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Office of Inspector General**

Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care

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What OIG Found

Despite the need for behavioral health services—which includes treatments and services for mental health and substance use disorders—many counties in New Mexico have few licensed behavioral health providers serving Medicaid managed care enrollees. These behavioral health providers are unevenly distributed across the State, with rural and frontier counties having fewer providers and prescribers per 1,000 Medicaid managed care enrollees. Further, a significant number of New Mexico's licensed behavioral health providers do not provide services to Medicaid managed care enrollees.

In addition, most of the State's licensed behavioral health providers serving Medicaid managed care enrollees work in behavioral health organizations (BHOs), which include federally qualified health centers and community mental health centers; however, BHOs report challenges with finding and retaining staff, as well as ensuring transportation for enrollees. As a result, these organizations cannot always ensure timely access for enrollees seeking behavioral health services. These organizations also report difficulty arranging or making referrals for services that they do not provide largely because of the lack of providers. In addition, they report challenges with continuity of care for enrollees, citing limited care coordination and lack of integration of primary and behavioral healthcare, provider shortages, and barriers to sharing health information, such as a lack of access to broadband. Nonetheless, BHOs highlight promising initiatives to increase the availability of behavioral health services, including open-access scheduling, treatment first, care integration, and telehealth.

What OIG Recommends

Although this report focuses on New Mexico, it provides insights into challenges that are likely shared by other States providing behavioral health services to Medicaid enrollees, especially in rural and frontier counties. In addition, because of the breadth and depth of these issues, additional support at the national level is needed. Therefore, we recommend that the Centers for Medicare & Medicaid Services (CMS) identify States that have limited availability of behavioral health services and develop strategies and share information with them to ensure that Medicaid managed care enrollees have timely access to these services. We also recommend that the New Mexico Human Services Department expand New Mexico's behavioral health workforce that serves Medicaid managed care enrollees. It should also improve access to services by reviewing its access to care standards and by increasing access to transportation, access to broadband, and the use of telehealth. Lastly, it should improve the effectiveness of services by increasing adoption of electronic health records, identifying and sharing information about strategies to improve care coordination, expanding initiatives to integrate behavioral and primary healthcare, and sharing information about open-access scheduling and the Treat First Clinical Model. Both CMS and the New Mexico Human Services Department concurred with our recommendations.

Key Takeaway

The challenges faced by New Mexico—including provider shortages and limited availability of behavioral health services—are likely shared by other States and will require both State and national attention.

Why OIG Did This Review

The need for behavioral health services is particularly pronounced in New Mexico—a State that has among the highest rates for suicide and deaths from overdose in the Nation. The Office of Inspector General (OIG) received a congressional request to look into concerns about behavioral health provider shortages and the availability of care for Medicaid managed care enrollees; these enrollees account for most of New Mexico's Medicaid population.

How OIG Did This Review

We analyzed State Medicaid managed care data on the number of behavioral health providers and the number of managed care enrollees by county. We also conducted a survey of selected BHOs that play a critical role in providing services to the State's Medicaid enrollees as well as to uninsured residents. In addition, we interviewed selected providers, State Medicaid agency officials, and key stakeholders.

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BACKGROUND

Objectives

1. To determine the number of behavioral health providers that serve New Mexico's Medicaid managed care enrollees in each county.
2. To determine the extent to which behavioral health organizations are able to meet the needs of the State's Medicaid managed care enrollees.
3. To identify challenges and promising initiatives for improving the availability of behavioral health services for the State's Medicaid managed care enrollees.

Research has shown that Medicaid enrollees experience a higher rate of behavioral health disorders—which include both mental health disorders and substance use disorders—than the general population.¹ In spite of the importance of treating such disorders, many Medicaid enrollees encounter significant barriers when accessing behavioral health treatment. These barriers include an overall shortage of behavioral health providers in the United States, combined with a relatively small number of behavioral health providers who accept Medicaid.² Such barriers can impede access to necessary services, resulting in untreated addiction and mental health conditions, worsening health, and increased medical costs.³

¹ Government Accountability Office (GAO), *Medicaid Expansion: Behavioral Health Treatment Use in Selected States in 2014*, (GAO-17-529), June 2017. Accessed at <https://www.gao.gov/assets/690/685415.pdf> on April 4, 2019.

² Substance Abuse and Mental Health Services Administration (SAMHSA), *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 24, 2013. Accessed at https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf on April 5, 2019. See also Medicaid and CHIP Payment and Access Commission (MACPAC), *Physician Acceptance of New Medicaid Patients*, January 24, 2019. Accessed at <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf> on April 5, 2019.

³ GAO, *Medicaid Expansion: Behavioral Health Treatment Use in Selected States in 2014*, June 2017. Accessed at <https://www.gao.gov/assets/690/685415.pdf> on April 4, 2019.

Improving access to behavioral healthcare is essential in New Mexico, where 56 percent of adults with mental illness do not receive treatment.⁴ Further, the State has among the highest rates for suicide and deaths from overdose in the Nation.⁵ New Mexico also ranks as one of the poorest States in the Nation, with more than half of the population either covered by public health insurance or uninsured.⁶

Behavioral health includes:

- promotion of emotional health,
- prevention of mental illnesses and substance use disorders, and
- treatment and services for mental and substance use disorders.

In 2013, New Mexico experienced major disruptions in services, with the closure and replacement of many of its largest behavioral health organizations (see text box below). The Office of Inspector General (OIG) received a congressional request to look into concerns about behavioral health provider shortages in Medicaid managed care. In response, OIG agreed to conduct a review to determine the number of behavioral health providers that serve the State's Medicaid managed care enrollees and the availability of care to meet the needs of this population. OIG also agreed to look at the extent to which providers have waiting lists, the extent to which providers have difficulty making referrals, and any challenges with continuity of care.

Historical perspective of behavioral health in New Mexico

The behavioral health system in New Mexico experienced major disruptions in the provision of care that affected Medicaid managed care enrollees. In 2013, the New Mexico Human Services Department suspended Medicaid payments to 15 behavioral health organizations due to an accusation of fraud; these 15 organizations provided about 85 percent of all behavioral health services to enrollees. Although all of these organizations were eventually cleared of wrongdoing in subsequent years, 13 of them went out of business. These organizations were initially replaced by Arizona-based organizations; however, all but two of these replacement organizations are no longer practicing in the State.

⁴ SAMHSA, *Behavioral Health Barometer: New Mexico, Volume 4: Indicators as Measure Through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System*, 2017. Accessed at https://www.samhsa.gov/data/sites/default/files/NewMexico_BHBarometer_Volume_4.pdf on June 10, 2019.

⁵ New Mexico Health Care Workforce Committee, *2017 Annual Report*, October 1, 2017. Accessed at http://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/NMHCFW_2017Report_eDist_LoRes.pdf on April 3, 2019.

⁶ U.S. Census Bureau, *2013–2017 American Community Survey 5-Year Estimates, Selected Economic Characteristics*. Accessed at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> on June 10, 2019.

Medicaid managed care in New Mexico

Medicaid plays a critical role in providing behavioral healthcare. Nationally, Medicaid is the single largest payor for behavioral healthcare, accounting for approximately 11 percent of all Medicaid spending.⁷

Most States, including New Mexico, provide a portion—if not all—of their behavioral health services through Medicaid managed care plans. These plans typically provide behavioral health services through a network of participating providers in exchange for a fixed monthly fee per enrollee (often referred to as capitation).

New Mexico's Medicaid managed care program, Centennial Care, was implemented in 2014 and requires managed care plans to cover services for physical health, behavioral health, and long-term care.⁸ Most (80 percent) of New Mexico's Medicaid population is enrolled in one of New Mexico's three managed care plans.⁹ These plans provide services to enrollees throughout the State, and most of the behavioral health providers that participate in Medicaid managed care participate in all of the State's managed care plans.

Federal regulations require States to develop standards for access to care that all managed care plans must meet.¹⁰ These standards are intended to ensure that each plan maintains an adequate network to provide access to covered Medicaid services.¹¹ New Mexico's standards for behavioral health require that appointments for non-urgent behavioral healthcare be

⁷ This analysis is based on 2009 Medicaid data. Mark et al., *Insurance Financing Increased for Mental Health Conditions But Not for Substance Use Disorders 1986-2014*, June 2016. Accessed at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0002> on June 10, 2019.

⁸ The New Mexico Human Services Department oversees the Medical Assistance Division and the Behavioral Health Services Division. The Medical Assistance Division is responsible for contracting with Medicaid managed care organizations and the Behavioral Health Services Division oversees SAMHSA-funded behavioral health block grants.

⁹ These data were provided by the New Mexico Human Services Department. Note that the Native American population is typically exempt from the requirement to enroll in a managed care plan. See New Mexico Administrative Code (NMAC) 8.308.7.9(A). Also note that for most of the study period, there were four Medicaid managed care plans in the State.

¹⁰ 42 CFR § 438.206(a).

¹¹ 42 CFR § 438.206(b)(1).

available within 14 days and behavioral health outpatient appointments for urgent conditions be available within 24 hours.¹²

Licensed behavioral health providers

Licensed behavioral health providers have a range of education and training in specialties that address substance use and mental health needs. These behavioral health providers are able to engage in a broad range of interventions, including assessment, psychotherapy, and crisis intervention services.

Independently licensed providers may be directly reimbursed by Medicaid for their services. Such providers include psychiatrists, psychologists, and licensed clinical social workers.¹³ Certain independently licensed behavioral health professionals are also authorized to diagnose mental illness and substance use disorders, and in some cases, can prescribe medication as part of an enrollee's treatment plan.¹⁴

The next level of licensure consists of non-independently licensed providers. These providers typically work under the supervision of an independently licensed provider and generally cannot be directly reimbursed for their services. These providers include licensed master's level social workers, licensed mental health counselors, and licensed associate marriage and family therapists.¹⁵

Behavioral health organizations

Although outpatient behavioral health services can be provided by individuals (and by individuals who form group practices), behavioral health organizations (BHOs) are core providers that play a critical role in providing

¹² NMAC 8.308.2.12 (E), (F). The standard governing request-to-appointment time, for non-urgent behavioral healthcare, can be waived if the enrollee requests a later time. New Mexico also requires that appointments for behavioral health crisis services be available within two hours. See NMAC 8.308.2.12 (R). In addition, New Mexico requires its managed care organizations to comply with standards that address distance and travel time between enrollees and contracted providers. See NMAC 8.308.2.9 (A)(11)(c).

¹³ NMAC, 8.321.2.9 (H).

¹⁴ New Mexico Health Care Workforce Committee, *2017 Annual Report*, October 1, 2017. Accessed at http://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/NMHCWF_2017Report_eDist_LoRes.pdf on April 25, 2019.

¹⁵ NMAC 8.321.2.9 (J). Some behavioral health services may be provided by non-licensed providers who are not able to prescribe medication and are not able to practice without supervision. These include master's level behavioral health interns, certified peer support workers, and pre-licensure psychology post-doctorate students. New Mexico Network of Care, *Behavioral Health in New Mexico: Challenges, Medicaid Contributions, New Opportunities*. Accessed at <http://newmexico.networkofcare.org/content/client/1446/3Centennial%20Care%20Update-Final.pdf> on June 10, 2019.

services to the State’s Medicaid enrollees as well as to uninsured residents. BHOs include federally qualified health centers, community mental health centers, behavioral health agencies, rural health clinics, and core service agencies.¹⁶

In addition to outpatient services, a number of behavioral health services are delivered in inpatient or residential settings. These include psychiatric hospitals, residential treatment centers, as well as facilities that provide inpatient treatment for substance use disorders.

Methodology

We used several data sources to address the study’s objectives. We first analyzed State Medicaid managed care data to determine the number of behavioral health providers serving New Mexico’s managed care enrollees by county. We focused this part of the study on licensed behavioral health providers who render outpatient services to Medicaid managed care enrollees. Licensed behavioral health providers have the specific education and training needed to address a broad range of mental health and substance use disorders. We did not include non-licensed behavioral health workers and other physical health workers who may provide only limited behavioral health services such as diagnostic screening.¹⁷

Next, we conducted a survey of 53 selected BHOs to determine the extent to which these organizations are able to meet the needs of the State’s Medicaid managed care enrollees. In addition, we interviewed selected behavioral health providers, State Medicaid agency officials, and key stakeholders. We analyzed these data to identify challenges and promising initiatives for improving the availability of behavioral health services for Medicaid managed care enrollees.

See Appendix A for the detailed methodology.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

¹⁶ New Mexico may designate a BHO as a core service agency if it provides and coordinates certain core services, such as psychiatric services, medication management, crisis services, and treatments that support an enrollee’s recovery goals.

¹⁷ This study also does not include out-of-State behavioral health providers licensed by New Mexico who provide services remotely.

FINDINGS

Many counties have few behavioral health providers serving Medicaid managed care enrollees

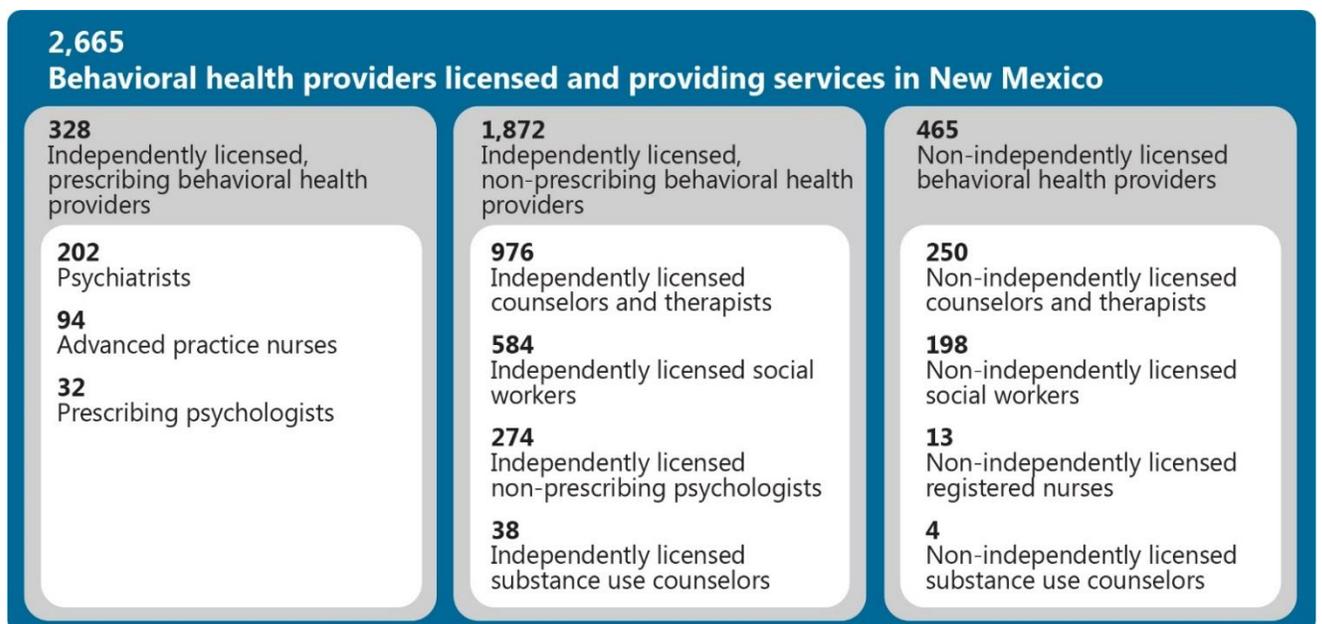
New Mexico has about 2,700 licensed behavioral health providers that serve its Medicaid managed care enrollees. These behavioral health providers are distributed unevenly across the State. As a result, many counties have few providers that serve Medicaid managed care enrollees.

New Mexico has 2,665 licensed behavioral health providers that serve nearly 670,000 Medicaid managed care enrollees

Licensed providers are essential to meeting the behavioral health needs of enrollees. Enrollees with serious mental illnesses or substance use disorders often require a team of providers that consist of several different types of licensed providers. These providers include prescribing providers such as psychiatrists and advance practice nurses. They also include other independently licensed providers, such as professional clinical counselors, clinical social workers, and marriage and family therapists. Additionally, there are non-independently licensed providers that include social workers, registered nurses, and substance use counselors. These providers generally cannot be directly reimbursed for their services and typically work under the supervision of an independently licensed provider.

In total, New Mexico has 2,665 licensed behavioral health providers that serve its Medicaid managed care enrollees in 2017. See Exhibit 1 for more detailed information about the number of licensed providers in New Mexico.

Exhibit 1: Licensed behavioral health providers in New Mexico.



Source: OIG analysis of State Medicaid data, 2019.

Many of the State’s licensed behavioral health providers do not serve Medicaid managed care enrollees

Shortages of behavioral health providers are a problem that affects behavioral healthcare for all populations, not just for its managed care enrollees.¹⁸ A study of the New Mexico healthcare workforce found that 9,528 behavioral health providers had active licenses in the State in 2016.¹⁹ The smaller number of providers that we identified—just 2,665 providers or 30 percent—indicates that many behavioral health providers in New Mexico do not provide services to Medicaid managed care enrollees. If only a small proportion of that workforce serves Medicaid enrollees, enrollees’ access to critical services can be impeded.

More than half of New Mexico’s counties have fewer than 2 licensed providers per 1,000 enrollees; all of these counties are rural or frontier

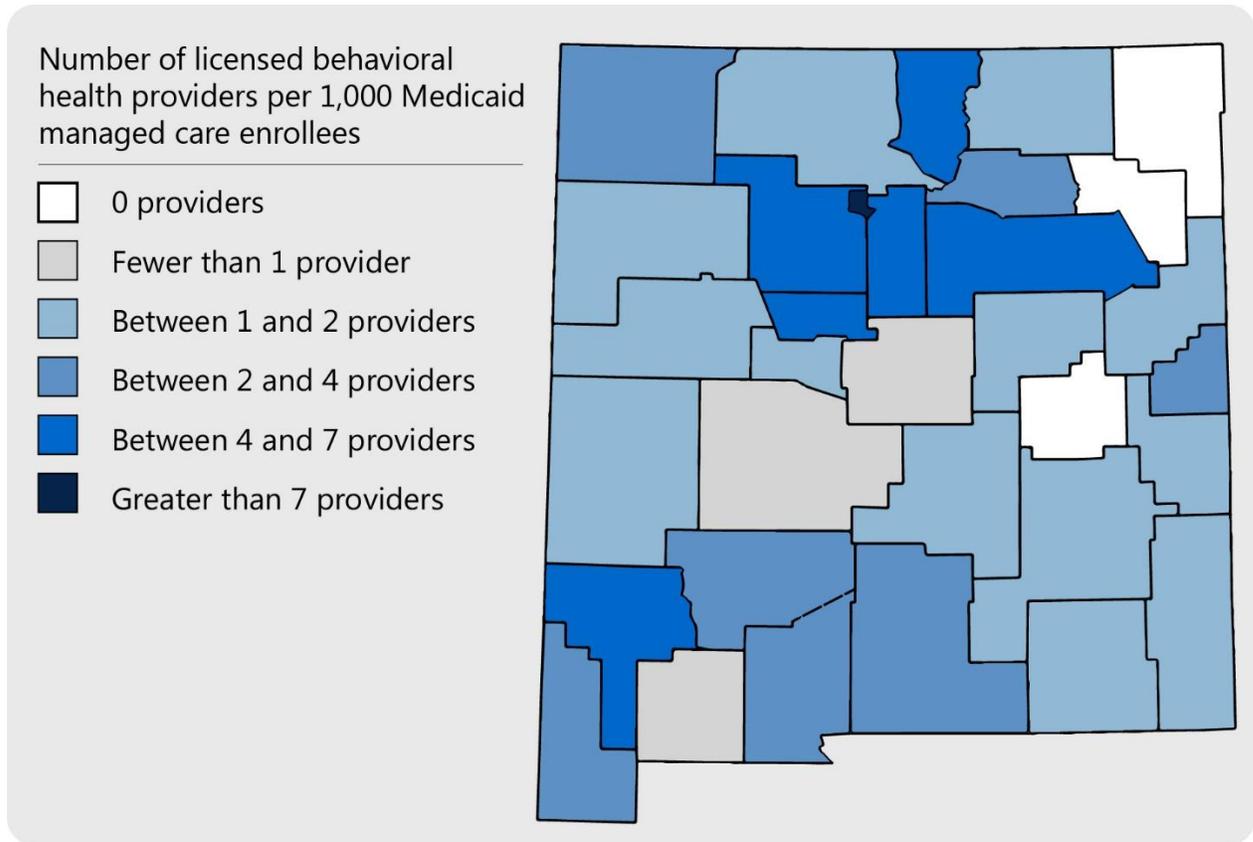
The 2,665 licensed behavioral health providers are distributed unevenly across the State. Notably, 19 of the State’s 33 counties have fewer than 2 licensed behavioral health providers for every 1,000 Medicaid managed care enrollees. All 19 of these counties are rural or frontier.²⁰ This includes 13 counties that have between 1 and 2 providers per 1,000 enrollees; 3 counties that have fewer than 1 provider per 1,000 enrollees; and 3 counties that have no providers at all. In contrast, four counties—most of them urban—have much larger numbers of licensed providers per 1,000 enrollees. These 4 counties ranged from 6 to 19 providers per 1,000 enrollees. See Exhibit 2 and Appendix B for the number of licensed behavioral health providers by county.

¹⁸ Almost all of New Mexico’s counties have a “health professional shortage area” for mental health. For more information see Health Resources and Services Administration, *Health Professional Shortage Areas Find*. Accessed at <https://data.hrsa.gov/tools/shortage-area/hpsa-find> on May 24, 2019.

¹⁹ Note that this analysis was mandated by the State of New Mexico’s Legislature. The 9,528 providers identified in the study are the same types of providers that are included in our report. See New Mexico Health Care Workforce Committee, *2017 Annual Report*, October 1, 2017. Accessed at http://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/NMHCFW_2017Report_eDist_LoRes.pdf on April 25, 2019.

²⁰ New Mexico designates counties as urban, rural, or frontier. Note that frontier counties have an average of 2.8 people per square mile, and rural counties have an average of 13.7 people per square mile.

Exhibit 2: Distribution of licensed behavioral health providers in New Mexico.



Source: OIG analysis of State Medicaid data, 2019.

Rural and frontier counties have disproportionately fewer licensed providers than urban counties. Only 29 percent of licensed providers are located in rural and frontier counties, even though nearly half of the State's Medicaid managed care enrollees reside in these counties. Further, rural and frontier counties have a median of 1.8 providers and 1.5 providers per 1,000 Medicaid managed care enrollees, respectively. In contrast, urban counties have a median of 6.4 providers. See Exhibit 3.

Similarly, rural and frontier counties have disproportionately fewer behavioral health prescribers. Ten frontier counties—with a total of 27,000 Medicaid managed care enrollees—have no prescribers. Further, rural and frontier counties have a median of 0.2 prescribers and 0.0 prescribers per 1,000 Medicaid managed care enrollees, while urban counties have a median of 0.7 prescribers.

Exhibit 3: Rural and frontier counties have a lower median number of providers and prescribers.

County Type	Median Number of Behavioral Health Providers per 1,000 Enrollees	Median Number of Prescribing Behavioral Health Providers per 1,000 Enrollees
Urban	6.4	0.7
Rural	1.8	0.2
Frontier	1.5	0.0

Source: OIG analysis of State Medicaid data, 2019.

Most behavioral health providers work in behavioral health organizations; however, these organizations report challenges with finding and retaining staff

Sixty-two percent of the State’s licensed behavioral health providers serving Medicaid enrollees work in BHOs.²¹ These organizations play a unique role in the State’s behavioral health system because they are responsible for coordinating care and providing essential services to managed care enrollees who have serious mental illnesses, severe emotional disturbances, or dependence on alcohol or drugs. BHOs are core providers typically offering behavioral health services to the State’s Medicaid enrollees as well as uninsured residents.²²

62% of licensed behavioral health providers work in BHOs.

Notably, 38 of the 53 selected BHOs report that they need additional staff to meet the needs of Medicaid managed care enrollees in their area. They report particularly needing prescribing providers and providers that specialize in treating substance use disorders. Of these BHOs, one in three did not have a prescriber on staff. Additionally, two in three BHOs did not have a provider specializing in substance use disorders on staff. Most of the BHOs in need of additional staff are located in rural and frontier areas. BHOs further note that staffing challenges affect enrollees with all types of diagnoses. As one BHO states, “there are far more requests for services beyond staff capacity.”

BHOs also highlight challenges with finding and retaining qualified staff to meet the needs of enrollees. Several cite an overall lack of licensed providers in the State or their area to meet the demands of the population,

²¹ The remaining providers work in group or independent practices, other outpatient settings, or inpatient facilities.

²² As noted earlier, BHOs include federally qualified health centers, core service agencies, community mental health centers, behavioral health agencies, and rural health clinics.

as well as challenges maintaining a highly trained workforce. According to several BHOs, there is an extremely limited pool of qualified candidates, and when they do find qualified candidates, it can be difficult to retain them. This challenge particularly affects rural and frontier BHOs. As one BHO explains, “It is difficult to find and hire therapists in [rural] New Mexico...it is really difficult work with a high burnout rate. Therapists from other areas, [who are not familiar with the specific needs of the community], do not last.”

Behavioral health organizations cannot always ensure timely access for enrollees seeking behavioral health services

BHOs provide essential behavioral health services to Medicaid managed care enrollees. Yet, many BHOs report that Medicaid managed care enrollees have difficulty accessing the full range of behavioral health services at the frequency they need. BHOs further report difficulty providing timely appointments for enrollees, and some BHOs maintain wait lists for certain services. Providing timely access to behavioral health services is important to ensuring positive health outcomes and to ensuring that patients’ behavioral health conditions do not go untreated.

43% of BHOs report that **enrollees have difficulty accessing the full range of behavioral health services at the frequency they need.**

More than half of BHOs are not able to offer timely appointments for enrollees

Most BHOs (29 of 53) report that they do not have urgent appointments available within 24 hours or routine appointments available within 14 days with providers in their BHO for Medicaid managed care enrollees. According to New Mexico’s standards, appointments for urgent conditions must be available within 24 hours and appointments for routine behavioral healthcare must be available within 14 days.²³ See Appendix C for more detailed information about the number of BHOs that are not able to offer timely urgent or timely routine appointments.

²³ NMAC 8.308.2.12 (E), (F).

More than 40% of BHOs are **unable** to provide:



urgent appointments with prescribers in their BHOs **within 24 hours.**



routine appointments with prescribers in their BHOs **within 14 days.**

Notably, 23 of 53 BHOs are unable to provide urgent appointments with prescribers in their BHOs within 24 hours. Twenty of these BHOs do not have prescribers on staff.²⁴ The other three have wait times for urgent appointments with prescribers that range from 2 days to 21 days. At the same time, four BHOs are unable to provide urgent appointments with non-prescribers in their BHO within 24 hours. For these BHOs, wait times with non-prescribers range from 2 days to 7 days.

In addition, 25 of 53 BHOs are unable to provide routine appointments with prescribers in their BHOs within the 14 days as established by New Mexico's standards. For the BHOs with prescribers on staff, wait times for routine appointments range from 20 days to 90 days. Four BHOs are unable to provide routine appointments with non-prescribers in their BHO within 14 days. For these BHOs, wait times for non-prescribers range from 30 days to 75 days.

Some BHOs maintain wait lists for certain behavioral health services

If the BHO is at capacity, it may have to maintain a wait list until services become available. Fourteen BHOs report having maintained a wait list in the past year for at least one of the services they provide. Most commonly, they had wait lists for certain outpatient services such as substance abuse treatment or counseling and therapy. Four BHOs had a wait list for up to one month; an additional six BHOs had a wait list for longer. BHOs report that wait lists particularly affect services for beneficiaries with autism spectrum disorder, depression, and substance use disorder.

“ We are not supposed to have a wait list, but the reality is that at different times providers have had to use a wait list because of workforce issues. ”

-BHO Administrator

²⁴ BHOs may provide appointments by arranging services with other providers who are not on their staff.

BHOs report that transportation is a challenge to ensuring access to timely services

A number of BHOs (9 of 53) highlight challenges with accessing nonemergency medical transportation, despite New Mexico's requirement that its Medicaid managed care organizations provide such transportation to enrollees who need it.²⁵ For example, one stakeholder notes that there are no nonemergency medical transportation providers in the area that offer service in the evening, making it particularly difficult for enrollees to access intensive outpatient substance abuse counseling services, which are often held in the evening. A few BHOs also note that difficulty accessing nonemergency medical transportation causes delays in care. For example, one BHOs notes, "[non-emergency medical transportation] has to be scheduled, and sometimes that takes a few days for approval. The patient is then seen a week after their initial scheduled appointment."

Behavioral health organizations report difficulty arranging or making referrals for services that they do not provide

BHOs arrange services or make referrals for services that enrollees need but that BHOs do not—or currently cannot—provide. Enrollees with mental health and substance use issues need a range of services that include: recovery and support services; non-intensive outpatient services; intensive outpatient services; and inpatient and residential services. BHOs report difficulty arranging behavioral health services in each category to meet the needs of Medicaid managed care enrollees. See Exhibit 4 for a description of the different service categories and Appendix D for the number of BHOs that report having difficulty arranging each service.

²⁵ New Mexico requires that Medicaid managed care organizations provide nonemergency medical transportation for enrollees who have no other means of transportation and need to get to and from medical services, including behavioral health services. NMAC 8.308.2.12 (P). New Mexico's managed care organizations contract with providers to offer nonemergency medical transportation services to enrollees. New Mexico Human Services Department, *Centennial Care Waiver Demonstration: Section 1115 Quarterly Report*, March 2, 2018. Accessed at [http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Reports/2017%20Quarterly%20Progress%20Reports/Final%20Report\(2\).pdf](http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Reports/2017%20Quarterly%20Progress%20Reports/Final%20Report(2).pdf) on February 15, 2019.

Exhibit 4: Behavioral health services includes a variety of services that are generally organized into four categories.

Recovery and support services

include a range of educational, psychosocial rehabilitation, and supported employment services.

Non-intensive outpatient services

is the broadest category and includes assessments and therapy for behavioral health conditions and medication assisted treatment for opioid use disorder.

Intensive outpatient services

are sometimes used as an alternative to inpatient psychiatric care, such as applied behavior analysis and intensive outpatient programs for substance use disorder.

Inpatient and residential services

are the most intensive level of treatment, often requiring 24-hour care in a hospital or group living environment.

Source: OIG analysis of State documentation on behavioral health services, 2019.

BHOs most commonly (43 of 53) report having difficulty arranging recovery and support services for Medicaid managed care enrollees. BHOs explain that provider shortages make it difficult to make referrals and can result in enrollees not receiving the support and services that they need. Notably, BHOs report difficulty arranging psychosocial rehabilitation services that help enrollees develop coping strategies, as well as respite care that provides short-term relief for primary caregivers. As one BHO notes, these services are “already provided by an extremely limited number of providers, which is continually shrinking.”

Most BHOs (42 of 53) also report having difficulty arranging intensive outpatient services. This includes arranging applied behavior analysis—a type of therapy that focuses on improving social skills and adaptive learning skills for enrollees with autism spectrum disorder. As one rural BHO explains, there are no providers that offer this type of therapy in the five neighboring counties, making it extremely difficult to arrange these services for enrollees. As a result, enrollees may need to travel long distances to the nearest provider. Another rural BHO adds that its nearest autism care provider is 4 hours away.

Similarly, most BHOs (39 of 53) report difficulty arranging inpatient and residential services. In particular, some BHOs note that there are a lack of inpatient psychiatric facilities and detox facilities. One stakeholder notes that, as a result, “it is a long, long wait to get enrollees into inpatient

psychiatric treatment, and it is even more difficult to secure inpatient psychiatric treatment for a child.” Further, these facilities may be far away. According to this stakeholder, the nearest child inpatient psychiatric treatment facility is 200 miles away. Another stakeholder notes that many of the inpatient facilities for substance use disorders “will not accept enrollees on any medication, often only accept men, and [will] not accept anyone with mental health diagnoses. This clearly leaves many enrollees without care.”

Further, many BHOs (33 of 53) report having difficulty arranging non-intensive outpatient services. Nearly half have difficulty arranging medication assisted treatment to treat opioid addiction, such as buprenorphine. BHOs also attribute this difficulty to the lack of providers. As one provider notes, the number of medication assisted treatment providers in one of the larger urban areas needs to double in size in order to meet current enrollee needs. BHOs also highlight difficulty arranging day treatment—services that focus on improving functional and behavioral deficits—and note a lack of providers offering these services.

Behavioral health organizations report challenges with continuity of care, citing limited care coordination, provider shortages, and barriers to sharing health information

Continuity of care is particularly important for patients with behavioral health diagnoses because they may require treatment from a number of providers for extended periods of time.²⁶ Continuity of care includes maintaining care when transferring from one setting to another, seeing the same provider each visit at the BHO, and exchanging health information throughout the continuum of care. BHOs report a number of concerns about continuity of care for Medicaid managed care enrollees.

Enrollees' care is not always maintained during transitions, due in part to limited coordination among providers

More than half of BHOs (29 of 53) report that enrollees' care is not always maintained when they are transferred from one level of care to another. Breakdowns during transitions of care can cause confusion regarding treatment plans, duplicative testing, discrepancies in medications, and missed appointments.²⁷

A number of BHOs report difficulties with coordinating enrollees' care during transitions. One BHO notes that constant provider turnover results in enrollees not effectively transitioning to other care providers, causing a significant proportion of these enrollees to leave care altogether. Another stakeholder notes that there is a lack of coordinated care for enrollees who need both mental health services and services for substance use disorders. Many of these enrollees must see multiple behavioral health providers to meet their needs, and those providers do not always coordinate patients' care.

A few BHOs use warm handoffs to promote continuity of care

Warm handoffs occur between two healthcare providers when a patient is being transferred from one setting to another. In addition to in-person communication between providers, the patient is also included in the discussion about his or her plan of care. This helps to build relationships between care coordinators, providers, patients, and their families and provide opportunities to clarify or correct information.

²⁶ Institute of Medicine Committee on Crossing the Quality Chasm, *Coordinating Care for Better Mental, Substance-Use, and General Health*, 2006. Accessed at <https://www.ncbi.nlm.nih.gov/books/NBK19833/> on March 27, 2019. See also Biringer et al., *Continuity of Care as Experienced by Mental Health Service Users: A Qualitative Study*, November 21, 2017. Accessed at <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2719-9> on March 27, 2019.

²⁷ Although BHOs strive to provide coordinated care, some types of BHOs are required to do so. See CareLink NM, *CareLink NM Health Homes: Provider Policy Manual*, 2018. Accessed at https://www.hsd.state.nm.us/uploads/files/Providers/Manuals%20and%20Guides/Managed%20Care%20Policy%20Manual/CLNM%20Pol%20Manual%2012_28_18.pdf on June 11, 2019.

A few BHOs also note that the lack of integration between primary and behavioral healthcare acts as a barrier to coordination efforts. Integrating primary and behavioral healthcare—which typically involves close collaboration of both physical and behavioral health providers in the same location—can be critical, since certain behavioral health disorders carry higher incidences of physical issues, including obesity, diabetes, asthma, migraines, heart disease and cancers.²⁸

Enrollees are not always able to see the same providers, often because of a lack of providers or high turnover

One-third of BHOs (17 of 53) report that enrollees cannot always see the same provider as the previous visit for the same service. Ongoing relationships with the same provider create stable conditions for enrollees; changes in providers can often create setbacks in treatment, and can sometimes give rise to anxiety, frustration, and a sense of being rejected.²⁹

A few BHOs highlight the importance of engaging in and maintaining such relationships to improve health outcomes. As one provider notes, “enrollees are scheduled with the same provider...which ensures sustained recovery.”

“Part of [ensuring continuity of care] is you have to keep people in the workforce. You can see a provider more than once—that is really critical—it can be done.”

- Key Stakeholder

BHOs find that a lack of providers limits their ability to keep

enrollees with the same provider. For example, according to one BHO, “more patients are being seen in psychiatric emergency services because of the lack of community providers, resulting in continuity of care issues.” Some BHOs also state that staff turnover results in some enrollees being unable to continue with the same provider, which affects enrollees’ health outcomes. For example, a rural provider, who focuses on treatment for autism spectrum disorder, notes that turnover impacts a child’s long-term outcomes since each new provider has to build a rapport with the child and learn the child’s complex treatment plan.

Enrollee health information is not always communicated because of barriers to sharing enrollee health information across providers

Half of BHOs (26 of 53) report that enrollees’ health information is not always communicated in an effective and timely manner throughout their

²⁸ The Colorado Health Foundation, *The Colorado Blueprint for Promoting Integrated Care Sustainability*, March 2012. Accessed at https://www.integration.samhsa.gov/TCHF_IntegratedCareReport.pdf on January 8, 2019.

²⁹ Biringer et al., *Continuity of Care as Experienced by Mental Health Service Users: A Qualitative Study*, November 21, 2017. Accessed at <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2719-9> on March 27, 2019.

continuum of care. Sharing health information helps coordinate care among different providers and across different settings. It also helps providers reduce unnecessary testing, avoid medication errors, and decrease administrative costs.³⁰ Electronic health record (EHR) systems can be a critical tool for supporting seamless and instantaneous health information exchanges across providers when those providers' EHR systems are interoperable (able to exchange information).

Many BHOs (26 of 53) use EHRs, and find that using EHRs helps them to improve services for enrollees. According to one BHO, its EHRs provide quicker access to health information and improves its ability to share records with providers and ensure continuity of care. Some BHOs further note that their EHRs enable providers to collaborate across behavioral health disciplines and with primary healthcare providers.

“ [EHRs] improve continuity of care for patients with multiple providers, maintain updated information, document patients' past records, and track patients' recovery goals and interventions. ”

- BHO Administrator

Despite the advantages of EHRs, some BHOs (13 of 52) have not adopted EHRs.³¹ Nearly all of these BHOs are rural. Rural providers face a unique set of barriers to implementing EHRs, such as difficulty connecting to broadband service. Broadband is high-speed internet access, and is needed to support EHRs and other health information technology services such as telehealth.³² In New Mexico, only 47 percent of people in rural areas have access to advanced broadband, compared to 95 percent of people in urban areas.³³ Other barriers to implementing EHRs include a lack of expertise on how to use such technology and what some BHOs perceive to be prohibitive startup costs. One stakeholder further explains, “it is difficult for provider organizations, unless they are very large and have sufficient scale, to afford the cost of an EHR.”

³⁰ Office of National Coordinator for Health Information Technology (ONC), *Why is health information exchange important?*, March 21, 2018. Accessed at <https://www.healthit.gov/fag/why-health-information-exchange-important> on March 18, 2019.

³¹ For information on nationwide BHO adoption of health information technology, see National Council for Community Behavioral Healthcare, *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health*, June 2012. Accessed at <https://www.thenationalcouncil.org/wp-content/uploads/2012/10/HIT-Survey-Full-Report.pdf> on May 3, 2019.

³² ONC, *Federal Health IT Strategic Plan: 2015-2020*. Accessed at https://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf on May 3, 2019.

³³ Federal Communications Commission, *2018 Communications Marketplace Report: Broadband Deployment Appendices*, December 31, 2017. Accessed at <https://docs.fcc.gov/public/attachments/FCC-18-181A9.pdf> on March 21, 2019.

Other BHOs note that the lack of interoperability between their EHR systems and other providers' systems presents problems. Interoperability allows unrelated records systems to exchange electronic health information. As one BHO explains, not enough providers in the area can accept and share information with other providers' EHR systems. Such barriers to interoperability can constrain BHOs' ability to share health information and coordinate care among different providers and across different settings.

Several BHOs also note difficulty with getting enrollee health information from certain types of providers. New Mexico operates a health information exchange (HIE)—a platform through which participating providers can share health information. The HIE has the potential to enable providers to share information about enrollees' demographics, diagnoses, medications, encounter history, procedures, and even clinical notes. However, there are only a small number of behavioral health providers that participate in the State's HIE. While the HIE is available to all providers, as one stakeholder notes, providers without EHRs are unable to participate in the HIE.

Behavioral health organizations highlight promising initiatives to increase the availability of services, including open-access scheduling, treatment first, care integration, and telehealth

Although BHOs report a number of challenges with the availability of behavioral health services, they also cite a number of promising initiatives. BHOs have adopted these initiatives to varying degrees. These initiatives increase the availability of services by improving access to providers, better coordinating enrollee care, and expanding the use of technology to deliver services.

Exhibit 5: Initiatives to increase the availability of behavioral health services.

- Instituting open-access scheduling**
- Adopting Treat First**
- Implementing CareLink**
- Using telehealth**

Many BHOs find that open-access scheduling improves the availability of services

Many BHOs (34 of 53) have implemented open-access scheduling or walk-in availability. Open-access—also known as advanced access and same-day scheduling—is a method of scheduling in which patients can receive an appointment on the day they call. Rather than booking each provider’s full

“ We can see 90 percent of our clients within 24 hours of placing a call.”

block of time weeks or even months in advance, this model leaves part of the day open for unscheduled visits. Another part of the schedule is booked only with clinically necessary follow-up visits and appointments for patients who chose not to come on the day they called. BHOs implement open-access scheduling in a variety of ways. For example, one BHO

reserves a few same-day appointments throughout the week, whereas another reserves one day per week for same-day appointments.

All 34 BHOs that have implemented this type of scheduling report that it has improved the availability of services for managed care enrollees. These BHOs commonly note that such initiatives immediately address crisis situations, with one BHO noting that “anything urgent or emergency can be seen immediately, or on the same day.” Several BHOs further note that these initiatives can potentially decrease the need for higher levels of care or hospitalization, as well as improve enrollee health outcomes. Another BHO notes that open-access not only increases access to services, it also decreases the number of no-show appointments.

The Treat First Clinical Model allows faster access to services

About half of the BHOs (25 of 53) have adopted the clinical model referred to as Treat First. Developed for New Mexico in March 2016, Treat First is designed to improve access to care by prioritizing treatment and reducing State assessment requirements.³⁴ Previously, the State required that the results of a comprehensive assessment and treatment plan for each new patient be submitted within 30 days of the first visit, emphasizing the assessment over treatment. Treat First allows for up to four encounters with a provisional diagnosis without a comprehensive assessment and treatment plan.

Almost all BHOs that have adopted this model of care (21 of 25 BHOs) report that it has improved the availability of services for managed care enrollees. According to one BHO, Treat First enrollees have easier and more immediate access to services, leading to increased patient satisfaction and

³⁴ Medical Assistance Division, *Letter of Direction #57: “Treat First” Model Extension*, August 25, 2016. Accessed at https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/LOD_%2357_Treat_First_Model_Extension_08.25.2016.pdf on June 10, 2019.

better rapport with the clinicians as well as reduced paperwork and less staff burnout among providers. In addition, stakeholders report that Treat First has resulted in a decrease in the number of enrollees that are no-shows for the next scheduled appointment, which they attribute to being able to begin treatment during the enrollee's first visit.

CareLink Health Homes Program helps to integrate physical and behavioral healthcare

In total, eight BHOs participate in New Mexico's CareLink Health Homes Program, which is an integrated healthcare service program.³⁵ The program provides a monthly capitated payment per eligible enrollee to each participating BHO. Each BHO agrees to serve as a health home and is responsible for providing and coordinating the physical and behavioral healthcare for the enrollee. The health home is also required to provide additional services, including comprehensive care management and referrals to community and social support services. Each health home must also measure and report on specific quality indicators.

According to one BHO that currently participates in CareLink, it is "better able to connect enrollees with services outside their agency and address conditions causing hospitalization." Other BHOs add that coordination of care between behavioral health and primary care is improved by more frequent contact between enrollees and providers. This coordination increases access to services and improves medication compliance, which can improve overall health outcomes.

Many BHOs find that telehealth improves availability of services

Telehealth uses internet and communications technologies such as videoconferencing, chat, and text messaging, to provide health information and treatments in real time.

Thirty BHOs report having implemented telehealth in some way. Several BHOs report using telehealth for assessments, and many BHOs report also providing medication management and

psychiatric services through telehealth. All 30 BHOs note that implementing telehealth has improved the availability of services for Medicaid managed care enrollees. According to one BHO that implemented telepsychiatry, this

“ We would not be able to serve 90% of the families we currently serve without telehealth. ”

- BHO Administrator

³⁵ Four additional BHOs that are not in our sample also participate in CareLink. CareLink is for Medicaid behavioral health beneficiaries with a *primary condition* of Serious Mental Illness and/or Severe Emotional Disturbance. See New Mexico Human Services Department, *CareLink NM Health Homes*. Accessed at <http://www.hsd.state.nm.us/health-homes.aspx> on April 5, 2019.

initiative increases its ability to offer more stable outpatient medication management because of an increased pool of qualified staff.³⁶ Another BHO highlights the value of using telehealth for assessments, noting that it “has opened up time for our therapists to provide more time for individual therapy and group therapy, reducing wait times and increasing access to services.”

Telehealth can offer particular benefits for enrollees located in remote locations. According to one BHO, its telehealth initiative has allowed it to spend less time and resources recruiting local providers in rural and frontier clinic sites, allowing for better continuity of care and increased access to psychiatric and

counseling services. One provider adds that “telehealth has been critical in establishing care for families in rural and underserved areas.”

At the same time, several BHOs note the limitations of telehealth. First, enrollees sometimes have limited receptiveness to telehealth. As one stakeholder points out, some enrollees do not feel comfortable with sharing their problems openly through technology.

Second, many rural and frontier areas have limited broadband connectivity. As one BHO explains, the internet service for enrollees that live in remote areas is sometimes not capable of sustaining a good connection for telehealth. Another provider further comments: “Telehealth has improved access tremendously. However, many communities in need of services either do not have internet access in their rural area or cannot afford to pay for the service.” Research indicates that internet access remains a challenge to rural telehealth; as mentioned earlier, rural areas in New Mexico have less

Project ECHO: Extension for Community Healthcare Outcomes

In addition to providing services to enrollees, telehealth can also be used to train and supervise providers. New Mexico’s Project ECHO uses teleconferencing to increase the availability of specialty care in behavioral health. The model links specialist teams with behavioral health providers in the community. Behavioral health providers become part of a learning community, where they receive mentoring and feedback from specialists. This model is now used in both urban and rural areas, and includes training on how to treat both mental and substance use disorders.

³⁶ New Mexico is one of nine States as of 2017 where medical boards issue telehealth-specific licenses or certificates that allow out-of-State providers to furnish telehealth services in a State that they are not located. See University of Michigan: Behavioral Health Workforce Research Center, *The Use of Telehealth Within Behavioral Health Settings: Utilization, Opportunities, and Challenges*, March 2018. Accessed at http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf on April 3, 2018.

access to broadband—a factor that limits the types of telehealth services available to them via a home internet connection.

CONCLUSION AND RECOMMENDATIONS

Concerns exist about the availability of behavioral health services—which includes treatments and services for mental health and substance use disorders—for enrollees in Medicaid managed care. The need for such services is particularly pronounced in New Mexico—a State that has among the highest rates for suicide and deaths from overdose in the Nation.

Many counties in New Mexico have few licensed behavioral health providers serving Medicaid managed care enrollees. These behavioral health providers are unevenly distributed across the State, with rural and frontier counties having disproportionately fewer providers and prescribers. Notably, only 29 percent of the State’s licensed providers are in rural and frontier counties, despite nearly half of the State’s Medicaid managed care enrollees residing in these counties. Further, a significant number of New Mexico’s licensed behavioral health providers do not provide services to Medicaid managed care enrollees.

Additionally, most of the State’s licensed behavioral health providers work in BHOs—which include federally qualified health centers and community mental health centers; however, BHOs report challenges with finding and retaining staff, as well as ensuring transportation for enrollees. As a result, these organizations cannot always ensure timely access for enrollees seeking behavioral health services. These organizations also report difficulty arranging or making referrals for services that they do not—or currently cannot—provide. In addition, they report challenges with continuity of care for enrollees, citing limited care coordination, provider shortages, and barriers to sharing health information.

Nonetheless, BHOs highlight promising initiatives that increase the availability of behavioral health services for Medicaid managed care enrollees, including open-access scheduling, treatment first, care integration, and telehealth. These initiatives increase the availability of behavioral health services by improving access to providers, coordinating enrollee care, and expanding the use of technology. In addition, New Mexico recently announced its intention to raise certain provider payment rates.³⁷

Although this report focuses on New Mexico, it provides insights into challenges that are likely shared by other States providing behavioral health services to Medicaid enrollees, especially in rural and frontier counties. These challenges—including provider shortages and limited availability of behavioral health—require attention not only at the State level, but at the

³⁷ New Mexico Human Services Department. Accessed at https://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/FY20_RateIncrease_PubNotice_FI_NAL.pdf on July 3, 2019.

national level as well. These challenges are particularly heightened as Medicaid agencies continue to be on the front lines of fighting opioid abuse and in ensuring that appropriate behavioral health services are available.

On the basis of the findings of this report, we recommend that the Centers for Medicare & Medicaid Services (CMS):

Identify States that have limited availability of behavioral health services and develop strategies and share information to ensure that Medicaid managed care enrollees have timely access to these services

CMS should identify States—in addition to New Mexico—that have limited availability of behavioral health services for Medicaid managed care enrollees. CMS should work with these States to develop strategies to ensure that enrollees have timely access to behavioral health services. CMS should particularly focus on these challenges in rural and frontier areas. CMS should build on its existing efforts to provide technical assistance and share best practices and lessons learned from States’ experiences. As a part of its efforts, CMS should work to ensure that States are monitoring the numbers and locations of behavioral health providers and that States are identifying any barriers that impede access to behavioral healthcare. For example, CMS could encourage States to monitor whether there are shortages of specific types of behavioral health providers, such as substance use counselors or psychiatrists. To encourage information sharing, CMS could identify any promising practices that other States have developed. CMS could then share this information with States—such as through case studies, tool kits, and other methods.

We also recommend that the New Mexico Human Services Department:

Expand New Mexico’s behavioral health workforce that serves Medicaid managed care enrollees

Having a sufficient number of behavioral health providers that serve Medicaid managed care enrollees in New Mexico is essential to improving the availability of services to this population. To achieve this, the New Mexico Human Services Department should:

- **Take steps to expand New Mexico’s overall behavioral health workforce.** To address workforce shortages of behavioral health providers, New Mexico should implement initiatives to recruit and retain additional behavioral health providers. For example, New Mexico could look to other States’ initiatives, including internship opportunities in behavioral health fields and market to both in-State and out-of-State candidates. New Mexico could also encourage non-licensed providers to pursue licensure. New Mexico should particularly target these

efforts towards developing its behavioral health workforce in rural and frontier counties.

- **Increase behavioral health providers' participation in Medicaid managed care.** A significant number of New Mexico's licensed behavioral health providers do not provide services to Medicaid managed care enrollees. New Mexico should develop initiatives to encourage more of its existing behavioral health workforce to serve Medicaid managed care enrollees. Such initiatives could include initiatives implemented by other States, such as periodic reviews of licensure requirements and reimbursement rates, direct outreach to providers, and simplification of administrative requirements.

Improve access to behavioral health services

Improving access to services is another essential element for bolstering services for Medicaid managed care enrollees. To achieve this, the New Mexico Human Services Department should:

- **Review its standards governing access to care and determine whether additional standards are needed for behavioral health providers.** New Mexico should determine whether its managed care organizations are meeting the existing State standards that apply to behavioral health providers. It should also evaluate whether any changes to its existing standards are needed in order to better meet the behavioral health needs of their Medicaid managed care enrollees.
- **Improve access to transportation for Medicaid managed care enrollees needing behavioral health services.** Transportation to medical care is essential for Medicaid managed care enrollees who have limited means of transport to and from needed behavioral health services. New Mexico should first take steps to determine if managed care organizations are meeting their contractual obligations and to identify any challenges with nonemergency medical transportation. It should then work with its managed care organizations to develop initiatives to provide improved nonemergency medical transportation to enrollees. It should identify these initiatives and effective practices by reviewing the approaches taken by other States to improve the availability of

transportation services.³⁸ These initiatives should include working with the managed care organizations to review their networks of nonemergency medical transportation providers and looking for ways to expand the number of providers, such as coordinating with local organizations.

- **Work with State partners to strengthen access to high-speed, reliable, and secure communications technologies in rural and frontier counties.** High-speed, reliable, and secure communications technology is needed for healthcare providers and enrollees to benefit from EHRs and other health information technology services such as telehealth. A lack of access to connectivity with sufficient bandwidth speeds—such as broadband connectivity—remains a significant barrier faced by rural providers. New Mexico should strengthen broadband access, particularly in rural and frontier counties. New Mexico should work with other State partners to look for opportunities to attract additional broadband service providers to communities that are currently without access to broadband. New Mexico should also pursue additional funding opportunities for broadband-related projects, including Federal programs that can fund projects related to broadband planning, public access, digital literacy, and deployment.³⁹
- **Expand the use of telehealth to increase the availability of behavioral health services.** BHOs note that telehealth has improved the availability of services for Medicaid managed care enrollees, particularly those in rural and frontier areas. New Mexico should expand the use of telehealth, as appropriate, to further increase the availability of services, particularly in rural and frontier areas. To do this, the State should encourage adoption of telehealth, expand participation in Project Echo, and

³⁸ CMS and the National Academies of Sciences, Engineering, and Medicine provide effective practices used by other States to address transportation issues. See National Academies of Sciences, Engineering, and Medicine, *Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination*, October 22, 2018. Accessed at <https://www.nap.edu/download/25184> on February 25, 2019; CMS, *Medicaid State Plan Amendments*. Accessed at <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html> on February 26, 2019; and, GAO, *Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States*, GAO-16-238, February 2, 2016. Accessed at <https://www.gao.gov/assets/680/674934.pdf> on February 7, 2019.

³⁹ For a list of Federal funding sources, including grants funded by the United States Department of Health and Human Services, see the Federal Communications Commission, *Funding Broadband-Enabled Health Care*. Accessed at <https://www.fcc.gov/general/funding-broadband-enabled-health-care> on May 6, 2019.

strengthen access to broadband to expand telehealth accessibility.

Improve the effectiveness of behavioral health services

Another key element of strengthening services for Medicaid managed care enrollees is to improve their effectiveness. To achieve this, the New Mexico Human Services Department should:

- **Take steps to increase adoption of electronic health records (EHRs) and participation in the State Health Information Exchange (HIE) by behavioral health providers.** BHOs report that EHRs improve care for enrollees and enable providers to collaborate across behavioral health settings and with primary healthcare providers. EHRs also allow providers to easily access patient information and in some cases to share that information with other providers. EHRs are also needed to participate in the State's HIE, which can provide information about enrollees' diagnoses, medications, procedures, and—in some cases—clinical notes. Some providers face challenges in adopting EHRs and participating in the State HIE including the prohibitive cost of many EHR systems and limited expertise on how to use such technology. To address these challenges, New Mexico should work with providers in accessing assistance and resources that support behavioral health providers' adoption and use of EHRs and encourage participation in the State's HIE.⁴⁰
- **Identify and share information about strategies to improve care coordination.** Coordination among behavioral health and other providers is especially important since certain behavioral disorders carry higher incidences of chronic physical illnesses. BHOs report some challenges with finding providers and coordinating among providers, particularly when enrollees are transferred from one level of care to another. New Mexico should identify and share information on strategies for improved care coordination among behavioral health and other providers. For example, New Mexico should review other States' strategies to promote coordinated care across various

⁴⁰ An example of a resource that may be helpful is the Regional Extension Centers, which provide on-the-ground technical assistance for individual and small provider practices that lack resources to adopt and maintain EHRs. Services include health information technology education and training, vendor selection consultation, and partnering with the State health information exchange. For more information, see ONC, *Regional Extension Centers (RECs)*, November 7, 2018. Accessed at <https://www.healthit.gov/topic/regional-extension-centers-recs> on March 7, 2019.

settings. New Mexico should facilitate information sharing among its providers—through the development of case studies, tool kits, and other methods—to encourage providers to use these strategies.

- **Expand initiatives to integrate behavioral and primary healthcare.** BHOs report that the increased integration between behavioral and primary healthcare can improve patient outcomes. For example, CareLink health homes is New Mexico’s integrated care model. The goal of this model is to enhance the integration of behavioral and primary healthcare as well as other services. New Mexico should assess the implementation of CareLink health homes and the value of integrating care. On the basis of the results, it should refine and expand this model or consider other models of integrated care, if appropriate.
- **Share information about open-access scheduling and the Treat First Clinical Model and promote expansion.** BHOs report that open-access scheduling and the Treat First Clinical Model help increase the availability of behavioral health services for Medicaid managed care enrollees. New Mexico should share information with the BHOs that do not use these tools about the benefits identified by the BHOs that do use them. New Mexico could also convene forums for BHOs to share strategies and technical assistance for successful implementation of these tools.

AGENCY AND STATE COMMENTS AND OIG RESPONSE

Both CMS and the New Mexico Human Services Department (the State) concurred with our recommendations. We made one recommendation to CMS and 10 recommendations to the State.

CMS concurred with our recommendation to identify States that have limited availability of behavioral health services and develop strategies and share information. CMS stated that it will work with States that identify themselves as having behavioral health shortages and States that have managed care plans that do not meet the State defined standards of network adequacy. CMS stated that it will provide technical assistance to those States by developing strategies and sharing information to ensure that Medicaid managed care enrollees have timely access to behavioral health services.

The State concurred with our 10 recommendations that seek to expand the State's behavioral health workforce, improve access to behavioral health services, and improve the effectiveness of behavioral health services.

In response to the two recommendations that seek to expand the State's behavioral health workforce, the State noted that it plans to, among other things, use Federal grants to increase behavioral health services provided in rural and frontier counties, while also implementing a Graduate Medical Education program for providers. The State also implemented an increase of Medicaid rates for behavioral health providers and will continue to meet with the Regulation and Licensing Department to discuss the streamlining of licensing requirements and implementation of reciprocity for out-of-state providers who move to New Mexico.

In response to the four recommendations that seek to improve access to behavioral health services, the State noted that it is in the process of promulgating a new rule for behavioral health. It also stated that it plans to provide additional non-emergency medical transportation for the justice-involved population upon their release. To strengthen access to communication technologies, it stated that it plans to pursue additional funding for broadband coverage and work with other State agencies to endorse increased funding for broadband efforts. It also stated that it will continue working with the State telehealth network to expand telehealth coverage.

In response to the four recommendations that seek to improve the effectiveness of behavioral health services, the State plans to explore funding for connectivity and data transmission to increase behavioral health

provider data sharing. It also noted that it is currently in discussions with the State's HIE to include behavioral health providers on the HIE. The State also noted that it recently expanded the number of health homes to better integrate behavioral and primary healthcare. Finally, the State added that it plans to collaborate with the New Mexico Behavioral Health Provider Association to increase the number of providers who are trained in the Treat First model.

We appreciate CMS's and the State's steps to address these important issues. OIG urges both CMS and the State to continue their work in this area to ensure timely access to behavioral health services for Medicaid managed care enrollees.

For the full text of CMS's comments, see Appendix E. For the full text of the New Mexico Human Services Department's comments, see Appendix F.

APPENDIX A: Detailed Methodology

We based this study on analyses of Medicaid managed care data from the State and on survey data from selected BHOs. We also conducted interviews with selected behavioral health providers, State Medicaid agency officials, and key stakeholders.

State Medicaid managed care data

We requested data from the State Medicaid Agency to determine the number and type of licensed behavioral health providers that serve the State's managed care enrollees. Using these data, we developed a list of all unique providers listed on at least one behavioral health claim during the period of January 1, 2017, through December 31, 2017.

For each of these providers, we requested information about their behavioral health specialty, their current enrollment status (i.e., "active"), and the primary county in which they provide services—and whether that county was urban, rural, or frontier.⁴¹ We also requested information about the organizations where each of the providers work. We then identified all unique active licensed behavioral health providers in the State, by county.⁴² We included providers in the following three categories:⁴³

- Independently licensed, prescribing behavioral health providers consist of psychiatrists (MD or DO with a psychiatric specialty), advanced practice nurses (i.e., clinical nurse specialists or clinical nurse practitioners with a psychiatric specialty), and licensed clinical psychologists (Ph.D., Psy.D. or Ed.D.) certified for prescribing.
- Independently licensed, non-prescribing behavioral health providers consist of licensed clinical psychologists (Ph.D., Psy.D. or Ed.D.) not certified for prescribing, licensed independent or clinical social workers (LISW or LCSW), licensed professional clinical mental health counselors (LPCC), licensed professional mental health counselors

⁴¹ Note that providers may practice at multiple locations, including locations outside of their primary service county. Further, we based our analysis on New Mexico's designation of urban, rural, and frontier counties. Note that frontier counties have an average of 2.8 people per square mile, and rural counties have an average of 13.7 people per square mile.

⁴² This analysis does not include out-of-State providers.

⁴³ In addition to the types of providers listed above, the State licenses other behavioral health providers, such as certified alcohol and drug abuse counselors (CADAC) and licensed physician assistants (PA) with a psychiatric specialty. Note that if types of behavioral health providers are not included in the bullets above, there were no providers of these types in the 2017 data.

(LPC), licensed marriage and family therapists (LMFT), licensed professional art therapists (LPAT), and licensed alcohol and drug abuse counselors (LADAC).

- Non-independently licensed behavioral health providers consist of licensed masters of social work (LMSW), licensed baccalaureates of social work (LBSW), licensed mental health counselors (LMHC), licensed associate marriage and family therapists (LAMFT), licensed substance abuse associates (LSAA), and registered nurses (RN) with a with a psychiatric specialty.

We also requested the total number of Medicaid managed care enrollees by county in 2017. Using these data, we determined the ratio of providers per 1,000 Medicaid managed care enrollees for each county. We also calculated the median ratio of providers and prescribers per 1,000 Medicaid managed care enrollees for urban, rural, and frontier counties.

Finally, we identified the number of licensed behavioral health providers that work in BHOs. Using the State data, we identified 351 BHOs that provide services to Medicaid managed care enrollees. These included all BHOs that provided outpatient behavioral health services to Medicaid managed care enrollees from January 1, 2017, through December 31, 2017.

Survey of behavioral health organizations

We selected a purposive sample of BHOs to survey. We included all BHOs designated as core service agencies because they are primary sources for comprehensive medical and support services for many Medicaid managed care enrollees in New Mexico. We then selected up to two additional BHOs with the largest behavioral health expenditures in each county to ensure geographic representation.⁴⁴ Finally, we included any additional BHOs that billed for more than \$1 million in 2017. In total, we selected 78 BHOs throughout the State.

Next, we conducted a survey of each of the selected BHOs. Our questions focused on the availability of behavioral health services for Medicaid managed care enrollees. We asked about the availability of both urgent and routine appointments for enrollees seeking services at the BHO from both prescribing and non-prescribing providers. We also asked about the extent to which BHOs maintain wait lists. Additionally, we asked about the extent to which they have difficulty arranging services that they do not or currently cannot provide. We also asked about any challenges with ensuring continuity of care, including maintaining care when transferring from one setting to another, seeing the same provider each visit, and exchanging health information throughout the continuum of care. Lastly, we asked about challenges and promising initiatives for improving the

⁴⁴ Five counties only had one BHO, and one county did not have a BHO.

availability of behavioral health services. We conducted the survey from August through November 2018. We received responses from a total of 53 BHOs in 27 of the 32 counties in New Mexico with a BHO. Of these BHOs, 16 were in urban counties, 20 were in rural counties, and 17 were in frontier counties.⁴⁵

Interviews with selected providers, State Medicaid officials and key stakeholders

We conducted interviews with selected providers from the BHOs, officials from the State's Medicaid managed care program, and key stakeholders.⁴⁶ We asked the behavioral health providers about their experience working with Medicaid managed care enrollees and the availability of behavioral health services. We conducted structured interviews with State Medicaid officials responsible for behavioral health services in the State and specific initiatives such as the Treat First Clinical Model. Lastly, we conducted structured interviews with key stakeholders, including representatives from the Local Collaborative Alliance New Mexico, a group of organizations that support community participation in behavioral health services. We focused our questions on the availability of behavioral health services for Medicaid managed care enrollees and on challenges and opportunities for improving the availability of behavioral health services in the State.

⁴⁵ The 53 BHOs received more than \$61 million in Medicaid managed care behavioral health expenditures in 2017. This amounts to 50 percent of the expenditures received by all BHOs in that year.

⁴⁶ We asked each BHO to identify at least one provider who had the most experience working with Medicaid managed care enrollees.

APPENDIX B: Number of Licensed Behavioral Health Providers That Serve Medicaid Managed Care Enrollees in New Mexico

Exhibit B-1: Number of licensed behavioral health providers, by provider type, 2017

	Total	Urban		Rural		Frontier	
Independently Licensed Prescribing Behavioral Health Providers	328	227	69%	83	25%	18	6%
Psychiatrists	202	151	75%	40	20%	11	5%
Advanced Practice Nurses*	94	52	55%	38	40%	4	4%
Prescribing Psychologists	32	24	75%	5	16%	3	9%
Independently Licensed Non-Prescribing Behavioral Health Providers	1,872	1,346	72%	449	24%	77	4%
Counselors and Therapists	976	682	70%	255	26%	39	4%
Social Workers	584	426	73%	131	22%	27	5%
Psychologists, Non-Prescribing	274	220	80%	45	16%	9	3%
Substance Use Counselors	38	18	47%	18	47%	2	5%
Non-Independently Licensed Behavioral Health Providers	465	325	70%	115	25%	25	5%
Counselors and Therapists	250	184	74%	58	23%	8	3%
Social Workers	198	131	66%	51	26%	16	8%
Registered Nurses	13	9	69%	4	31%	0	0%
Substance Use Counselors	4	1	25%	2	50%	1	25%
Total	2,665	1,898	71%	647	24%	120	5%

* Includes certified nurse practitioners with a psychiatric specialty and certified nurse specialists with a psychiatric specialty.

Rows may not total 100 percent due to rounding.

Source: OIG analysis of State Medicaid data, 2019.

Exhibit B-2: Number of licensed behavioral health providers, by county, 2017

County	Type	Total Medicaid Managed Care Enrollees*	Independently Licensed, Prescribing Providers	Independently Licensed, Non-Prescribing Providers	Non-Independently Licensed Providers	Total Licensed Providers	Licensed Providers per 1,000 Enrollees
Bernalillo	Urban	187,932	149	911	230	1,290	6.9
Catron	Frontier	654	-	1	-	1	1.5
Chaves	Rural	25,574	3	22	8	33	1.3
Cibola	Frontier	7,353	2	7	2	11	1.5
Colfax	Frontier	4,448	-	4	2	6	1.3
Curry	Rural	16,123	2	37	14	53	3.3
De Baca	Frontier	902	-	-	-	-	-
Dona Ana	Urban	92,905	48	157	46	251	2.7
Eddy	Rural	18,215	7	14	5	26	1.4
Grant	Rural	9,472	3	33	5	41	4.3
Guadalupe	Frontier	1,910	-	3	-	3	1.6
Harding	Frontier	67	-	-	-	-	-
Hidalgo	Frontier	1,677	1	1	2	4	2.4
Lea	Rural	24,730	4	14	7	25	1.0
Lincoln	Frontier	6,117	-	8	-	8	1.3
Los Alamos	Urban	775	1	11	3	15	19.4
Luna	Rural	13,544	2	6	3	11	0.8

Exhibit B-2: Number of licensed behavioral health providers, by county, 2017 (continued)

County	Type	Total Medicaid Managed Care Enrollees*	Independently Licensed, Prescribing Providers	Independently Licensed, Non-Prescribing Providers	Non-Independently Licensed Providers	Total Licensed Providers	Licensed Providers per 1,000 Enrollees
McKinley	Rural	17,377	10	17	3	30	1.7
Mora	Frontier	1,295	-	4	-	4	3.1
Otero	Rural	16,798	13	32	4	49	2.9
Quay	Frontier	3,513	-	4	2	6	1.7
Rio Arriba	Rural	17,449	2	21	9	32	1.8
Roosevelt	Rural	6,444	1	6	-	7	1.1
San Juan	Rural	32,683	16	45	9	70	2.1
San Miguel	Frontier	11,315	12	25	16	53	4.7
Sandoval	Rural	33,006	15	111	33	159	4.8
Santa Fe	Urban	56,777	29	267	46	342	6.0
Sierra	Frontier	6,435	2	10	1	13	2.0
Socorro	Frontier	6,414	1	3	-	4	0.6
Taos	Rural	12,064	4	64	12	80	6.6
Torrance	Frontier	7,986	-	7	-	7	0.9
Union	Frontier	576	-	-	-	-	-
Valencia	Rural	26,852	1	27	3	31	1.2
Total		669,705*	328	1,872	465	2,665	4.0

* This includes an additional 323 enrollees in which the county was unknown.

Source: OIG analysis of State Medicaid data, 2019.

APPENDIX C: Number of Selected Behavioral Health Organizations That Report Having Difficulty Providing Timely Appointments

Urgent Appointments		
	Number of BHOs	Percentage of BHOs
With a prescriber in their BHO		
Within 24 Hours	30	56.6%
After 24 Hours	23	43.4%
With a non-prescriber in their BHO		
Within 24 Hours	49	92.5%
After 24 Hours*	4	7.5%
Routine Appointments		
	Number of BHOs	Percentage of BHOs
With a prescriber in their BHO		
Within 14 Days	28	52.8%
After 14 Days	25	47.2%
With a non-prescriber in their BHO		
Within 14 Days	49	92.5%
After 14 Days**	4	7.5%

* Three of the four BHOs are unable to provide urgent appointments with prescribers and non-prescribers in their BHOs within 24 hours.

** All four BHOs are unable to provide routine appointments with prescribers and non-prescribers in their BHOs within 14 days.

Source: OIG analysis of BHO survey data, 2019.

Appendix D: Number of Selected Behavioral Health Organizations That Report Having Difficulty Arranging Each Service

	Number of BHOs	Percentage of BHOs
Recovery and Support Services		
Behavioral Health Respite Care	27	50.9%
Family Support Services	22	41.5%
Psychosocial Rehabilitation Services	22	41.5%
Supportive Housing Pre-Tenancy and Tenancy Services	22	41.5%
Behavior Management Skills Development Services	17	32.1%
Comprehensive Community Support Services (CCSS)	15	28.3%
Non-Intensive Outpatient Services		
Day Treatment	24	45.3%
Medication Assisted Treatment (MAT): Buprenorphine Treatment for Opioid Use Disorder	24	45.3%
Screening, Brief Intervention & Referral to Treatment (SBIRT)	16	30.2%
Crisis Intervention Services	12	22.6%
Behavioral Health Professional Services for Screenings, Evaluations, Assessments and Therapy	4	7.5%
Intensive Outpatient Services		
Opioid Treatment Program (OTP)	22	41.5%
Applied Behavior Analysis (ABA)	28	52.8%
Intensive Outpatient Program for Substance Use Disorders or Mental Health Conditions (IOP)	21	39.6%
Cognitive Enhancement Therapy (CET)	20	37.7%
Assertive Community Treatment Services	19	35.8%
Multi-Systemic Therapy (MST)	17	32.1%

	Number of BHOs	Percentage of BHOs
Inpatient and Residential Services		
Accredited/ Non-accredited Residential Treatment Center (ARTC, RTC) or Group Home	30	56.6%
Institution for Mental Diseases (IMD)	30	56.6%
Treatment Foster Care I and II	18	34.0%

Source: OIG analysis of BHO survey data, 2019.

APPENDIX E: Centers for Medicare & Medicaid Services Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 16, 2019

TO: Joanne Chiedi
Acting Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care (OEI-02-17-00490)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to working with states to provide Medicaid managed care enrollees with high quality behavioral health services.

CMS recognizes the importance of collaborating with states to increase the availability of behavioral health services for Medicaid beneficiaries. CMS also believes that states are in the best position to develop meaningful and appropriate network adequacy and service availability standards that reflect the scope of their programs, the populations served, and the unique demographics and characteristics of each state. To assist states in developing their network adequacy and service availability standards, CMS formed a working group of states to discuss common access challenges and goals, as well as to create a forum for states to present their successful techniques for establishing and monitoring network adequacy in their programs. In April 2017, CMS published the Network Adequacy Toolkit, which provides technical assistance to states in the development and oversight of Medicaid managed care plan networks including mental health providers.¹

CMS also has a section 1115 demonstration initiative focused on improving access to substance use disorder treatment, which is designed to incentivize states to ensure Medicaid beneficiaries have access to a full continuum of care to treat substance use disorder, while also implementing standards and processes to improve the quality of care being provided.² As part of these demonstrations, participating states are expected to take actions to improve provider capacity across a continuum of care including outpatient, intensive outpatient, and residential settings and ensure access to medication assisted treatment at all of these levels of care.

¹ <https://www.medicare.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf>

² <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>

In addition, in November 2018, CMS issued a letter to State Medicaid Directors that outlines both existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness and children with serious emotional disturbance.³ The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease for these patients. As a part of this new opportunity, participating states will be expected to conduct a thorough assessment of the availability of mental health providers at different levels of care across their state and develop strategies and take actions to fill gaps in provider availability and participation in Medicaid. CMS believes these opportunities offer states the flexibility to make significant improvements on access to quality behavioral health care.

Recognizing the unique challenges faced by rural communities in accessing care, in May 2018, CMS launched the agency's first Rural Health Strategy to help improve access to high quality, affordable healthcare in rural communities.⁴ As part of this initiative, CMS is working with state Medicaid agencies to improve access to care through provider engagement and support, focusing particularly on behavioral health. In addition, the initiative includes forming a council of experts tasked with addressing rural health issues, engaging stakeholders in rural communities, and partnering with health organizations to raise awareness.

Aligning with these efforts, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), enacted in October 2018, includes a number of significant Medicaid provisions aimed at improving access to behavioral health care for Medicaid beneficiaries, including those in managed care.⁵ Specifically, the SUPPORT Act includes a provision that requires CMS to issue guidance to states regarding federal reimbursement for services and treatment for substance use disorders under Medicaid delivered via telehealth. It also requires CMS to issue a Report to Congress identifying best practices and potential solutions for reducing barriers to using services delivered via telehealth for substance use disorders among pediatric populations under Medicaid. The SUPPORT Act also includes a number of other significant Medicaid provisions, such as a new mandatory benefit covering all forms of medication assisted treatment, a new optional benefit to cover specialized inpatient and residential substance use disorder treatment, and a demonstration program providing planning funding to up to ten states to increase the capacity of Medicaid providers to deliver substance use disorder treatment. CMS is in the process of developing guidance on several of these statutory requirements in the SUPPORT Act, and is working to implement the benefit changes and opportunities aimed at improving access to behavioral health care in Medicaid.

Lastly, in July 2019, CMS issued a notice of proposed rulemaking designed to help streamline federal oversight of access to care requirements that protect Medicaid beneficiaries.⁶ If the proposed rule is finalized, CMS would replace the ongoing access reviews required by current regulations with a more comprehensive and outcomes-driven approach to monitoring access across delivery systems, developed through workgroups and technical expert panels that include key state and federal stakeholders.

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

⁴ <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>

⁵ <https://www.congress.gov/bill/115th-congress/house-bill/6>

⁶ <https://www.cms.gov/newsroom/press-releases/cms-launches-comprehensive-effort-strengthen-monitoring-medicaid-beneficiary-access-patients-while>

CMS is committed to providing opportunities for states to improve access to behavioral health care and through the efforts described above, we are assisting states and other stakeholders in meeting this goal.

OIG's recommendation and CMS' response are below.

OIG Recommendation

Identify States that have limited availability of behavioral health services and develop strategies and share information to ensure that Medicaid managed care enrollees have timely access to these services.

CMS Response

CMS concurs with this recommendation. CMS will work with states who identify themselves as having behavioral health shortages, or through the course of their network monitoring, consistently have managed care plans that do not meet state defined standards of network adequacy. CMS will utilize our robust efforts described above to provide technical assistance to those states by developing strategies and sharing information to ensure that Medicaid managed care enrollees have timely access to behavioral health services.

APPENDIX F: New Mexico Human Services Department Comments



Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary

August 16, 2019

Ms. Suzanne Murrin
Deputy Inspector General
Department of Health and Human Services
Office of Inspector General
Washington, DC 20201

Dear Deputy Inspector Murrin:

Thank you for granting New Mexico the opportunity to comment on the draft report entitled *Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care*, OEI-02-17-00490.

Attached are New Mexico Human Services Department's comments and specific actions related to each of the ten recommendations. Included are draft timelines for the actions outlined for each recommendation.

If you have any questions about this report, please do not hesitate to email me at David.scrase@state.nm.us or call me at 505-827-7750.

Sincerely,

A handwritten signature in black ink, appearing to read "David R. Scrase", is written over a light blue horizontal line.

David Scrase, M.D.
Secretary

New Mexico's Comments
Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care
OEI-02-17-00490

1. Expand NM's behavioral health workforce that serves Medicaid managed care enrollees

a. Take Steps to expand NM's overall BH workforce

- i. The Human Services Department (HSD) concurs with this recommendation.
 - 1. Since January 1, 2019, HSD has implemented a multiprong strategy to expand NM's overall BH workforce including but not limited to:
 - a. BH provider rate increase in July 2019 and October 2019 totaling \$50M;
 - b. Utilization of federal grants (\$27.5M) to increase BH services provided in rural and frontier counties;
 - c. Dedicated staff to serve as support for BH providers regarding new services, Medicaid enrollment, certification, etc.
 - d. Submission of an application for the CMS SUD Medicaid Workforce grant on 8/9/2019; and
 - e. Implementation of a Graduate Medical Education program for providers in 2020.
 - 2. NM's Behavioral Health Collaborative (BHC) is comprised of Secretaries for various state agencies. The BHC developed four strategic goals, one of which is the Expansion of the Behavioral Health Network. The BHC will be requesting \$25M for next fiscal year in an effort to accomplish the objectives of all four goals.

b. Increase BH providers' participation in Medicaid managed care

- i. HSD concurs with this recommendation.
 - 1. HSD's managed care program, Centennial Care, included new BH services with the implementation of its 1115 waiver renewal on January 1, 2019. New Medicaid reimbursable BH services include: Screening, Brief Intervention & Referral to Treatment; Accredited Residential Treatment Centers for Adults; and Supportive Housing.
 - 2. Since 2017, HSD has reduced the departmental administrative requirements for BH providers who render specialty services.
 - 3. HSD continues to meet with the Regulation and Licensing Department to discuss the streamlining of licensing requirements and implementation of reciprocity for out of state providers moving to NM.
 - 4. HSD will conduct a BH provider network analysis over the next six months.

2. Improve access to BH services

a. Review its standards governing access to care and determine whether additional standards are needed for behavioral health providers.

- i. HSD concurs with this recommendation.
 - 1. On January 14, 2019, HSD released a Medicaid Supplement to BH providers and the MCOs regarding BH service updates.
 - 2. In January 2019, HSD release the BH Billing and Policy Manual.

New Mexico's Comments
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3. On December 1, 2019, HSD will complete the BH rule promulgation process.
- b. Improve access to transportation for Medicaid managed care enrollees needing behavioral health services.**
 - i. HSD concurs with this recommendation.
 1. NM Medicaid covers non-emergency medical transportation for members with physical health (PH) and BH appointments.
 2. Within the next six months, HSD will implement non-medical transportation for the justice involved population upon release to ensure access to pharmacy and other services.
- c. Work with State partners to strengthen access to high-speed, reliable, and secure communications technologies in rural and frontier counties.**
 - i. HSD concurs with this recommendation.
 1. Since 2014, NM Medicaid has reimbursed for BH and physical health services provided via telehealth. BH providers have the highest utilization of telehealth.
 2. HSD is pursuing funding for broadband coverage and is working with other state agencies to endorse increased funding for these efforts.
- d. Expand the use of telehealth to increase the availability of behavioral health services.**
 - i. HSD concurs with this recommendation.
 1. With the implementation of Centennial Care in 2014, HSD identified telemedicine as a focus area for improving health outcomes by addressing barriers to physical and behavioral health care needs in our rural and frontier areas.
 2. Beginning in 2019, HSD included telemedicine as a contractually required Delivery System Improvement Performance Target for the MCOs.
 3. In 2018, HSD included the use of telemedicine for the provision of Applied Behavior Analysis (ABA) services, Medication Assisted Treatment (MAT) and Opioid Treatment Program (OTP).
 4. HSD is working with the State telehealth network to expand coverage.
- 3. Improve the effectiveness of behavioral health services.**
 - a. Take steps to increase adoption of EHRs and participation in the HIE by behavioral health providers.**
 - i. HSD concurs with this recommendation.
 1. HSD is exploring funding for connectivity and data transmission to increase data sharing.
 2. HSD is in discussions with NM's HIE to include BH providers on the HIE.
 - b. Identify and share information about strategies to improve care coordination.**
 - i. HSD concurs with this recommendation.
 1. Effective January 1, 2019, the Medicaid Centennial Care MCOs are able to fully or partially delegate care coordination functions to providers.

New Mexico's Comments
Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care
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This includes PH and BH providers who know their communities and are able to link members to services.

- c. Expand initiatives to integrate behavioral and primary healthcare.**
 - i. HSD concurs with this recommendation.
 - 1. Since April 1, 2016 CareLink NM allowed 2 pilot Health Homes to coordinate care for members with Serious Mental Illness and/or Severe Emotional Disturbance. In 2018, HSD expanded the number of health homes to 12.
- d. Share information about open-access scheduling and the Treat First Clinical Model and promote expansion.**
 - i. HSD concurs with this recommendation.
 - 1. The Treat First model was piloted in Spring of 2016 with 8 BH agencies in 21 clinics across the state. As of April 2019, 18 BH agencies have been Certified as a Treat First Agency in 69 clinics. HSD continues to collaborate with the NM Behavioral Health Provider Association to train provider in the Treat First model to increase the number of qualified providers. The following is the link to the NM Treat First website:
<https://treatfirst.org/>
 - 2. HSD conducts several learning collaboratives with BH providers regarding open access scheduling. Each BH agency has shared its customized approach to implementation, how they improve access, reduce "No Show" rates and improve client satisfaction. The agencies that use an Open Access model have shared how Treat First has improved client engagement when used in conjunction with Open Access.

ACKNOWLEDGMENTS

Vincent Greiber served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Grant Conway. Office of Evaluation and Inspections staff who provided support include Clarence Arnold and Kevin Manley.

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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