a reasonable distance from a prospective patient's home is not a guarantee that the patient will be able to access services when needed. This is why the Centennial Care MCO contracts also include appointment timeliness standards. As noted above, HSD monitors MCO compliance with contractual requirements through a wide array of reports, including reports on provider to member ratio and geographic access.

There are no MCO reports comparable to the geographic access reports that would allow HSD to monitor compliance with appointment timeliness standards.

There are, however, no reports comparable to the geographic access reports that allow HSD to monitor compliance with appointment timeliness standards. The only direct sources of this information are the annual MCO provider network development and management plan and evaluation reports.

The network development plan and evaluation reports vary widely among the MCOs in the level of detail they include. For 2014, for example, UHC reported simply that its PCPs were in compliance for routine appointments. Molina's report did not separate PCPs from other provider types. Presbyterian reported in more detail: its PCP providers were in compliance for routine appointments, but the wait time for urgently needed primary medical care appointments, contractually required to be 24 hours or less, was averaging 9.2 days. BCBS did not include any information about appointment timeliness in its report.

Provider Network Adequacy and Access: Other Physical Health Providers

Geographic access for most other physical health provider types was also met by most MCOs throughout CY14 and for the first two quarters of CY15. Table 8 highlights the provider types for which the MCOs are having difficulty consistently meeting contractual requirements. With the exception of dermatologists, which have shortages in all three types of counties, the shortages are mostly in rural and frontier counties. This is not a surprising finding, as New Mexico's overall maldistribution of health care providers, who are largely concentrated in urban areas, is well-documented. (Appendix B has data on all PH provider types.)

Table 8: Physical Health Provider Types with Limited Access
CY14 and CY15 (first 2 quarters)

	Urban Counties						Rural Counties						Frontier Counties					
Geo-Access Standard	**Urban = 30 miles**						**Rural = 60 miles**						**Frontier = 90 miles**					
	2014				2015		2014				2015		2014				2015	
Provider Type	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr
Certified Midwives	4	4	4	4	4	4	2	2	3	3	3	3	4	4	4	4	4	4
Dermatology	0	1	1	1	1	1	0	0	0	0	0	0	3	1	1	1	1	1
Endocrinology	3	4	4	4	4	4	0	0	0	1	1	0	0	0	0	1	1	1
Hematology/oncology	4	4	4	4	4	4	2	2	2	3	3	3	4	3	3	4	4	4
Neurology	4	4	4	4	4	4	2	1	1	1	1	2	1	2	1	1	1	2
Neurosurgeons	3	4	4	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	3	3	4	4	4	4	0	0	1	1	1	0	1	1	1	1	1	0

Source: 2014 and 2015 MCO Geo-Access Reports

4	Met by all 4 MCOs
3	Met by 3 MCOs
2	Met by 2 MCOs
1	Met by 1 MCO
0	Met by no MCO

In addition to specific provider access, MCOs report geographic access for their members to the existing network of FQHCs, rural health centers and Indian Health Service, tribal health provider, and urban Indian provider (I/T/U) facilities. Since the number and location of these types of facilities is largely fixed, whether an MCO is able to meet the distance requirement for these types of facilities depends on the geographic distribution of their enrolled members.

Appointment wait times for other physical health providers. The MCO annual provider network development and management plans, as noted above, offer little information regarding appointment wait times. For 2014, UHC reported only that its specialists were not in compliance with requirements. Presbyterian reported that the wait time for specialist outpatient referral and consultation was on average 32.8 days, exceeding the 21 days or less contractual requirement. However, its dentists, pharmacies and diagnostic laboratories were in compliance for both routine and urgent care services. Molina's report combined all physical health providers, and indicated that 94 percent of the combined providers it surveyed were in compliance with standards for routine appointments, and 85 percent were in compliance for urgent appointments. The Molina provider survey reports each type of specialist separately, with no aggregate measure of compliance. BCBS did not include any information about appointment timeliness in its report.

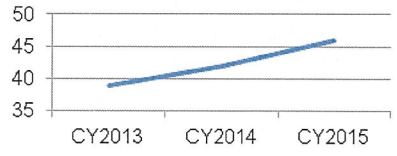
Medicaid recipients who cannot get a timely appointment with their healthcare provider may turn to hospital emergency rooms for care. Persistent use of emergency rooms for non-emergency conditions is a national trend, generally attributed to newly-insured people continuing to seek healthcare at the place they are most familiar with. The care coordination elements of the Centennial Care program are intended, in part, to reduce unnecessary medical costs by educating new recipients and redirecting them away from costly emergency rooms and towards more appropriate care levels when their health condition permits.

High rates of Medicaid recipients going to the ER for routine urgent care may be an indicator of lack of access to primary care.

Despite the goals of Centennial Care, and a 27 percent increase in total spending on care coordination from CY14 to CY15, HSD has reported steadily increasing total ER use since it first began tracking the data in 2013, as Chart 1 shows. Total ER costs increased from $99 million in CY14 to $116 million in CY15, over 17 percent.

High rates of Medicaid recipients going to the ER for routine urgent care for conditions such as colds, ear infections or respiratory infections may also, to some extent, be an indicator of lack of access to primary care. Centennial Care utilization reports show a wide variation in performance among the MCOs in this area. Throughout 2014 and the first half of 2015, Presbyterian and UHC reported an average of approximately 15 percent of ER visits by their members were for non-emergent conditions, Molina reported an average of over 30 percent, and BCBS reported over 75 percent, possibly reflecting issues with its PCP network.

Chart 1: Medicaid Emergency Room Utilization Trend
Rate of ER Visits per 1,000 Member Months



Source: HSD MCO reports

Provider Network Adequacy and Access: Long Term Services

For long-term services, almost all MCOs met all requirements for personal care service agencies and nursing facilities but no MCO met all requirements for assisted living facilities. In its quarterly reports to CMS, HSD has noted that there is a shortage of assisted living facilities throughout the state. In

Table 9: Long Term Care Providers
CY14 and CY15 (first 2 quarters)

	Urban Counties						Rural Counties						Frontier Counties					
Geo-Access Standard	Urban = 30 miles						Rural = 60 miles						Frontier = 90 miles					
	2014				2015		2014				2015		2014				2015	
Provider Type	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr
Assisted Living Facilities	3	3	3	1	1	2	0	0	0	0	0	0	3	2	3	2	3	3
Personal Care Service Agencies - Delegated	4	4	4	4	4	4	3	4	4	4	4	4	4	4	4	4	4	4
Personal Care Service Agencies - Directed	3	4	4	4	4	4	3	4	4	4	4	4	3	4	4	4	4	4
Nursing Facilities	4	3	4	4	4	4	4	3	4	4	4	4	4	4	4	4	4	4

Source: 2014 and 2015 MCO Geo-Access Reports

4	Met by all 4 MCOs
3	Met by 3 MCOs
2	Met by 2 MCOs
1	Met by 1 MCO
0	Met by no MCO

addition, the geographic access percentages are calculated using the total membership of an MCO, even though not all members will need long term services. So an MCO may be contracted with enough of the assisted living facilities in a given region to ensure that all of its members who need assisted living services receive them, but the MCO may still fail to meet the 90 percent access requirement. See Table 9 for geographic access for LTC providers.

The apparent sufficiency of the provider network in this area is supported by the fact that none of the MCOs have reported receiving member grievances regarding lack of access to assisted living.

Provider Network Adequacy and Access: Behavioral Health

There are gaps in access to outpatient provider agencies, as well as in specific service categories including behavioral management services, day treatment services, assertive community treatment, multi-systemic therapy, and intensive outpatient services.

As with long-term services, not all Medicaid recipients will require behavioral health services, and among recipients who do seek services, there is a wide variation of the type and acuity of care that might be needed. Less than a quarter of any MCO's total Centennial Care membership received behavioral health services in 2014.

Again, geographic access is calculated using the total membership of an MCO, even though not all members will utilize all – or any – categories of behavioral health services. There will inevitably be regions where an MCO fails to meet the contractual requirements and yet succeeds at meeting the actual needs of its members. However, while the mixed picture provided by the MCO reports may not be an entirely accurate measurement of access, it does corroborate the state's documented shortage of behavioral health providers and the LFC's documented decline in children's behavioral health services.

The Centennial Care MCOs are consistently meeting contractual geographic access requirements for some key provider types that could be considered the foundation of the behavioral health system: core service agencies, psy-

chiatrists, and the broad category of other licensed independent behavioral health practitioners. Most MCOs are also meeting the geographic requirements for community mental health centers and psychologists.

There are however, some gaps in access to outpatient provider agencies, as well as in specific service categories including behavioral management services, day treatment services, assertive community treatment, multi-systemic therapy, and intensive outpatient services. In these areas there appear to be significant differences in capacity among the MCO provider networks. For example there are several service categories for which BCBS failed to meet any geoaccess requirement, while some of the other MCOs were able to meet all requirements for some or all county types. These differences are not fully explained in MCO or HSD reports. (Appendix C has data on all BH provider types and services.)

Table 10: Behavioral Health Providers
CY14 and CY15 (first 2 quarters)

	Urban Counties						Rural Counties						Frontier Counties					
Geo-Access Standard	**Urban = 30 miles**						**Rural = 60 miles**						**Frontier = 90 miles**					
	2014				2015		2014				2015		2014				2015	
Provider Type or Service	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr
Outpatient Provider Agencies	3	3	3	3	3	3	1	1	2	3	2	2	2	2	2	3	2	2
Behavior Management Services	4	4	4	3	3	3	1	1	2	3	2	1	4	4	4	3	3	3
Day Treatment Services	1	1	1	2	2	2	0	0	0	1	1	1	0	0	0	1	1	1
Assertive Community Treatment	2	2	2	3	3	3	0	0	0	2	1	1	1	1	1	2	1	1
Multi-Systemic Therapy	1	2	3	3	3	3	0	0	1	2	2	2	1	1	2	3	2	2
Intensive Outpatient Services	3	3	3	3	3	3	2	2	2	2	2	2	3	3	2	2	3	3

Source: 2014 and 2015 MCO Geo-Access Reports

4	Met by all 4 MCOs
3	Met by 3 MCOs
2	Met by 2 MCOs
1	Met by 1 MCO
0	Met by no MCO

Access to Inpatient Treatment is Limited. There are also significant gaps in geographic access to inpatient behavioral health facilities. HSD asserts that these gaps are not necessarily problematic for two reasons. First, there are simply a limited number of psychiatric hospitals, hospitals with psychiatric units and programs, and residential treatment centers, and these types of facilities are largely concentrated in urban areas. Regardless of geographic concentration, HSD reports that there is adequate bed capacity statewide to meet the limited need for the acute level of care these facilities provide. Furthermore, HSD's overarching behavioral health policy is focused on outpatient, community based services as the preferred treatment setting and modality, and having mostly-empty inpatient facilities in every county would be inefficient and run counter to this policy.

These are sensible explanations, but they do make the shortages in the provider types and outpatient services noted above more pressing, and, for some services, make the discrepancies between the MCOs' networks more prob-

lematic. Multisystemic Therapy (MST) is an effective, evidence-based approach for treating at-risk youth with serious behavioral health problems. Before HSD suspended payments to 15 New Mexico behavioral health providers in June, 2013, the MCOs together were providing MST services to 1,421 young Medicaid patients, at a total cost of $6.6 million for 2013. By the end of 2015, spending had dropped to $6.1 million, and the MCOs were providing MST services to only 869 patients.

HSD and the MCOs have pursued a number of strategies for improving access, including continued reliance on telemedicine and the state's mental health crisis hotline, as well as focusing on expanding workforce capacity by developing a new supervisory protocol for mid-level practitioners and offering continuing education trainings. HSD is also working to increase the number of methadone clinics approved to accept Medicaid patients.

Behavioral health reporting, in particular, appears to be an area where HSD's oversight is inadequate.

Appointment wait times for behavioral health services have been in excess of contractual requirements. There are no routine quarterly MCO reports that address appointment wait times for behavioral health. According to HSD, the department responded to reports of long wait times for behavioral health services by requesting ad hoc reports from the MCOs in September, 2014. Two MCOs, BCBS and Molina, did not complete the ad hoc report, saying that they had not finalized their planned annual telephone surveys and had no data to report. This inability to get data when requested, especially in light of how little information about appointment wait times is included in the annual provider network development and management plans, may indicate that behavioral health reporting, in particular, is an area where HSD's oversight could be stronger.

For the ad hoc request, Presbyterian surveyed six high volume core service agencies (CSAs), and identified longer than expected wait times for individual counseling, psychiatry, multi-systemic therapy, treatment foster care, and behavioral management services, and reported the top reasons for long wait times were a lack of providers, lack of bilingual providers, client attendance, and lack of transportation for clients. Presbyterian's 2014-2015 annual provider network development and management plan reported that wait times for non-urgent appointments averaged three days, well below the contractual requirement of 14 days, and urgent appointments averaged six hours, also below contractual requirements of 24 hours. However, crisis appointment wait times averaged four hours, twice as long as the contractual requirement of two hours. HSD reports that Presbyterian's wait times for crisis appointments improved during 2015.

UHC's 2014-2015 annual provider network development and management plan did not include any specific information regarding behavioral health appointment wait times. It did, however, note the loss of key providers in the southeast and northern part of the state, and indicated that although the plan is working to educate providers about state appointment availability standards, UHC has "little recourse" when providers do not meet those standards.

UHC responded to HSD's ad hoc survey by compiling anecdotal information gathered from a poll of 26 care coordinators, explaining that it had no other means available to otherwise capture the requested data. They found wait times for appointments, assessments and services ranged from one to three weeks in the northern portion of the state, one to two weeks in the central portion, and one to four weeks in the south, with the exception of La Frontera, where wait times were averaging between six and eight weeks. UHC identified longer than expected wait times for psychiatrists, medication management, residential substance abuse treatment, multi-systemic therapy, assertive community treatment, outpatient therapy, and behavioral management services.

As noted, Molina did not respond to the department's ad hoc request, but its 2014 annual provider network development and management plan and evaluation includes results from a telephone survey of 442 providers. Eighty -six percent of surveyed providers responded that they were able to schedule routine behavioral health appointments within ten business days or less. Ninety-one percent met the contractual requirement of 24 hours for urgent appointments, but less than 46 percent met the requirement of 2 hours for crisis appointments.

The 2014 annual provider network development and management plan and evaluation submitted by BCBS acknowledged deficiencies in its network of behavioral health providers, but did not provide any specific information about appointment timeliness for behavioral health.

Addressing the Gaps

HSD and the MCOs report a variety of efforts to deal with gaps in access to care. Briefly, in addition to on-going recruitment of new providers, the MCOs rely primarily on transportation services to help their members travel to providers when necessary, as well as on expanding telemedicine services.

Addressing the Gaps: Transportation

Transportation services are available to all Medicaid recipients as needed to obtain covered medical and behavioral health services, and the MCOs report that transportation services are one of their key methods for meeting the needs of members in areas with fewer providers or who may need to travel to reach a specialist.

In response to recipient complaints, HSD and the MCOs have initiated regular meetings with transportation providers and developed corrective action plans when appropriate.

That said, only one MCO, Molina Healthcare, met the contractual requirements for transportation providers for all county types for all quarters of 2014. The overall situation improved in 2015, with all MCOs meeting contractual requirements in urban, rural and frontier counties for the first two quarters of 2015.

Notably, a large majority of the member complaints received to date in 2015 were due to problems with non-emergency transportation services, including

late arrivals and no-shows which resulted in missed medical appointments. Even though the grievances represent a relatively small percent of total transportation services provided, HSD and the MCOs appear to have taken the problems seriously, holding regular meetings with the transportation providers to review complaints, requiring additional trainings for drivers, implementing two corrective action plans, and designating staff to assist members in rescheduling missed appointments.

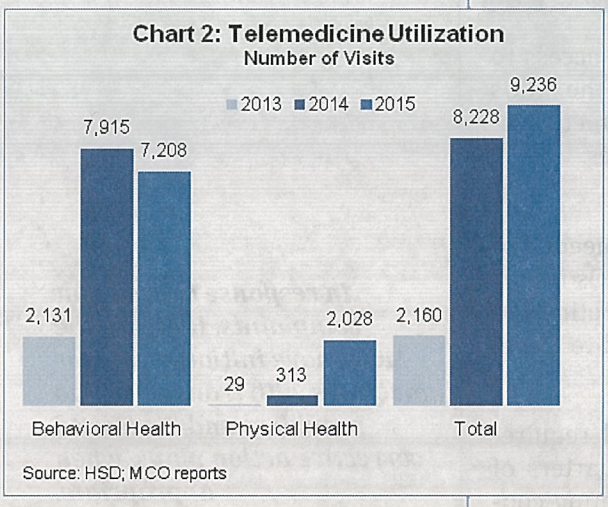
Addressing the Gaps: Telemedicine

Medicaid's use of telemedicine increased dramatically with the implementation of Centennial Care.

Telemedicine is widely seen as a method for improved and more timely access to health care for people who live in remote and/or underserved areas, which may in turn lead to improved health outcomes and lower costs. New Mexico is one of 47 states that require health plans, including Medicaid, to include coverage for telemedicine services. Telemedicine is the provision of health care by a provider at one location to a patient and/or provider at a different location, who communicate directly through interactive simultaneous audio and video technology. New Mexico is one of nine states that also allow the use of 'store-and-forward' technology, where data or images are captured at the patient's location and later transmitted to a specialist for evaluation.

During 2014, all four of the Centennial Care MCOs worked with UNM's Project Echo, and Molina and UHC each also pursued independent initiatives. Molina, for example, established a system for identifying, training and equipping new telemedicine providers, and UHC focused on establishing teledermatology and telepulmonology services.

In 2015, BCBS invested additional funds in its telemedicine network by transferring some of its pay for performance funding to Project Echo to purchase and install video-conferencing equipment for providers around the state. Molina and UHC expanded their existing telemedicine programs and both began offering members the option of video visits for non-emergent physical and behavioral health conditions.



As Chart 2 shows, Medicaid's use of telemedicine increased dramatically with the implementation of Centennial Care. Unfortunately, the data for the last three years are not entirely comparable, because for 2013 and 2014 telemedicine utilization information from the MCOs combined totals from rural and frontier counties, while data for 2015 (as of third quarter) also includes urban counties. Even so, the trend clearly shows that the program is expanded the use of telemedicine as a key tool for improved access, particularly in the area of physical health.

Addressing the Gaps: Recruitment

The New Mexico Health Care Workforce Committee, the LFC, and others have documented the shortage of healthcare workers in New Mexico, and made numerous recommendations for addressing that shortage. Many of these

recommendations, such as expanded education opportunities and loan repayment programs, are outside the scope of HSD to respond to directly. HSD reports that it is actively working to enroll more providers into the Medicaid system and also pursuing initiatives to maximize the scopes of practice for existing providers, by, for example, clarifying the billing procedures for licensed non-independent providers.

However, the fact that some MCOs have much larger provider networks than others indicates that there are other, more complex, factors at work than a generic shortage of providers. Comparison of PCPs within Bernalillo County, using published MCO provider directories, found just over four percent of the 1,289 listed PCPs were credentialed to see patients enrolled in any of the four MCOs. Sixteen percent were credentialed with three MCOs, twenty-eight percent were credentialed with two MCOs, and fifty-two percent were credentialed with just one MCO. There are many reasons a provider may chose to participate in only one MCO, but there is little doubt that having more providers credentialed with multiple MCOs would improve access and offer Medicaid recipients more choices.

Having more providers credentialed with multiple MCOs would improve access, offer Medicaid recipients more choices, and make the overall Centennial Care provider network more efficient.

The annual provider satisfaction surveys from the MCOs could be an important tool to help figure out why providers do not appear to want to participate in multiple plans. The surveys collect responses to a wide variety of questions dealing with the daily challenges faced by providers: adequacy of the MCO's network of PCPs and specialists for referrals, timeliness of prior authorizations and claim payments, credentialing, pharmacy benefits and authorizations, etc. Unfortunately, each MCO reports the survey results somewhat differently – some provide only individual scores for each question, while others provide composite scores for combined groups of questions. This makes direct comparison across all four MCOs impossible, except on the single question of overall provider satisfaction.

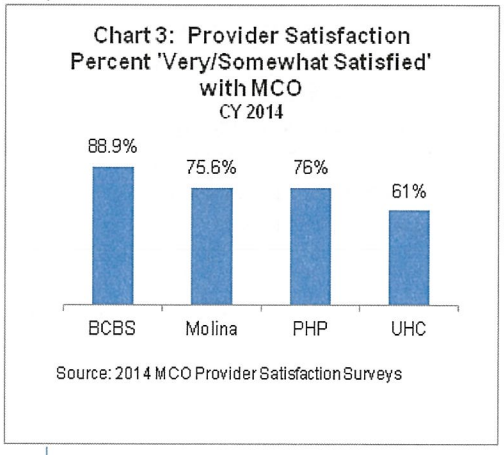


Chart 3 shows the percentage of providers in 2014 who responded they were 'very' or 'somewhat' satisfied with the MCO. In general, the positive responses to more specific questions were quite lower than overall satisfaction rates. Improvement in these areas is clearly one way HSD and the MCOs could address provider recruitment and retention, and thereby increase patient access to care.

Direct Assessment of Primary Care Availability

According to the New Mexico Health Care Workforce Committee's 2015 Annual Report, when measured against national benchmarks, New Mexico has a persistent shortage of healthcare providers. In addition, providers are unequally distributed around the state, leading to significant shortages in some counties and surpluses in other counties. For primary care providers, the Committee found twenty five counties with shortages, and another six with surpluses. The Committee also found this maldistribution problem within counties, where providers tend to be clustered in urban areas.

Geographic access and appointment timeliness standards are both Centennial Care contractual requirements and it is not clear why HSD mandates more in-depth reporting on one than the other.

Despite this context of a statewide shortage of providers, the Centennial Care MCO reports, summarized above, indicate that the Medicaid MCOs are not encountering difficulties in meeting their contractual requirements for primary care provider network adequacy, geographic access, or appointment timeliness. However, as noted, the MCO network adequacy and geographic access reports are detailed and informative, while the data on appointment timeliness is incomplete or, in some cases, non-existent.

Trust but verify. The new reports mandated by CMS and the contractual requirements of Centennial Care are strong steps to ensure adequate provider networks. They do not, however, by themselves guarantee that Medicaid recipients will always find a provider when they need one. In 2014, the California Department of Managed Health Care received a large number of complaints related to access from individuals enrolled through the state's health insurance exchange. The department used a direct survey of randomly-selected providers to discover that over 25 percent of the physicians listed in the provider directories of two MCOs had moved their office locations and/or were not accepting patients enrolled with the MCOs. The two plans argued that the errors were related to the generalized confusion that accompanied the roll-out of the Affordable Care Act, and that the problems had been fixed. California is nonetheless planning another survey this year to follow-up.

Over the past five years, the majority of cases where an MCO was found not in compliance with state access standards were discovered in the three states that used regular direct tests.

The 2013 HHS OIG study referenced above also addressed this issue, and found that while all states take steps to ensure MCO compliance with access standards, few states use 'direct tests' such as calls to providers to verify MCO reports. Yet over the past five years, the majority of cases where an MCO was found not in compliance with state access standards were discovered in the three states that used regular direct tests. The HHS OIG recommended to CMS that it strengthen its oversight of state access standards and require states to conduct direct tests, to better identify and address violations.

In December, 2014, the HHS OIG released a second report focusing on the availability of MCO primary care and specialist providers nationwide, as determined through a telephone survey conducted between July and October, 2013. The report found 51 percent of providers were unavailable to Medicaid enrollees, either because they were not accepting new patients (eight percent), no longer participating in the MCO's plan (eight percent), or no longer practicing at the location listed in the MCO provider directory (35 percent).

More positively, the report found the Medicaid enrollees could obtain appointments with the 49 percent of providers who were available within relatively short periods of time. The median wait time for a new appointment of any type was two weeks; the median wait time for primary care was 10 days, while the median for specialists was 20 days.

PCP appointment timeliness in New Mexico.
Because the LFC was not able to obtain meaningful data about appointment timeliness from any Centennial Care report or other existing source, LFC staff followed the HHS model and conducted a 'secret shopper' survey of New Mexico Medicaid primary care providers. Seven urban, rural and frontier counties were selected from among the ten counties with the largest growth in their Medicaid population, and a phone survey was conducted of a representative sample of 15 percent of PCPs within those counties. The survey questions confirmed PCP enrollment with at least one Centennial Care MCO, and then asked whether the provider was accepting new patients and, if so, how soon a new patient appointment could be scheduled. (The full methodology of the survey can be found in Appendix D.)

Who is a PCP? The designation of a provider as a PCP is, in theory, made by agreement between the provider and the MCO. During the LFC survey, virtually all internal medicine providers identified by any MCO as a PCP responded that they specialized in a certain area and would not accept primary care patients. Similarly, many OB/GYNs responded that they did not provide primary care and would only see a new patient after referral from their PCP.

Survey Finding One: The Centennial Care MCO provider directories and websites present significantly inaccurate information regarding which PCPs are active in their networks and which are accepting new patients.
The provider information used for the survey was drawn initially from the printed provider directories because there is no other source that can be used to identify which specific providers have been designated as PCPs by the MCOs, and which of those providers are enrolled in multiple MCOs. However, because these directories are acknowledged to be out of date very shortly after they are created, the contact information was checked against the more up-to-date on-line provider directories the week prior to the survey, and should have been more reliable.

Despite using the most current information available, between 5 percent and 50 percent of the PCPs contacted by the LFC survey said that they were either not a Medicaid provider or not a member of a specific MCO's plan. See Table 11, below. Further, the MCO reports cited earlier in this brief indicate that statewide, between 83.5 percent and 90.7 percent of MCO PCPs are accepting new patients. However, in the seven counties the LFC surveyed, only 37.9 percent to 70 percent of providers contacted were in fact accepting new patients.

For a new Medicaid recipient, having to make multiple phone calls just to find a provider who is in-network and accepting new patients can be a distinct barrier to access.

Table 11: LFC Primary Care Provider Phone Survey Results: Accuracy of MCO Information

	Urban			Rural			Frontier
	Bernalillo	Doña Ana	Santa Fe	Chaves	McKinley	San Juan	Mora
Number of PCPs in sample	196	51	58	22	10	21	6
Number confirmed as a Centennial Care provider	145	38	43	18	8	20	3
Percent confirmed as a Centennial Care provider	74%	74.5%	74.1%	81.8%	80%	95.2%	50%
Number accepting new Centennial Care patients	85	30	22	11	7	10	3
Percent accepting new Centennial Care patients	43.4%	58.8%	37.9%	50%	70%	47.6%	50%

Source: LFC Survey March 8 – 22, 2016

Survey Finding Two: Wait times for appointment frequently exceed Centennial Care contract requirements. Centennial Care contracts require wait times for routine, asymptomatic appointments should not be more than 30 calendar days. The Centennial Care MCO reports indicate solid network adequacy for PCPs in each of the surveyed counties. In Bernalillo, Santa Fe and San Juan counties, however, average wait times exceed the contractual requirements. In McKinley and Mora counties none of the PCPs surveyed for some MCOs were accepting new patients at all, which made it impossible to calculate an average wait time for the county.

The appointment timeliness results vary by and within MCO: all MCOs appear to be out of compliance in at least two of the surveyed counties, but at the same time, all are in compliance in at least two counties. Table 12 shows the average wait time for surveyed PCPs in each county by MCO. Shaded cells highlight wait times longer than 30 days.

Table 12: LFC Primary Care Provider Phone Survey Results: Average Wait Times for New Patient Appointment, in Days

	Urban			Rural			Frontier
	Bernalillo	Doña Ana	Santa Fe	Chaves	McKinley*	San Juan	Mora*
BCBSNM	36	12	28	2	n/a	14	28
MHNM	51	35	49	12	21	30	14
PHP	33	9	23	35	17	77	n/a
UHC	66	46	27	18	31	28	n/a
County Average	**43**	**25**	**32**	**21**	**n/a**	**52**	**n/a**

Note: 'n/a' means that no surveyed PCP in that county was accepting new patients for that MCO and it was not possible to calculate a county average wait time.
Source: LFC Survey March 8 – 22, 2016

Appointment wait times for pediatricians were generally lower than wait times for other PCPs. This difference was particularly notable in Bernalillo County, where the average wait time for a new patient appointment was over six weeks. The overall wait time, however, masks a significant difference in access for children and adults. Primarily due to the decision by UNM hospital's pediatrics clinic in Albuquerque to shift to a walk-in basis only, with essentially same or next-day appointments, the wait time for a new patient appointment with a pediatric PCP averaged two weeks, while the wait time for an adult averaged ten weeks.

Survey Finding Three: Wait times for new patient appointments do not appear closely connected to classification of the county as having a surplus or shortage of primary care providers. As explained above, the New Mexico Health Care Workforce Committee's work is based on a national metric of providers per capita and is not a direct measure of access to care. It is nonetheless informative to review the results of the LFC survey in the context of with the Committee's classification of New Mexico counties as having a surplus or a shortage of primary care providers.

The Committee's 2015 Annual Report determined that Bernalillo, Chaves and Santa Fe counties are among the six New Mexico counties with a surplus of PCPs. However, the LFC survey found long average wait times in Bernalillo and Santa Fe counties and, to compound the problem, these two counties had the lowest rate of providers actually accepting new Medicaid patients.

Doña Ana, McKinley, Mora and San Juan counties are all categorized as having a shortage of PCPs, yet in Doña Ana wait times were mixed and resulted in one of the lowest county averages. On the other hand, the longer wait

times and lack of PCPs willing to accept new Medicaid patients in McKinley, Mora and San Juan counties are a closer parallel with the Committee's classification.

Conclusion

The LFC's review of Centennial Care MCO reports, combined with the results from the LFC phone survey, lead to concern that some Medicaid recipients in New Mexico face challenges in accessing the healthcare system. As is the case in the healthcare system broadly, provider shortages can leave gaps in network adequacy for Medicaid.

The rapid expansion of the Medicaid population, New Mexico's pre-existing shortage of healthcare providers, and the state's significant economic challenges make it even more difficult to address these concerns, and the department should monitor this area more closely.

There are shortages for physical health specialists such as dermatologists and rheumatologists, and there are significant behavioral health network gaps, particularly in access to various intensive outpatient therapies. Primary care appointment wait times frequently exceed 30 days, and emergency room utilization for routine acute care conditions continues, some of which is very likely connected to an inability to get an appointment with a PCP.

To ensure that all New Mexican Medicaid recipients have access to basic primary care, HSD needs to take a more active oversight role of Centennial Care MCO provider networks and appointment timeliness.

HSD notes that it requires the MCOs to submit numerous reports that allow it to monitor compliance with contractual requirements related to provider networks and access to care. Indeed, information gathered through the department's robust reporting requirements is the basis for most of this brief. However, each report presents only a fragment of the whole picture, and despite clear report templates and instructions from HSD, the MCOs do not always present their data in a uniform manner or comparable level of detail. MCO reports are frequently late, and the data reported in them is not entirely accurate, as can be seen from the discrepancies found by the LFC survey.

Further, receiving and reviewing reports is not the same as taking a vigorous oversight role. HSD has numerous subject matter experts and other staff dedicated to reviewing MCO reports. The department has been active in addressing problems with the reports, and has, to date, assessed MCO sanctions totaling over $5.5 million, the bulk of which were for issues with inaccurate and/or late reports, or related to MCO call centers and nurse advice lines.

The department has not been equally forceful when it comes to addressing the gaps in access to care that are revealed by those same MCO reports. HSD takes the position that there are some provider shortages that are endemic to the state, and declines to take corrective action for network gaps perceived as beyond the MCO's control.

The department is, of course, not responsible for the state's shortage of healthcare providers and services. However, HSD and the Centennial Care MCOs developed and agreed to the geographic access and appointment timeliness requirements found in the Centennial Care contracts, and it is reasonable for the program to be evaluated by its own standards. Nearly half the population is now enrolled in Medicaid, which places a greater responsibility for the status of the healthcare workforce on HSD and the Centennial Care MCOs than ever before.

Nearly half the population is now enrolled in Medicaid, which places a greater responsibility for the status of the healthcare workforce on HSD and the Centennial Care MCOs than ever before.

The MCOs have developed action plans to target issues they or HSD have identified as problematic. The MCO action plans in 2014 and the first half of 2015 were primarily focused on reports, staffing issues at call centers and nurse advice lines, care coordination, and transportation grievances. One action plan addressed a shortage of vision care providers in Grant County caused by the temporary withdrawal of Walmart Vision from the UHC network; there were no other MCO action plans related to gaps in provider networks.

In addition to the work of its own staff, HSD contracts with an external quality review organization (EQRO) to measure the level of MCO compliance with Centennial Care contracts. The EQRO review primarily focuses on whether the MCO has a process in place that meets contract requirements. The department's FY15/FY16 EQRO contract included $684 thousand for the 2015 report, which rated all four MCOs as 100 percent compliant with provider network requirements, finding that "all policies, procedures and supporting documentation reviewed were accurate and addressed all aspects of the contract requirements. There were no deficiencies identified during this review." This is a notably different sort of finding than whether or not the MCOs had provider networks that met the substance of the contractual requirements.

As noted at the beginning of this brief, New Mexico will not see improved health outcomes unless Medicaid recipients have meaningful access to healthcare to begin with. To ensure that New Mexicans have access to basic primary care, as well as necessary specialty and behavioral health services, HSD needs to enhance its oversight of Centennial Care contractual requirements regarding MCO provider networks and appointment timeliness.

Appendix A:
Medicaid Enrollment Change by County
October 2013 to February 2016

County	October 2013 total enrollment	February 2016 base enrollment	February 2016 OAG enrollment	February 2016 total enrollment	Change in enrollment	Percent change
Bernalillo	149,019	172,087	74,528	246,615	97,596	66%
Catron	517	667	359	1,026	509	99%
Chaves	21,295	23,131	7,755	30,886	9,591	45%
Cibola	8,821	9,632	3,828	13,460	4,639	53%
Colfax	2,897	3,625	1,483	5,108	2,211	74%
Curry	13,417	14,420	4,609	19,029	5,612	42%
De Baca	477	611	214	825	348	73%
Dona Ana	70,801	76,297	31,784	108,081	37,280	53%
Eddy	14,271	16,592	5,005	21,597	7,326	51%
Grant	7,267	8,167	3,679	11,846	4,579	63%
Guadalupe	1,426	1,578	588	2,166	740	52%
Harding	56	88	39	127	71	127%
Hidalgo	1,209	1,403	613	2,016	807	67%
Lea	17,331	21,556	5,590	27,146	9,815	57%
Lincoln	4,905	5,422	2,250	7,672	2,767	56%
Los Alamos	639	824	416	1,240	601	94%
Luna	10,004	11,518	4,394	15,912	5,908	59%
McKinley	29,932	32,502	11,631	44,133	14,201	47%
Mora	982	1,249	582	1,831	849	86%
Otero	12,027	15,056	6,899	21,955	9,928	83%
Quay	2,639	2,984	1,188	4,172	1,533	58%
Rio Arriba	15,656	16,490	6,717	23,207	7,551	48%
Roosevelt	5,129	5,651	1,984	7,635	2,506	49%
San Juan	37,004	41,853	14,741	56,594	19,590	53%
San Miguel	9,009	9,570	3,999	13,569	4,560	51%
Sandoval	27,804	32,994	12,585	45,579	17,775	64%
Santa Fe	24,935	30,401	12,781	43,182	18,247	73%
Sierra	3,877	4,578	2,031	6,609	2,732	70%
Socorro	5,630	6,075	2,514	8,589	2,959	53%
Taos	8,585	10,172	5,372	15,544	6,959	81%
Torrance	6,279	6,494	2,553	9,047	2,768	44%
Union	785	738	235	973	188	24%
Valencia	20,676	23,435	9,041	32,476	11,800	57%
Unspecified	655	1,080	200	1,280	625	95%
TOTAL	**535,956**	**608,940**	**242,187**	**851,127**	**315,171**	**58.8%**

Source: HSD Medicaid Eligibility Report, February 2016; Monthly Statistical Report, July 2013 – January 2014.

Appendix B:
Physical Health Practitioners and Facilities
2014 and First Two Quarters 2015

	Urban Counties						Rural Counties						Frontier Counties					
	2014				2015		2014				2015		2014				2015	
Physical Health Practitioners and Facilities	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr
PH – Standard 1	**Urban = 30 miles**						**Rural = 45 miles**						**Frontier = 60 miles**					
Primary Care Provider*	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Pharmacies	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
PH – Standard 2	**Urban = 30 miles**						**Rural = 60 miles**						**Frontier = 90 miles**					
Cardiology	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Certified Nurse Practitioner	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Certified Midwives	4	4	4	4	4	4	2	2	3	3	3	3	4	4	4	4	4	4
Dermatology	0	1	1	1	1	1	0	0	0	0	0	0	3	1	1	1	1	1
Dental	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Endocrinology	3	4	4	4	4	4	0	0	0	1	1	0	0	0	0	1	1	1
ENT	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Hematology/oncology	4	4	4	4	4	4	2	2	2	3	3	3	4	3	3	4	4	4
Neurology	4	4	4	4	4	4	2	1	1	1	1	2	1	2	1	1	1	2
Neurosurgeons	3	4	4	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0
OB/GYN	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Orthopedics	4	4	4	4	4	4	3	4	4	4	4	4	4	4	4	3	4	4
Pediatrics	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Physician Assistant	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Podiatry	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Rheumatology	3	3	4	4	4	4	0	0	1	1	1	0	1	1	1	1	1	0
Surgeons	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Urology	3	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Transportation	3	3	4	4	4	4	2	2	4	4	4	4	4	4	3	4	4	4

Note: Primary care providers are designated as such by the MCOs they participate in, and may practice in the fields of family practice, general practice, internal medicine, gerontology, obstetrics and gynecology, or pediatrics; for particularly complex patient cases they may be specialists.
Note: Standards for pediatrics count only members who are 0 – 18 years old; standards for OB/GYN count only female members 14 years and older.
Source: 2014 and 2015 MCO Geo-Access Reports

4	Met by all 4 MCOs
3	Met by 3 MCOs
2	Met by 2 MCOs
1	Met by 1 MCO
0	Met by no MCO

Appendix C:
Behavioral Health Practitioners and Facilities
2014 and First Two Quarters 2015

	Urban Counties						Rural Counties						Frontier Counties					
	2014				2015		2014				2015		2014				2015	
Behavioral Health Practitioners and Facilities	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr	1st qtr	2nd qtr	3rd qtr	4th qtr	1st qtr	2nd qtr
Geo-Access Standard	**Urban = 30 miles**						**Rural = 60 miles**						**Frontier = 90 miles**					
Freestanding Psychiatric Hospitals	2	3	2	2	1	2	0	1	0	0	0	0	1	1	1	0	0	1
Inpatient Psychiatric Hospitals	4	3	4	3	3	4	1	0	0	0	0	0	1	1	1	1	0	2
General Hospitals with Psychiatric Units	3	3	3	3	3	3	0	0	0	0	0	0	1	1	2	0	1	1
Partial Hospital Programs	0	0	0	3	2	2	0	0	0	0	0	0	0	0	0	2	1	1
Accredited Residential Treatment Centers (RTCs)	1	2	2	2	1	1	0	0	0	0	0	0	1	1	1	2	1	1
Non-Accredited RTCs and Group Homes	2	2	2	3	2	2	1	1	1	2	0	0	1	1	2	2	1	2
Treatment Foster Care I & II	4	4	3	4	4	4	1	1	1	0	0	0	3	3	3	3	3	3
Core Service Agencies	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4	4	4	4
Community Mental Health Centers	2	3	4	4	4	4	2	2	2	3	3	3	4	4	4	4	4	4
IHS and Tribal 638s providing BH	0	0	2	1	0	0	0	0	2	0	0	0	1	1	2	0	0	0
Outpatient Provider Agencies	3	3	3	3	3	3	1	1	2	3	2	2	2	2	2	3	2	2
Behavior Management Services	4	4	4	3	3	3	1	1	2	3	2	1	4	4	4	3	3	3
Day Treatment Services	1	1	1	2	2	2	0	0	0	1	1	1	0	0	0	1	1	1
Assertive Community Treatment	2	2	2	3	3	3	0	0	0	2	1	1	1	1	1	2	1	1
Multi-Systemic Therapy	1	2	3	3	3	3	0	0	1	2	2	2	1	1	2	3	2	2
Intensive Outpatient Services	3	3	3	3	3	3	2	2	2	2	2	2	3	3	2	2	3	3
Methadone Clinics	0	0	0	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0
FQHCs providing BH services	4	4	4	4	4	4	0	0	0	2	1	2	3	3	3	3	3	3
RHCs providing BH services	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Psychiatrists	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Psychologists	4	4	4	4	4	4	1	2	2	2	3	3	3	3	3	3	4	4
Suboxone certified MDs	3	3	3	2	3	3	1	1	1	0	1	1	2	2	3	2	3	2
Other Licensed Independent BH practitioners	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

Source: 2014 and 2015 MCO Geo-Access Reports

4	Met by all 4 MCOs
3	Met by 3 MCOs
2	Met by 2 MCOs
1	Met by 1 MCO
0	Met by no MCO

Appendix D: LFC PCP Phone Survey Methodology

The methodology for the LFC survey was adapted from the methodology used by the HHS OIG for its 2014 survey of Medicaid managed care providers nationwide. LFC staff first identified the ten New Mexico counties with the greatest increases in Medicaid enrollment from October 2013 to September 2015. From that list, selected 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 primary care providers (PCPs) 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.

Identifying PCPs was a major hurdle for this study. Because many providers participate in more than one MCO plan, it is impossible to develop a single list of unduplicated PCPs without knowing, by name, which providers have been designated as PCPs by which MCOs. Regular Centennial Care PCP and geographic access reports include total numbers of PCPs, but these reports do not identify the PCPs by name. The network adequacy reports do list all MCO providers by name, but they do not indicate which providers have been designated PCPs. HSD responded to LFC requests for a comprehensive, unduplicated list of PCPs by stating that it does not maintain such a list, and referring LFC staff to the MCO on-line provider directories. The on-line directories are designed for individual patients to search for nearby providers and, with one exception, do not permit users to generate county-level lists of PCPs.

LFC staff therefore began with the only available county-level lists of MCO-designated PCPs, the printed MCO provider directories. These were used to develop a single unduplicated list of 2,289 PCPs within the selected counties. Please note that number differs from the number of PCPs reported in the MCO geographic access, network adequacy, and PCP reports (which also differ from each other), and cannot be duplicated using the MCO on-line directories. This point was discussed at length with HSD staff, ultimately concluding that the total number of unduplicated, MCO-designated PCPs will vary across time and measurement tools. The discrepancies between/among the reports and the LFC survey are relatively predictable and understandable in the context of such a dynamic variable.

LFC staff used five different on-line survey sample size calculators and determined an appropriately robust sample size of 15 percent, or a total of 344 PCPs. To maintain MCO proportionality, LFC staff eventually contacted 364 PCPs.

The process then shifted to a purposive approach to ensure the most accurate information. Because the printed directories are acknowledged by all parties to be out of date almost as soon as they are printed, through the normal activity of providers joining and leaving an MCO, the total random sample was divided amongst the MCOs and then checked against the MCO on-line directories. Any PCP found in the MCO's printed directory who was not also listed in the MCO's on-line directory, and any PCP clearly identified on-line as not accepting new patients, was excluded and replaced, keeping MCO sample size proportionally correct. Current PCP contact information was drawn from the on-line directory.

Phone calls were then made to each PCP'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 plan; and the provider was (or was not) accepting new Centennial Care 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 March 8 and March 22, 2016.