New Mexico Medicaid

Access Monitoring Review Plan

for

Fee-For-Service Recipients

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Period of Review: Calendar Year 2015

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NMHSD 2016 Medicaid Access Monitoring Review Plan for 2015

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Introduction

The Medical Assistance Division of the New Mexico Human Services Department (HSD/MAD) administers the New Mexico Medicaid program on behalf of the state and in collaboration with the federal Centers for Medicare and Medicaid Services (CMS) under the US Department of Health and Human Services.

As the single state agency responsible Medicaid programs and services in New Mexico, HSD/MAD, in accordance with 42 CFR 447.203, has developed methods to periodically measure and monitor the participation and availability of health care providers in the New Mexico Medicaid program to ensure that Medicaid fee-for-service (FFS) beneficiaries ("recipients") have access to care that is comparable to the non-Medicaid general population.

The first formal draft of the New Mexico Access Monitoring Review Plan was posted online on August 25, 2016. HSD/MAD published a link to the Plan and request for public comments in two newspapers – *The Albuquerque Journal* and the *Las Cruces Sun* News – on August 25, 2016. A letter was sent to tribal leaders and Indian health providers on August 25, 2016 to solicit tribal comments. The Plan was discussed at the Native American Technical Advisory Committee (NATAC) meeting on August 28, 2016. HSD/MAD conducted a formal public hearing on September 20, 2016 and, in response to questions that were asked during that hearing, HSD/MAD conducted a phone call with Indian Health Service (IHS) representatives to review and respond to questions and concerns about the draft Plan. This version of the New Mexico Access Monitoring Review Plan, addresses and incorporates the comments that were received during the public/tribal comment period. With this Plan, HSD/MAD also submits a full summary of all comments that were received.

The purpose of this Plan is to establish baseline data from which additional studies and analyses can be performed. It is important to note that this Plan addresses only the Medicaid FFS population, in accordance with 42 CFR 447.203. In New Mexico, the Medicaid FFS population represents approximately 15 percent of total Medicaid enrollment. The 85 percent of Medicaid enrollees who are enrolled in the state's managed care program, Centennial Care, are not included in this study.

Time Period

This Access Review Monitoring Review Plan reflects data from calendar year 2015. When necessary, the month of July is used to reference a detailed comparison of one year to another year in order to assure the most accurate baseline comparisons. This first study is intended to meet the CMS requirements stated in the Code of Federal Regulations at 42 CFR

Part 447 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services; Final Rule, which requires the initial baseline year to be calendar year 2015, and limited to Medicaid FFS recipients only.

The 2015 Plan consists of:

1. Defining the characteristics of the recipient population, including identifying the population for whom access to providers will be evaluated.
2. Quantifying information from the Medicaid Call Center, which contains reports from recipients regarding access questions and concerns.
3. Comparing the Medicaid fee schedule to the Medicare fee schedule.
4. Identifying the areas of the state where the recipient population resides and defining the health care service areas that correspond to the recipients residing in those areas.
5. Focusing on specific services, as required by CMS, including:
    - Primary Care services
    - Physician Specialist services
    - Behavioral Health services
    - Pre- and Post-Natal Obstetric services, including labor and delivery
    - Home Health services
    - Dental Health services

Overview

The New Mexico Medicaid program provides health care coverage for nearly 40 percent of the state's total population, specifically serving low-income parents and adults, children, pregnant women, individuals with disabilities, and the elderly.

The New Mexico Medicaid program first began enrolling most Medicaid recipients into risk-based Medicaid managed care organizations in July 1997. Over time, enrollment in managed care has expanded to include recipients who are dually eligible for Medicare and Medicaid, and recipients who are in nursing facilities or receiving other long-term services and supports.

In January 2014, New Mexico implemented a more innovative managed care program through an 1115 demonstration waiver. The new program, called Centennial Care, established processes to allow a Medicaid applicant to select a managed care organization at the time of application, thereby eliminating the need to be in the FFS program for up to 60 days while waiting for the managed care enrollment, selection, or

assignment process to occur. Most Medicaid recipients are enrolled in managed care with no time spent in the FFS program. Enrollment in Centennial Care is mandatory for most Medicaid recipients in New Mexico; however, some recipients are considered exempt from managed care. These include:

- Native Americans, except those who are in nursing facilities or who are dually Medicare/Medicaid eligible or meet a nursing facility level of care and receive home and community benefits. Most Native Americans are considered exempt from Centennial Care, but may opt-in to the program at any time. Most Native Americans in New Mexico are served under the FFS program.
- Recipients who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs).
- Recipients with a nursing facility level of care whose services are provided through the Program of All-inclusive Care for the Elderly (PACE).
- Recipients with very limited benefits (that is, non "full benefit" recipients), which include recipients with family planning only benefits, recipients whose benefits are limited to paying Medicare premiums, and recipients whose coverage is limited to payment of coinsurance, deductible, and copayments following Medicare payment, such as Qualified Medicare Beneficiary (QMB) only individuals.

Defining Recipients

HSD/MAD's intention is to clearly identify the recipients for whom access is monitored in this Plan.

The characteristics of the recipients included in this plan are "full benefit" FFS recipients who:

1. Are not dually eligible for Medicare, since Medicare is the primary payer and providers must enroll separately to participate in Medicare;
2. Are not in ICF-IIDs, since these facilities are responsible for arranging for professional services; and
3. Are not enrolled in the PACE program, because these recipients by definition are all dually enrolled in Medicare.

Also, because the status of any recipient can change over the course of the year -- such as being enrolled in FFS for only part of the year, being eligible for only part of the year, or changing eligibility categories -- and because providers can change enrollment status over the course of the year, it was determined that HSD/MAD would be able to establish a more accurate baseline by studying recipient access for the month of July 2015, essentially

creating a “snapshot” of recipient access based on recipient and provider enrollment for that month.

This will permit a year-to-year (July-to-July), comparison using similar monitoring tools and the same methodology.

Quantifying Information from the Medicaid Call Center - Questions and Concerns Raised by Recipients

New Mexico operates a Medicaid call center as a service to all Medicaid recipients to personally engage and assist them with their needs. Each recipient’s Medicaid card includes the toll-free number for the call center. The Medicaid call center operates Monday through Friday from 8 a.m. to 5 p.m. Recipients can leave a message after hours or on weekends and receive a call-back within 24 business hours. Calls to the call center are logged detailing the issues raised and the resolution. A weekly report is produced detailing the number of calls and the issue topics.

In order to identify trends in questions or concerns expressed by Medicaid FFS recipients about provider access issues, HSD/MAD reviewed call center activity for five months in 2015. The call center information does not distinguish between callers receiving services through the FFS program or through the Managed Care program. The analysis of calls shows over 65,000 calls in that period, or about 13,000 calls per month. Figure 1 shows the volume of calls during those five months by topic. Most of these recipient calls (94%) requested assistance with eligibility questions, which were typically resolved by call center staff. Call center data show that the issue of provider access was not raised by FFS callers during those five months in 2015. The representative months studied were April, May, July, October and November 2015.

All calls are classified by the reason for the call. The following table shows the categories for which the Call Center was contracted.

Table 1: Number of NM Medicaid Call Center calls by topic, for five months in 2015

NM Medicaid Recipient Call Center (all recipients)
Sampling: 5 months in 2015

Topic/ Issue: Nature of Call(s)	Number
Claim Issue	1
CMS	2
CCO - Incorrect Info	0
CMS	1
CCO Call Ctr - Can't Reach Anyone	1
Complaint	2
Complaint about ISD	0
Compliment	2
CYFD Eligibility	71
Don't Know CCO	9
Presumptive Eligibility	0
Eligibility - Manager Approval	201
Eligibility	61,258
General Questions	1,531
MCO Selection	54
LTC Project	0
Other	134
Policy Questions	5
Provider Access-Unable to find (FFS)	0
RA Request	0
Replacement Cards	2
Provider Access-Unable to find network provider (Managed Care)	0
Research	239
TOTAL	65,513

The lack of calls to ask questions or express concerns about access to providers is a strong indicator that health care services are generally accessible and known to Medicaid FFS recipients.

While HSD/MAD collects and analyzes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for managed care recipients, the Department does not have CAHPS surveys for FFS recipients. Consequently, HSD/MAD does not have CAHPS response data from FFS recipients.

Comparing Medicaid and Medicare Payment Rates

The New Mexico Medicaid program does not have access to private payer data or provider rates in the general commercial markets in New Mexico. HSD/MAD has compared the level of New Mexico Medicaid fee schedule allowed amounts to Medicare claim allowed amounts for the same service. This comparison was compiled using ranges of codes, rather than individual codes, in order to provide a clearer comparison. The information is based on a weighted average on the frequency of use of the code in each code range. The comparison was made by studying actual amounts that Medicare allowed for services versus what New Mexico Medicaid allowed for the same services.

Table 2, below, shows the New Mexico Medicaid SFY 2015 practitioner payment rates compared to Medicare.

Table 2 – ***New Mexico Medicaid SFY 2015 payment rates compared to Medicare***

New Mexico SFY 2015 payment rates compared to Medicare **by Type of Service**		
Description of Services	**Procedure Codes**	**NM Medicaid Average Percent Compared to Medicare**
SKIN including biopsies, removal of lesions, grafts, treatment of burns and sores, and tissue reconstruction	10021-17999	96.43%
BREAST and MASTECTOMY including biopsy and reconstruction	19000-19499	95.94%
MUSCULOSKELETAL SURGERIES penetrating wounds and trauma, joints and joint replacement, surgeries involving bone, muscle, and other soft tissue	20005-29999	102.30%

RESPIRATORY SYSTEM SURGERIES AND PROCEDURES including nose, sinus, throat, lungs	30000-32999	97.22%
CARDIOVASCULAR SYSTEM SURGERIES AND PROCEDURES including heart, arteries and bypass procedures	33010-37799	107.15%
BLOOD AND LYMPHATIC SYSTEM SURGERIES AND PROCEDURES including spleen, bone marrow, and lymph glands	38100-38999	121.66%
DIGESTIVE SYSTEM SURGERIES AND PROCEDURES including lips, mouth, esophagus, stomach, intestines, spleen, liver, and pancreas	40490-49999	103.74%
URINARY SYSTEM SURGERIES AND PROCEDURES including kidney, ureter, and bladder	50010-53899	109.36%
MALE GENITAL SYSTEM SURGERIES AND PROCEDURES	54000-55899	107.24%
FEMALE GENITAL SYSTEM SURGERIES AND PROCEDURES including sterilizations	56405-58999	103.42%
MATERNITY CARE AND DELIVERY Including antepartum and fetal procedures, deliveries, postpartum, and miscarriages	59000-59830	92.27%
ENDOCRINE AND NERVOUS SYSTEM SURGERIES AND PROCEDURES	60000-64911	103.24%
EYE AND EAR SURGERIES AND PROCEDURES	65091-69990	91.36%
RADIOLOGY AND IMAGING	All radiology codes	116.00%
PSYCHIATRIC AND PSYCHOTHERAPY for MD, DO, and PhD. (Not all BH services are included in this line.)	90791-90899	99.01%
DIALYSIS professional services (facility payments are not included)	90935-90999	94.47%
GASTROENTEROLOGY nonsurgical includes tests, evaluations, studies, procedures	91010-91299	91.21%
OPHTHALMOLOGY nonsurgical	92002-92287	85.40%
EAR, NOSE, THROAT including audiology testing	92502-92700	87.54%
LABORATORY	80000-89999	100%
CARDIOVASCULAR nonsurgical, but including therapeutic services, monitoring, tests, evaluations, studies, catheterization, echocardiography	92920-93998	94.88%
PULMONARY nonsurgical, including testing and ventilator management	94002-94799	90.14%
NEUROLOGY AND NEUROMUSCULAR nonsurgical including sleep studies, testing and diagnostic	95782-96155	96.24%

procedures		
PHYSICAL MEDICINE therapeutic treatments and modalities	97001-97576	92.10%
EVALUATION AND MANAGEMENT office type visits	99201-99215	86.50%
HOSPITAL INPATIENT inpatient hospital visits, observation, and discharge	99221-99239	87.72%
INPATIENT CONSULTATIONS	99251-99255	Medicare doesn't cover
EMERGENCY DEPARTMENT SERVICES emergency room visits	99281-99285	83.91%
NURSING FACILITY CARE, REST HOME, AND CUSTODIAL CARE SERVICES nursing facility visits	99304-99350	92.27%
MISC. INPATIENT NEONATAL & PEDIATRIC INTENSIVE CARE, CRITICAL CARE, etc.	99466-99486	Medicare doesn't cover

Table 3, below, shows that more than 99 percent of the Medicaid FFS population is Native American, generally with access to IHS/tribal health care facilities and providers. Most services at outpatient IHS and tribal health care facilities are paid at outpatient Office and Management and Budget (OMB) rates, as published in the Federal Register and therefore not affected by the fee schedule. HSD/MAD notes that since OMB rates are federally established, the adequacy of these payment rates for ensuring access for Native American Medicaid beneficiaries is outside of the state's control.

Services paid at the OMB rate include:

- Primary Care services
- Physician Specialist services
- Outpatient Behavioral Health services
- Pre- and Post-Natal Obstetric services, including labor and delivery (inpatient services and delivery services are paid in addition to the inpatient OMB rate)
- Dental Health services

Recipient Demographics

In July 2015, there were 78,318 Medicaid recipients in the Medicaid FFS program, of which 78,140 were Native American (99.8%). Given the large majority of Native Americans in the

Medicaid FFS program, it is necessary and important for HSD/MAD to consider recipient access to IHS and other tribal health care providers, including tribal 638 facilities.

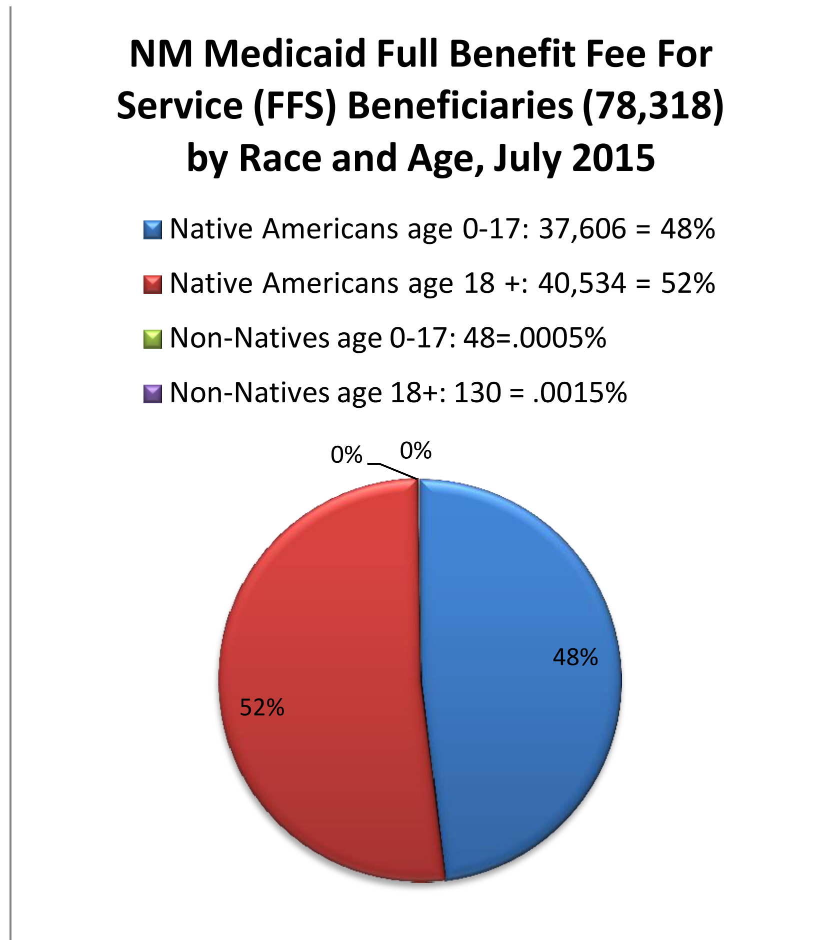
New Mexico is the fifth largest state (geographically) and has 33 counties. The counties are typically much smaller than for most western states, meaning that the population center for each county (usually the county seat) may be relatively close to the population center of another county.

Table 3 (below) shows the Medicaid FFS population by age and county of residence.

Table 3 – NM Medicaid Fee-For-Service Recipient Residence by County July 2015

County	NATIVE AMERICANS BY AGE GROUP			NON-NATIVE AMERICANS BY AGE GROUP			ALL RECIPIENTS
	0 - 17	18 & above	TOTAL	0 - 17	18 & above	TOTAL	
Bernalillo	4,894	6,136	11,030	9	59	68	11,098
Catron	12	15	27				27
Chaves	25	36	61	2	1	3	64
Cibola	2,426	2,518	4,944		1	1	4,945
Colfax	10	20	30				30
Curry	20	27	47	1		1	48
De Baca	4	3	7				7
Dona Ana	145	200	345	8	7	15	360
Eddy	34	51	85		12	12	97
Grant	17	34	51		1	1	52
Guadalupe	4	4	8				8
Harding							0
Hidalgo	1	2	3				3
Lea	32	25	57	1	6	7	64
Lincoln	118	124	242		3	3	245
Los Alamos	8	13	21				21
Luna	26	36	62		1	1	63
McKinley	12,456	12,765	25,221				25,221
Mora	9	6	15				15
Otero	1,070	992	2,062	1	1	2	2,064
Quay	9	9	18		1	1	19
Rio Arriba	1,133	1,233	2,366	1	9	10	2,376
Roosevelt	17	38	55				55
Sandoval	3,478	3,869	7,347	7	2	9	7,356
San Juan	9,790	10,150	19,940	6	2	8	19,948
San Miguel	61	84	145	1	2	3	148
Santa Fe	650	830	1,480	7	18	25	1,505
Sierra	8	25	33				33
Socorro	532	484	1,016	1	2	3	1,019
Taos	277	386	663				663
Torrance	42	56	98				98
Union	1	2	3				3
Valencia	297	361	658	3	2	5	663
TOTAL	**37,606**	**40,534**	**78,140**	**48**	**130**	**178**	**78,318**

Table 4: ***Total NM Full-Benefit Fee-For-Service population by race (two groups) and age (two groups: 0-17 and 18+)***



This analysis of age groups show that just under half (48%) of FFS recipients are under age 18, while slightly more than half (52%) are 18 years or older.

HSD/MAD notes that 84 percent of the Medicaid FFS population lives in just seven New Mexico counties.

- Approximately 58 percent of Medicaid FFS recipients reside in McKinley County (associated with Gallup, the 11th largest city in New Mexico) and the adjoining San Juan County (associated with Farmington, the 6th largest city in New Mexico). These counties in northwestern New Mexico lie primarily within the Navajo Nation. Together, they constitute about 45,000 of the 78,318 FFS recipients statewide.

  Both county populations are served by health care resources in the cities of Gallup and Farmington, respectively, several IHS and tribal 638 facility providers throughout

those counties, and across the border in Arizona, as well as additional providers in adjacent counties and across state lines in Durango, Colorado.

All but eight FFS recipients in these two counties are Native American. Both counties have some of the largest IHS facilities in the state at several locations within the counties and across the border in Arizona.

- Approximately 26 percent of the Medicaid FFS population lives in counties that are considered “urban” or part of an “urban corridor”, which covers Bernalillo, Sandoval and Valencia counties, and which offer significant urban-scale health care facilities and services from many providers within a relatively close driving distance.

  These urban areas include the Albuquerque metropolitan area (the largest city in the state) and Rio Rancho (the 3rd largest city in the state). Doña Ana County with Las Cruces (the second largest city in the state) is also considered urban.

  Two smaller cities in the adjacent counties of Santa Fe and Los Alamos also provide some urban-like health care services.

- The remaining 16 percent of the Medicaid FFS population live in other counties across New Mexico with varying characteristics.

  According to www.frontierus.org, all of the counties in New Mexico are considered frontier counties except for the following: Bernalillo, Doña Ana, Los Alamos, Sandoval, Santa Fe, and Valencia.

The underserved designation by HRSA, when applicable, is indicated on the tables associating services with counties. However, because of the distribution of the FFS population and because the population center of one county is often close to the population center of another county, the area in which residents of a county routinely seek health care services is often in an adjoining county. Therefore, the health service area in which the resident of a county typically seeks health care may be in what is called a “health care service area”.

The tables below that relate to each service consider the number providers available in the recipients’ ***county*** as Table A (such as Table 8 A or Table 10 A); while the corresponding larger ***Healthcare Service Area*** is always shown in Table B (such as Table 8 B or Table 10 B).

Native American recipient access, even for those geographically close to IHS or tribal health care facilities, must also be considered from the aspect of:

- Recipient choice of providers.
- Access to services following referrals from IHS or tribal facilities.
- Access to services not provided through IHS or tribal facilities.
- Timely access to emergency services.

Table 5 (below) shows the numbers and percentages of Native Americans receiving care during Calendar Year 2015 in the following settings:

- Only from IHS and tribal health care facilities.
- Only from non-IHS/non-tribal health care facilities.
- From both IHS/tribal health care facilities *and* by non-IHS/non-tribal providers.

In 2015, the largest number of recipients, approximately 33 percent, was seen in both IHS/tribal settings *and* non-IHS/non-tribal settings. This varies significantly from county to county, depending on the IHS or tribal facilities in the county or nearby, as well as by the number of non-IHS/non-tribal providers nearby.

Generally, the non-IHS/non-tribal providers rendering the most services to Native Americans are hospital facility providers in the counties with the largest numbers of Native Americans (McKinley and San Juan counties), the University of New Mexico Hospital (UNMH), and behavioral health and vision providers.

Table 5** – **<u>Native Americans Receiving Care in IHS or Tribal Setting</u>

County	Number of NA Recipients with only IHS or Tribal Facility Services	Percent of NA Recipients with only IHS or Tribal Facility Services	Number of NA Recipients with only non-IHS or non-Tribal Service Providers	Percent of NA Recipients with only non-IHS or non-Tribal Service Providers	Number of NA Recipients with Services from both IHS or Tribal Facilities *and* Non-IHS Providers	Percent of NA Recipients with Services from both IHS or Tribal Facilities *and* Non-IHS Providers	Number of NA Recipients with No Services During Review Period	Percent of NA Recipients with No Services During Review Period	Total Native American Recipients
Bernalillo	1,462	13.25%	4,269	38.70%	3,183	28.86%	2116	19.18%	11,030
Catron	7	25.93%	7	25.93%	13	48.15%	0	0.00%	27
Chaves	4	6.56%	46	75.41%	1	1.64%	10	16.39%	61
Cibola	1,318	26.66%	1,047	21.18%	1,801	36.43%	778	15.74%	4,944
Colfax	3	10.00%	12	40.00%	6	20.00%	9	30.00%	30
Curry	1	2.13%	28	59.57%	4	8.51%	14	29.79%	47
De Baca	0	0.00%	7	100.00%	0	0.00%	0	0.00%	7
Dona Ana	19	5.51%	205	59.42%	21	6.09%	100	28.99%	345
Eddy	1	1.18%	52	61.18%	6	7.06%	26	30.59%	85
Grant	3	5.88%	27	52.94%	10	19.61%	11	21.57%	51
Guadalupe	0	0.00%	7	87.50%	0	0.00%	1	12.50%	8
Harding	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0
Hidalgo	1	33.33%	1	33.33%	1	33.33%	0	0.00%	3
Lea	3	5.26%	33	57.89%	0	0.00%	21	36.84%	57
Lincoln	27	11.16%	81	33.47%	94	38.84%	40	16.53%	242
Los Alamos	1	4.76%	4	19.05%	10	47.62%	6	28.57%	21
Luna	5	8.06%	32	51.61%	10	16.13%	15	24.19%	62
McKinley	10,934	43.35%	2,806	11.13%	7,739	30.68%	3742	14.84%	25,221
Mora	5	33.33%	7	46.67%	1	6.67%	2	13.33%	15
Otero	552	26.77%	276	13.39%	1,053	51.07%	181	8.78%	2,062
Quay	0	0.00%	13	72.22%	1	5.56%	4	22.22%	18
Rio Arriba	837	35.38%	260	10.99%	974	41.17%	295	12.47%	2,366
Roosevelt	5	9.09%	26	47.27%	8	14.55%	16	29.09%	55
Sandoval	1,740	23.68%	1,700	23.14%	2,922	39.77%	985	13.41%	7,347
San Juan	4,388	22.01%	6,336	31.78%	5,904	29.61%	3312	16.61%	19,940
San Miguel	18	12.41%	59	40.69%	27	18.62%	41	28.28%	145
Santa Fe	332	22.43%	371	25.07%	536	36.22%	241	16.28%	1,480
Sierra	4	12.12%	23	69.70%	0	0.00%	6	18.18%	33
Socorro	252	24.80%	246	24.21%	426	41.93%	92	9.06%	1,016
Taos	123	18.55%	151	22.78%	301	45.40%	88	13.27%	663
Torrance	6	6.12%	49	50.00%	19	19.39%	24	24.49%	98
Union	0	0.00%	0	0.00%	2	66.67%	1	33.33%	3
Valencia	109	16.57%	237	36.02%	181	27.51%	131	19.91%	658
Total	22,160	28.36%	18,418	23.57%	25,254	32.32%	12,308	15.75%	78,140

The above chart (Table 5) shows that of the 65,832 Native Americans receiving services in 2015, 72 percent received some services at IHS or tribal health care facilities, emphasizing the important role that these facilities play in the delivery of services in the New Mexico FFS program.

These providers are included in this analysis because they can provide primary care services, some physician specialist services, and pre- and post-natal obstetric services, as well as some outpatient behavioral health services. Some facilities also provide dental services.

Because of the manner in which claims are billed, HSD/MAD can identify when an IHS or tribal health care provider is rendering dental and behavioral health services.

Table 6 (below) provides a list of New Mexico IHS/Tribal Providers (facilities) and their locations.

Table 6: <u>List of NM Medicaid IHS and Tribal 638 Providers</u>

IHS OR TRIBAL FACILITY NAME	COUNTY	SERVICE TYPE
NOTE: The providers are listed based on their provider enrollment agreement. Some providers have enrolled in such a manner as to identify some services separately, such as audiology and behavioral health. It should not be assumed that a facility that does not have a separate billing identity for behavioral health, audiology, or transportation does not provide those services. It is up to the facility to determine if they want some of their services to be associated with a unique provider identifier.		
ALBUQUERQUE AREA INDIAN HEALTH BD	Bernalillo	audiology
ALBUQUERQUE AREA INDIAN HLTH BD-PUEBLO AUDLGY	Bernalillo	audiology
ALBUQUERQUE IHS DENTAL CLINIC	Bernalillo	dental clinic
ALBUQUERQUE PHS INDIAN HOSPITAL	Bernalillo	medical facility
ALBUQUERQUE PHS INDIAN HOSPITAL	Bernalillo	dental clinic
FIRST NATIONS COMMUNITY HEALTH SOURCE	Bernalillo	FQHC
ISLETA DENTAL CLINIC	Bernalillo	dental clinic
ISLETA HEALTH CENTER	Bernalillo	medical facility
TOHAJIILEE BHS	Bernalillo	behavioral health
PUEBLO OF ACOMA	Cibola	community benefits
ACOMA CANONCITO LAGUNA PHS	Cibola	medical facility
ACOMA CANONCITO LAGUNA PHS	Cibola	dental facility
INDIAN HEALTH SERVICE	Cibola	medical facility
INDIAN HEALTH SERVICE	Cibola	dental facility

LAGUNA DENTAL CLINIC	Cibola	Dental
NEW SUNRISE RTC	Cibola	behavioral health
PINE HILL AMBULANCE SERVICE	Cibola	ambulance
PINE HILL HEALTH CENTER	Cibola	medical facility
PINE HILL HEALTH CENTER	Cibola	dental facility
CROWNPOINT PHS INDIAN HOSP	McKinley	medical facility
CROWNPOINT PHS INDIAN HOSP	McKinley	dental facility
CROWNPOINT-THOREAU CLINIC	McKinley	medical facility
CROWNPOINT-THOREAU CLINIC	McKinley	dental facility
GALLUP INDIAN MEDICAL CENTER	McKinley	ambulatory surgery
GALLUP PHS INDIAN MED CENTER	McKinley	medical facility
GALLUP PHS INDIAN MED CENTER	McKinley	dental facility
PUEBLO OF ZUNI - TEEN HEALTH CENTER	McKinley	medical facility
TOHATCHI HEALTH CENTER	McKinley	medical facility
TOHATCHI HEALTH CENTER	McKinley	dental facility
ZUNI AUDIOLOGY PROGRAM	McKinley	audiology
ZUNI INDIAN HOSPITAL	McKinley	medical facility
ZUNI INDIAN HOSPITAL	McKinley	dental facility
ZUNI RECOVERY CENTER	McKinley	behavioral health
MESCALERO PHS INDIAN HOSPITAL	Otero	medical facility
MESCALERO PHS INDIAN HOSPITAL	Otero	dental facility
CHINLE COMPREHENSIVE HEALTH CARE FACILITY	AZ - border area	medical facility
CHINLE COMPREHENSIVE HEALTH CARE FACILITY	AZ - border area	dental facility
FOUR CORNERS REGIONAL HEALTH CENTER	AZ - border area	medical facility
FOUR CORNERS REGIONAL HEALTH CENTER	AZ - border area	dental facility
FT DEFIANCE INDIAN HOSPITAL	AZ - border area	medical facility
FT DEFIANCE INDIAN HOSPITAL	AZ - border area	dental facility
FT DEFIANCE INDIAN HOSPITAL	AZ - border area	ambulatory surgical
GROWING IN BEAUTY	AZ - border area	behavioral health
NAVAJO NATION EMER MED SER	NM & AZ - border area	ambulance
SOUTHERN COLORADO UTE SERVICE	CO - border area	medical facility
SOUTHERN COLORADO UTE SERVICE	CO - border area	dental facility
TUBA CITY REGIONAL HEALTH CARE	AZ - border area	medical facility
TUBA CITY REGIONAL HEALTH CARE	AZ - border area	dental facility
UTAH NAVAJO HEALTH SYSTEM INC	UT - border area	medical facility
UTE MOUNTAIN UTE HEALTH CENTER	CO - border area	medical facility
UTE MOUNTAIN UTE HEALTH CENTER	CO - border area	dental facility
EIGHT NORTHERN INDIAN PUEBLOS CNCL INC	Rio Arriba	medical facility
JICARILLA EMERGENCY MEDICAL SERVICES	Rio Arriba	ambulance

JICARILLA SERVICE UNIT	Rio Arriba	medical facility
JICARILLA SERVICE UNIT	Rio Arriba	dental facility
SANTA CLARA HEALTH CENTER	Rio Arriba	medical facility
SANTA CLARA HEALTH CENTER	Rio Arriba	dental facility
SANTA CLARA PUEBLO	Rio Arriba	medical facility
DBHS SHIPROCK TRTMNT CTR OUTPATIENT	San Juan	medical facility
DZILTH-NA-O-DITH-HLE HEALTH CENTER	San Juan	medical facility
DZILTH-NA-O-DITH-HLE HEALTH CENTER	San Juan	dental facility
NORTHERN NAVAJO MEDICAL CENTER	San Juan	medical facility
NORTHERN NAVAJO MEDICAL CENTER	San Juan	dental facility
NORTHERN NAVAJO MEDICAL CENTER	San Juan	ambulatory surgery
SANOSTEE HEALTH STATION	San Juan	medical facility
SANOSTEE HEALTH STATION	San Juan	dental facility
TOADLENA HEALTH STATION	San Juan	medical facility
TOADLENA HEALTH STATION	San Juan	dental facility
COCHITI HEALTH CLINIC	Sandoval	medical facility
CROWNPOINT-PUEBLO PINTADO CLI	Sandoval	medical facility
CROWNPOINT-PUEBLO PINTADO CLI	Sandoval	dental facility
FSIP INC BEHAVIORAL HEALTH SERVICES	Sandoval	medical facility
JEMEZ HEALTH CENTER	Sandoval	medical facility
JEMEZ HEALTH CENTER	Sandoval	dental facility
JEMEZ PUEBLO AMBULANCE SERVICES	Sandoval	ambulance
JEMEZ TRANSPORTATION	Sandoval	transportation
PUEBLO DE COCHITI	Sandoval	dental facility
PUEBLO OF JEMEZ	Sandoval	FQHC
PUEBLO OF SANDIA	Sandoval	medical facility
PUEBLO OF SANDIA	Sandoval	dental facility
SAN FELIPE HEALTH CLINIC	Sandoval	medical facility
SAN FELIPE PUEBLO	Sandoval	medical facility
SAN FELIPE PUEBLO	Sandoval	dental facility
SANTA ANA HEALTH CENTER	Sandoval	medical facility
SANTO DOMINGO BEHAVIORAL HLTH PROG	Sandoval	medical facility
SANTO DOMINGO HEALTH CENTER	Sandoval	medical facility
SANTO DOMINGO HEALTH CENTER	Sandoval	dental facility
ZIA HEALTH CENTER	Sandoval	medical facility
SANTA FE INDIAN HOSPITAL	Santa Fe	medical facility
SANTA FE INDIAN HOSPITAL	Santa Fe	dental facility
SANTA FE INDIAN SCHOOL	Santa Fe	medical facility
ALAMO NAVAJO HEALTH CENTER	Socorro	medical facility
ALAMO NAVAJO HEALTH CENTER	Socorro	dental facility

BUTTERFLY HEALING CENTER	Taos	
TAOS PUEBLO HEALTH COMM SVCS DIV	Taos	medical facility
TAOS/PICURIS HEALTH CENTER	Taos	medical facility
TAOS/PICURIS HEALTH CENTER	Taos	dental facility
PUEBLO OF ISLETA BEHAVIORAL HEALTH	Valencia	behavioral health

Healthcare Service Areas

New Mexico is divided into 33 counties. Most of the counties are rural in nature but have a single population center where the majority of the residents of the county reside. Usually, but not always, this population center is the county seat. In order to better identify the characteristics of each county, the number of population centers in each county are indicated on the following Table 7, unless the area is urban or semi-urban.

The population center may be small. The three smallest population centers in counties range between 1,606 and 2,999 residents.

Typically these small counties with low populations and small population centers rely on cities or towns in other areas for commercial interactions as wells as healthcare.

This plan considered the relationship that one county has with an adjacent county by including, in Table 7, areas where recipients may have additional healthcare resources available nearby. This inclusion is necessary to accurately reflect healthcare access in New Mexico.

In determining the service areas, the following were considered:

- Distance from a population center within the same county or an adjacent county.
- Travel time and difficulty to reach a population center with available medical services.
- Functional association between one area and another area with available medical services.
- Numbers and types of various medical service providers available in the service area in relation to the county population.

The analysis shows that most of the FFS population in rural areas lives within a one-hour drive-time to access primary health care services. (One hour of travel time in most areas of New Mexico would cover approximately 70 miles.) These services may be accessed in a nearby city or adjacent county, at an IHS or tribal health care provider, or in nearby cities

across state lines in a neighboring state. A one-hour drive-time is considered reasonable and accessible given the rural nature of New Mexico. This is consistent with drive-times for the general population in commercial healthcare plans in our large, highly-rural state, as well as for our managed care population. For the more isolated rural areas, more immediate access to emergency services as well as access to urgent care at night and on weekends is an ongoing concern for all individuals in those areas.

Table 3 (above) shows the distribution of FFS recipients in specific counties in New Mexico and the closest healthcare services areas to those counties. Table 7 (below) shows the approximate mileage to these additional healthcare resources. The miles stated is the distance from the largest population area in the county to the city or town indicated as having other available healthcare resources. The population for each county is from 2010 census data. Table 7 also notes the number of population centers in each county, as well as nearby population centers in adjacent counties, which constitute the "healthcare service area". Counties are identified as urban, semi-urban, and rural, with driving distances noted for the nearby health care service centers.

Table 7: NM Counties and " Healthcare Service Areas" with the number of population centers therein

Table 7. Additional Healthcare Service Areas Available to Residents of Each County

Main Beneficiary Residence County	Urban / Semi-Urban / Rural	County Popu-lation	Fee for Service Recip-ients	Number of Population Centers	Under-served Desig-nation	Other Cities and Towns with Healthcare Services Available to County Residents
Bernalillo	Urban	676,685	11,098	Urban Corridor	No	Bernalillo, Sandoval, and Valencia counties form an urban corridor in which the largest population centers essentially border each other. Albuquerque to Rio Rancho is 16 miles, Rio Rancho to Los Lunas is 38 miles; Albuquerque to Los Lunas is 25 miles. 43% of the state's population resides in this area.
Catron	Rural	3,456	27	0	Yes	Silver City - 98 miles; Socorro - 109 miles
Chaves	Semi-Urban	65,764	64	1	Yes	Artesia - 41 miles which is not underserved; Ruidoso 75 - miles
Cibola	Rural	27,329	4,945	1	Yes	Gallup - 57 miles; Albuquerque - 80 miles which is not underserved
Colfax	Rural	12,414	30	1	yes	Trinidad CO - 22 miles; Wagon Mound - 65 miles

Curry	Rural	50,398	48	1	No	Portales -19 miles; Fort Sumner - 57 miles
De Baca	Rural	1,828	7	1	Yes	Clovis - 57 miles which is not underserved
Dona Ana	Urban	214,295	360	1	Partially	El Paso TX - 63 miles
Eddy	Rural	57,578	97	2	No	Hobbs, a semi urban area - 78 miles
Grant	Rural	28,609	52	1	No	Lordsburg miles - 41 miles; Deming - 53 miles
Guadalupe	Rural	4,371	8	1	Yes	Las Vegas 57 -miles; Tucumcari - 58 miles
Harding	Rural	698	0	0	Yes	Wagon Mound 35 miles; Clayton 88 miles; Tucumcari 92 miles
Hidalgo	Rural	4,423	3	1	Yes	Silver City - 37 miles; Deming - 58 miles
Lea	Semi-Urban	71,180	64	1	Yes	Alamogordo - 70 miles; Seminole TX - 29 miles
Lincoln	Rural	19,420	245	1	Yes	Alamogordo - 51 miles; Roswell - 75 miles
Los Alamos	Urban	17,785	21	1	No	Espanola - 18 miles; Santa Fe - 33 miles
Luna	Rural	24,518	63	1	No	Las Cruces (urban area) - 52 miles; Silver City - 53 miles; Lordsburg - 58 miles
McKinley	Rural	76,708	25,221	1	Yes	Window Rock AZ 26 miles; Ft. Defiance AZ 31 miles; Grants 62 miles
Mora	Rural	4,596	15	1	Yes	Las Vegas - 43 miles
Otero	Rural	64,362	2,064	1	No	Ruidoso 58 - miles; El Paso TX - 66 miles
Quay	Rural	8,455	19	1	Yes	Santa Rosa - 60 miles
Rio Arriba	Rural	39,465	2,376	1	Partially	Santa Fe - 25 miles
Roosevelt	Rural	19,120	55	1	Yes	Clovis - 57 miles
San Juan	Semi-Urban	118,737	19,948	2	Yes	Durango CO - 51 miles
San Miguel	Rural	27,967	148	1	No	Santa Fe - 63 miles
Sandoval	Urban	139,394	7,356	Urban Corridor	Partially	Bernalillo, Sandoval, and Valencia counties form an urban corridor in which the largest population centers essentially border each other. Albuquerque to Rio Rancho is 16 miles, Rio Rancho to Los Lunas is 38 miles; Albuquerque to Los Lunas is 25 miles. 43% of the state's population resides in this area.
Santa Fe	Urban	148,686	1,505	1	Partially	Albuquerque - 64 miles; Rio Rancho - 57 miles
Sierra	Rural	11,282	33	1	Yes	Las Cruces - 64 miles
Socorro	Rural	17,256	1,019	1	Yes	Belen NM 43 miles; Los Lunas - 52 miles; Albuquerque 78 miles

Taos	Rural	32,907	663	1	No	Santa Fe - 69 miles
Torrance	Rural	15,485	98	1	Yes	Albuquerque - 38 miles; Santa Rosa - 54 miles
Union	Rural	4,201	3	1	Yes	Boise City OK - 43 miles; Raton - 83 miles
Valencia	Urban	75,737	663	Urban Corridor	Yes	Bernalillo, Sandoval, and Valencia counties form an urban corridor in which the largest population centers essentially border each other. Albuquerque to Rio Rancho is 16 miles, Rio Rancho to Los Lunas is 38 miles; Albuquerque to Los Lunas is 25 miles. 43% of the state's population resides in this area.
TOTALS:		**2,085,109**	**78,318**			

When available, the categorization of NM counties by the Health Resource and Services Administration (HRSA) with regards to access to preventive and primary healthcare services is noted. The Health Professional Shortage Areas (HPSAs) are designated by HRSA based on shortages of providers and may be based solely on the county resources without always considering the medical services available in adjacent counties. Of the 33 counties in New Mexico, HRSA considers 20 counties as “underserved” and four counties as “partially underserved.”

Analysis of Provider Access for Six Service Categories

In this access review, we looked at six categories of health care services and the providers of those services:

- Primary Care services
- Physician Specialist services
- Behavioral Health services
- Pre- and post-Natal Obstetric services, including labor and delivery
- Home Health services
- Dental Health services

In evaluating access to care, we considered the Medicaid FFS recipients and numbers and types of providers within each county. Those tables (tables A) are labelled “County Area Only”. However, as stated above, in order to understand healthcare access to recipients there is always a second table (tables B) labelled “Healthcare Service Area” which counts the healthcare providers that are available to recipients in the county as well as the expanded healthcare service areas for each county as indicated in Table 7.

The following service categories were analyzed to compare the number of Medicaid FFS recipients by county to the number of providers in the county and surrounding service areas, as noted above in Table 7 (above).

Data for the following tables are from the NM Medicaid provider enrollment system and the NM Medicaid recipient enrollment system.

TABLE 8 A -COUNTY AREA ONLY - PRIMARY CARE

COUNTIES		POPULATION			PRIMARY CARE PROVIDERS IN COUNTY							
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMERI-CANS	NON NAT-IVE AMER I-CANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTITIONERS	SCHOOLS	SCHOOL BASED HEALTH CENTERS	TOTAL
Bernalillo		11,030	68	11,098	5	3	9	98	2,048	3	10	**2,176**
Catron	underserved	27		27			2		3			**5**
Chaves	underserved	61	3	64	2		3	23	129	1	4	**162**
Cibola	underserved	4,944	1	4,945	1	3	2	4	53	2		**65**
Colfax	underserved	30		30	1		1	4	36	1	2	**45**
Curry		47	1	48	1		2	12	93	1		**109**
De Baca	underserved	7		7			1	1	4		1	**7**
Dona Ana	partially	345	15	360	2		19	48	339	2	4	**414**
Eddy		85	12	97	2		5	14	83	3		**107**
Grant		51	1	52	1		8	6	56	2		**73**
Guadalupe	underserved	8		8	1		1	2	8	1	1	**14**
Harding	underserved			0			1		2		1	**4**
Hidalgo	underserved	3		3			3	1	5			**9**
Lea	underserved	57	7	64	2		4	10	75	2		**93**
Lincoln	underserved	242	3	245	1		3	4	31	1	1	**41**
Los Alamos		21		21	1			9	48			**58**
Luna		62	1	63	1		4	8	24			**37**
McKinley	underserved	25,221		25,221	1	6	4	6	265	2		**284**
Mora	underserved	15		15			2	1	8	1	1	**13**
Otero		2,062	2	2,064	1	1	5	9	89	2		**107**
Quay	underserved	18	1	19	1		1	5	38	1	1	**47**
Rio Arriba	partially	2,366	10	2,376	1	4	11	5	66	5	1	**93**
Roosevelt	underserved	55		55	1		2	4	25	1		**33**
Sandoval	partially	7,347	9	7,356	1	10	9	7	137	3	2	**169**
San Juan	underserved	19,940	8	19,948	1	4	1	25	261	4		**296**
San Miguel		145	3	148	1		6	9	55	4	2	**77**
Santa Fe	partially	1,480	25	1,505	1	2	8	59	315	3		**388**
Sierra	underserved	33		33			3	6	25	1		**35**
Socorro	underserved	1,016	3	1,019	1	1	3	2	38	1		**46**
Taos		663		663	1	2	8	10	91	4	2	**118**
Torrance	underserved	98		98			3	1	12	1	1	**18**
Union	underserved	3		3	1			2	4			**7**
Valencia	underserved	658	5	663			2	6	42	2	1	**53**
Total		**78,140**	**178**	**78,318**	**33**	**36**	**136**	**401**	**4,508**	**54**	**35**	**5,203**

TABLE 8 B - HEALTHSERVICE AREA - PRIMARY CARE												
COUNTIES		POPULATION			PRIMARY CARE PROVIDERS IN SERVICE AREA							
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMERI-CANS	NON NAT-IVE AMER I-CANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTITIONERS	SCHOOLS	SCHOOL BASED HEALTH CENTERS	TOTAL
Bernalillo		11,030	68	11,098	6	14	20	111	2227	8	13	2399
Catron	underserved	27		27	2	1	13	8	97	3	0	124
Chaves	underserved	61	3	64	4	0	5	27	179	4	5	224
Cibola	underserved	4,944	1	4,945	7	12	15	107	2366	7	10	2524
Colfax	underserved	30		30	2	0	4	6	49	2	3	66
Curry		47	1	48	2	0	5	16	122	2	1	148
De Baca	underserved	7		7	1	0	3	12	97	1	1	115
Dona Ana	partially	345	15	360	12	0	19	125	730	2	4	892
Eddy		85	12	97	4	0	9	24	158	5	0	200
Grant		51	1	52	2	0	15	15	85	2	0	119
Guadalupe	underserved	8		8	3	0	8	16	101	6	4	138
Harding	underserved			0	2	0	4	8	52	2	3	71
Hidalgo	underserved	3		3	2	0	15	15	85	2	0	119
Lea	underserved	57	7	64	5	0	9	26	172	5	0	217
Lincoln	underserved	242	3	245	3	0	4	27	155	2	5	196
Los Alamos		21		21	3	4	12	72	407	5	1	504
Luna		62	1	63	4	0	34	63	424	4	4	533
McKinley	underserved	25,221		25,221	2	19	6	10	318	4	0	359
Mora	underserved	15		15	1	0	8	10	63	5	3	90
Otero		2,062	2	2,064	12	1	5	91	509	3	1	622
Quay	underserved	18	1	19	2	0	2	7	46	2	2	61
Rio Arriba	partially	2,366	10	2,376	2	6	19	63	381	8	1	480
Roosevelt	underserved	55		55	2	0	4	16	118	2	0	142
Sandoval	partially	7,347	9	7,356	6	14	20	107	2227	8	13	2395
San Juan	underserved	19,940	8	19,948	3	4	1	39	338	4	0	389
San Miguel		145	3	148	2	3	14	68	370	7	2	466
Santa Fe	partially	1,480	25	1,505	7	13	26	165	2500	9	12	2732
Sierra	underserved	33		33	2	0	22	53	364	3	4	448
Socorro	underserved	1,016	3	1,019	6	4	14	104	2108	6	10	2252
Taos		663		663	2	4	16	70	406	7	2	507
Torrance	underserved	98		98	3	2	13	98	2048	5	11	2180
Union	underserved	3		3	2	0	1	6	40	1	2	52
Valencia	underserved	658	5	663	6	18	20	111	2227	8	13	2403
Total		**78,140**	**178**	**78,318**	**124**	**119**	**385**	**1,696**	**21,569**	**144**	**130**	**24,167**

TABLE 9 A: COUNTY AREA ONLY - SPECIALTY CARE

COUNTIES		POPULATION			SPECIALTY PROVIDERS IN COUNTY					
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION (none establish-ed)	NATIVE AMERI-CANS	NON NATIVE AMERI-CANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTITIONERS	TOTAL
Bernalillo		11,030	68	11,098	5	unknown	9	110	1,404	**1,528**
Catron		27		27			2			**2**
Chaves		61	3	64	2		3	12	68	**85**
Cibola		4,944	1	4,945	1	unknown	2	2	6	**11**
Colfax		30		30	1		1	4	23	**29**
Curry		47	1	48	1		2	7	54	**64**
De Baca		7		7			1			**1**
Dona Ana		345	15	360	2		19	47	207	**275**
Eddy		85	12	97	2		5	6	55	**68**
Grant		51	1	52	1		8	4	28	**41**
Guadalupe		8		8	1		1		1	**3**
Harding				0			1			**1**
Hidalgo		3		3			3		1	**4**
Lea		57	7	64	2		4	8	35	**49**
Lincoln		242	3	245	1		3		16	**20**
Los Alamos		21		21	1			3	36	**40**
Luna		62	1	63	1		4	3	14	**22**
McKinley		25,221		25,221	1	unknown	4	4	201	**210**
Mora		15		15			2			**2**
Otero		2,062	2	2,064	1	unknown	5	6	53	**65**
Quay		18	1	19	1		1	1	16	**19**
Rio Arriba		2,366	10	2,376	1	unknown	11		22	**34**
Roosevelt		55		55	1		2		6	**9**
Sandoval		7,347	9	7,356	1	unknown	9	10	55	**75**
San Juan		19,940	8	19,948	1	unknown	1	22	203	**227**
San Miguel		145	3	148	1		6	4	22	**33**
Santa Fe		1,480	25	1,505	1	unknown	8	40	200	**249**
Sierra		33		33			3	2	6	**11**
Socorro		1,016	3	1,019	1	unknown	3		16	**20**
Taos		663		663	1	unknown	8	4	51	**64**
Torrance		98		98			3		2	**5**
Union		3		3	1				3	**4**
Valencia		658	5	663		unknown	2	2	5	**9**
Total		**78,140**	**178**	**78,318**	**33**	unknown	**136**	**301**	**2,809**	**3,279**

TABLE 9 B: HEALTHCARE SERVICE AREAS - SPECIALTY CARE

COUNTIES		POPULATION			SPECIALTY PROVIDERS IN SERVICE AREA					
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION (none establish-ed)	NATIVE AMERI-CANS	NON NATIVE AMERI-CANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTITIONERS	TOTAL
Bernalillo		11,030	68	11,098	6	unknown	20	122	1464	1606
Catron		27		27	2	unknown	13	4	44	61
Chaves		61	3	64	4	0	5	12	98	115
Cibola		4,944	1	4,945	7	unknown	15	116	1611	1742
Colfax		30		30	2	0	4	4	24	32
Curry		47	1	48	2	0	5	7	60	72
De Baca		7		7	1	0	3	7	54	64
Dona Ana		345	15	360	12	0	19	123	662	804
Eddy		85	12	97	4	0	9	14	90	113
Grant		51	1	52	2	0	15	7	43	65
Guadalupe		8		8	3	0	8	5	39	52
Harding				0	2	0	4	1	19	24
Hidalgo		3		3	2	0	15	7	43	65
Lea		57	7	64	5	0	9	14	93	116
Lincoln		242	3	245	3	0	4	12	86	102
Los Alamos		21		21	3	unknown	12	43	256	311
Luna		62	1	63	4	0	34	54	250	338
McKinley		25,221		25,221	2	unknown	6	6	207	219
Mora		15		15	1	0	8	4	22	34
Otero		2,062	2	2,064	12	unknown	5	82	525	612
Quay		18	1	19	2	0	2	1	17	20
Rio Arriba		2,366	10	2,376	2	unknown	19	40	222	281
Roosevelt		55		55	2	0	4	7	60	71
Sandoval		7,347	9	7,356	6	unknown	20	122	1464	1606
San Juan		19,940	8	19,948	3	unknown	1	41	284	326
San Miguel		145	3	148	2	unknown	14	44	222	280
Santa Fe		1,480	25	1,505	7	unknown	26	160	1659	1845
Sierra		33		33	2	0	22	49	213	284
Socorro		1,016	3	1,019	6	unknown	14	109	1412	1535
Taos		663		663	2	unknown	16	44	251	311
Torrance		98		98	6	unknown	13	107	1394	1514
Union		3		3	2	0	1	4	26	31
Valencia		658	5	663	6	unknown	20	122	1464	1606
Total		**78,140**	**178**	**78,318**	**127**	unknown	**385**	**1,494**	**14,378**	**16,257**

TABLE 10 A: COUNTY AREA ONLY - OBSTETRICAL CARE

COUNTIES		POPULATION			OBSTETRICAL PROVIDERS IN COUNTY					
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION (none estab-lished)	NATIVE AMERI-CANS	NON NATIVE AMERI-CANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS OBSTETRICS	INDIVIDUAL PRACTITIONERS OBSTETRICS	TOTAL
Bernalillo		11,030	68	11,098	5		9	12	253	**279**
Catron		27		27			2			**2**
Chaves		61	3	64	2		3		8	**13**
Cibola		4,944	1	4,945	1		2	1	3	**7**
Colfax		30		30	1		1		6	**8**
Curry		47	1	48	1		2		10	**13**
De Baca		7		7			1			**1**
Dona Ana		345	15	360	2		19	3	50	**74**
Eddy		85	12	97	2		5	1	9	**17**
Grant		51	1	52	1		8		7	**16**
Guadalupe		8		8	1		1			**2**
Harding				0			1			**1**
Hidalgo		3		3			3		1	**4**
Lea		57	7	64	2		4	1	4	**11**
Lincoln		242	3	245	1		3		2	**6**
Los Alamos		21		21	1			1	3	**5**
Luna		62	1	63	1		4	1	3	**9**
McKinley		25,221		25,221	1	3	4		33	**41**
Mora		15		15			2			**2**
Otero		2,062	2	2,064	1		5		8	**14**
Quay		18	1	19	1		1			**2**
Rio Arriba		2,366	10	2,376	1		11	1	7	**20**
Roosevelt		55		55	1		2		1	**4**
Sandoval		7,347	9	7,356	1		9		7	**17**
San Juan		19,940	8	19,948	1	1	1	5	31	**39**
San Miguel		145	3	148	1		6	1	8	**16**
Santa Fe		1,480	25	1,505	1		8	5	27	**41**
Sierra		33		33			3		1	**4**
Socorro		1,016	3	1,019	1		3		6	**10**
Taos		663		663	1		8	3	9	**21**
Torrance		98		98			3			**3**
Union		3		3	1					**1**
Valencia		658	5	663			2		2	**4**
Total		**78,140**	**178**	**78,318**	**33**	**4**	**136**	**35**	**499**	**707**

TABLE 10 B: HEALTHCARE SERVICE AREA - OBSTETRICAL CARE (counts are for IHS and Tribal Facilities are labor and delivery - additional sites provide prenatal care but not delivery)

COUNTIES		POPULATION			OBSTETRICAL PROVIDERS IN SERVICE AREA					
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION (none estab-lished)	NATIVE AMERICANS	NON NATIVE AMERICANS	TOTAL	Hospital ER	IHS or TRIBAL FACILITIES	FQHCS, RHC, HB-RHC	GROUP PRACTICES and OTHER CLINICS OBSTETRICS	INDIVIDUAL PRACTITIONERS OBSTETRICS	TOTAL
Bernalillo		11,030	68	11,098	6		20	12	262	294
Catron		27		27	2		13	0	13	26
Chaves		61	3	64	4		5	0	11	16
Cibola		4,944	1	4,945	7		15	13	289	317
Colfax		30		30	2		4	0	7	11
Curry		47	1	48	2		5	0	11	16
De Baca		7		7	1		3	0	10	13
Dona Ana		345	15	360	12		19	21	106	146
Eddy		85	12	97	4		9	2	13	24
Grant		51	1	52	2		15	1	11	27
Guadalupe		8		8	3		8	1	8	17
Harding				0	2		4	0	0	4
Hidalgo		3		3	2		15	1	11	27
Lea		57	7	64	5		9	3	14	26
Lincoln		242	3	245	3		4	0	10	14
Los Alamos		21		21	3		12	7	37	56
Luna		62	1	63	4		34	4	61	99
McKinley		25,221		25,221	2	3	6	1	36	46
Mora		15		15	1		8	1	8	17
Otero		2,062	2	2,064	12		5	18	66	89
Quay		18	1	19	2		2	0	0	2
Rio Arriba		2,366	10	2,376	2		19	6	34	59
Roosevelt		55		55	2		4	0	11	15
Sandoval		7,347	9	7,356	6		20	12	262	294
San Juan		19,940	8	19,948	3	1	1	8	45	55
San Miguel		145	3	148	2		14	6	35	55
Santa Fe		1,480	25	1,505	7		26	17	287	330
Sierra		33		33	2		22	3	51	76
Socorro		1,016	3	1,019	6		14	11	252	277
Taos		663		663	2		16	8	36	60
Torrance		98		98	6		13	11	244	268
Union		3		3	2		1	0	6	7
Valencia		658	5	663	6		20	12	262	294
Total		**78,140**	**178**	**78,318**	**127**	**4**	**385**	**179**	**2,509**	**3,077**

TABLE 11 A: COUNTY AREA ONLY - BEHAVIORAL HEALTH SERVICES

COUNTIES		POPULATION			BEHAVIORAL HEALTH PROVIDERS IN COUNTY								
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMER-ICANS	NON NATIVE AMER-ICANS	TOTAL	IHS & Tribal Facilities with BH services	FQHCS, RHC, HB-RHC with BH Services	Psych Hospitals or Units	BH Agencies, CMHCs, Core Service Agencies	BH Group Practices	BH INDIVIDUAL PRACTITIONERS	Schools	School Based Health Centers	TOTAL
Bernalillo		11,030	68	11,098	2	3	4	91	104	1,687	3	10	**1,904**
Catron	underserved	27		27		2				2			**4**
Chaves	underserved	61	3	64		1		7	7	55	1	4	**75**
Cibola	underserved	4,944	1	4,945	4	2		2	1	21	2		**32**
Colfax	underserved	30		30		1		1	2	20	1	2	**27**
Curry		47	1	48				6	3	70	1		**80**
De Baca	underserved	7		7		1		1		5		1	**8**
Dona Ana	partially	345	15	360		13	2	25	30	375	2	4	**451**
Eddy		85	12	97		4		8		52	3		**67**
Grant		51	1	52		2	1	7	1	73	2		**86**
Guadalupe	underserved	8		8						7	1	1	**9**
Harding	underserved			0								1	**1**
Hidalgo	underserved	3		3		1				4			**5**
Lea	underserved	57	7	64		1	1	2	1	49	2		**56**
Lincoln	underserved	242	3	245				2	1	21	1	1	**26**
Los Alamos		21		21				1	2	17			**20**
Luna		62	1	63		1		1		19			**21**
McKinley	underserved	25,221		25,221	6	4		2	2	61	2		**77**
Mora	underserved	15		15		2				5	1	1	**9**
Otero		2,062	2	2,064	1	4	1	4	3	84	2		**99**
Quay	underserved	18	1	19				3	2	8	1	1	**15**
Rio Arriba	partially	2,366	10	2,376	3	8		5	1	59	5	1	**82**
Roosevelt	underserved	55		55		1		2	2	17	1		**23**
Sandoval	partially	7,347	9	7,356	9	8		12	16	189	3	2	**239**
San Juan	underserved	19,940	8	19,948	2	1		8	8	143	4		**166**
San Miguel		145	3	148		3		7	1	78	4	2	**95**
Santa Fe	partially	1,480	25	1,505	2	7	1	28	24	433	3		**498**
Sierra	underserved	33		33				4		42	1		**47**
Socorro	underserved	1,016	3	1,019	1	2		1		12	1		**17**
Taos		663		663	1	7		8	9	110	4	2	**141**
Torrance	underserved	98		98		3		1		23	1	1	**29**
Union	underserved	3		3						3			**3**
Valencia	underserved	658	5	663	1			5	4	70	2	1	**83**
Total		**78,140**	**178**	**78,318**	**32**	**82**	**10**	**244**	**224**	**3,814**	**54**	**35**	**4,495**

TABLE 11 B: HEALTHCARE SERVICE AREA - BEHAVIORAL HEALTH SERVICES

COUNTIES		POPULATION			BEHAVIORAL HEALTH PROVIDERS IN SERVICE AREA								
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMER-ICANS	NON NATIVE AMER-ICANS	TOTAL	IHS & Tribal Facilities with BH services	FQHCS, RHC, HB-RHC with BH Services	Psych Hospitals or Units	BH Agencies, CMHCs, Core Service Agencies	BH Group Practices	BH INDIVIDUAL PRACTITIONERS	Schools	School Based Health Centers	TOTAL
Bernalillo		11,030	68	11,098	12	11	4	108	124	1945	8	13	2225
Catron	underserved	27		27	1	6	1	8	1	87	3	0	107
Chaves	underserved	61	3	64	0	3	0	9	8	95	4	5	124
Cibola	underserved	4,944	1	4,945	12	9	4	95	107	1768	7	10	2012
Colfax	underserved	30		30	0	3	0	1	2	25	2	3	36
Curry		47	1	48	0	2	0	9	5	92	2	1	111
De Baca	underserved	7		7	0	1	0	7	3	75	1	1	88
Dona Ana	partially	345	15	360	0	13	3	31	39	427	2	4	519
Eddy		85	12	97	0	5	1	10	1	101	5	0	123
Grant		51	1	52	0	4	1	8	1	96	2	0	112
Guadalupe	underserved	8		8	0	3	0	10	3	93	6	4	119
Harding	underserved			0	0	2	0	3	2	16	2	3	28
Hidalgo	underserved	3		3	0	4	1	8	1	96	2	0	112
Lea	underserved	57	7	64	0	5	1	10	1	101	5	0	123
Lincoln	underserved	242	3	245	0	1	0	9	7	74	2	5	98
Los Alamos		21		21	3	10	1	33	27	499	5	1	579
Luna		62	1	63	0	17	3	33	31	471	4	4	563
McKinley	underserved	25,221		25,221	10	6	0	4	3	82	4	0	109
Mora	underserved	15		15	0	5	0	7	1	83	5	3	104
Otero		2,062	2	2,064	1	4	2	11	13	157	3	1	192
Quay	underserved	18	1	19	0	0	0	3	2	15	2	2	24
Rio Arriba	partially	2,366	10	2,376	5	15	1	33	25	491	8	1	579
Roosevelt	underserved	55		55	0	1	0	8	5	87	2	0	103
Sandoval	partially	7,347	9	7,356	12	11	4	108	124	1945	8	13	2225
San Juan	underserved	19,940	8	19,948	2	1	0	9	10	149	4	0	175
San Miguel		145	3	148	2	10	1	35	25	511	7	2	593
Santa Fe	partially	1,480	25	1,505	13	18	5	131	144	2308	9	12	2640
Sierra	underserved	33		33	0	13	2	29	30	417	3	4	498
Socorro	underserved	1,016	3	1,019	3	5	4	96	101	1733	6	10	1958
Taos		663		663	3	14	1	36	33	543	7	2	639
Torrance	underserved	98		98	1	6	4	91	97	1681	5	11	1896
Union	underserved	3		3	0	1	0	1	2	23	1	2	30
Valencia	underserved	658	5	663	12	11	4	108	124	1945	8	13	2225
Total		**78,140**	**178**	**78,318**	**92**	**220**	**48**	**1,102**	**1,102**	**18,231**	**144**	**130**	**21,069**

TABLE 12 A: COUNTY AREA ONLY - DENTAL SERVICES

COUNTIES		POPULATION			DENTAL PROVIDERS IN COUNTY				
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMER-ICANS	NON NATIVE AMERICANS	TOTAL	IHS or TRIBAL FACILITIES with Dental Services	FQHCS, RHC, HB-RHC with Dental Services	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTIONERS	TOTAL
Bernalillo	partially	11,030	68	11,098	3	3	79	258	**343**
Catron	underserved	27		27		1			**1**
Chaves		61	3	64		1	5	17	**23**
Cibola	underserved	4,944	1	4,945	4		2	13	**19**
Colfax		30		30			1	3	**4**
Curry		47	1	48		2	4	12	**18**
De Baca	underserved	7		7		2		3	**5**
Dona Ana	partially	345	15	360		9	15	57	**81**
Eddy		85	12	97		1	3	26	**30**
Grant		51	1	52		3		5	**8**
Guadalupe	underserved	8		8			1		**1**
Harding	underserved			0					**0**
Hidalgo	underserved	3		3		2		5	**7**
Lea	underserved	57	7	64			3	12	**15**
Lincoln		242	3	245		2	1	3	**6**
Los Alamos		21		21			2	1	**3**
Luna	underserved	62	1	63		2	3	7	**12**
McKinley		25,221		25,221	5		6	47	**58**
Mora	underserved	15		15		2		2	**4**
Otero	underserved	2,062	2	2,064	1	1		4	**6**
Quay	underserved	18	1	19				2	**2**
Rio Arriba	partially	2,366	10	2,376	2	3	2	16	**23**
Roosevelt		55		55		2	2	6	**10**
Sandoval		7,347	9	7,356	7	1	8	41	**57**
San Juan		19,940	8	19,948	3	1	13	64	**81**
San Miguel		145	3	148		3	3	7	**13**
Santa Fe	partially	1,480	25	1,505	1	4	9	46	**60**
Sierra	underserved	33		33		2		3	**5**
Socorro	underserved	1,016	3	1,019	1			2	**3**
Taos		663		663	1	1	2	12	**16**
Torrance	underserved	98		98		2		2	**4**
Union	underserved	3		3					**0**
Valencia		658	5	663		1	6	48	**55**
Total		**78,140**	**178**	**78,318**	**28**	**51**	**170**	**724**	**973**

TABLE 12 B: HEALTHCARE SERVICE AREA - DENTAL SERVICES

COUNTIES		POPULATION			DENTAL PROVIDERS IN HEALTHCARE SERVICE AREA				
RECIPIENT RESIDENCE AREA	HRSA DESIG-NATION	NATIVE AMERI-CANS	NON NATIVE AMERI-CANS	TOTAL	IHS or TRIBAL FACILITIES with Dental Services	FQHCS, RHC, HB-RHC with Dental Services	GROUP PRACTICES and OTHER CLINICS	INDIVIDUAL PRACTIONERS	TOTAL
Bernalillo	partially	11,030	68	11,098	10	5	93	347	455
Catron	underserved	27		27	1	4	0	7	12
Chaves		61	3	64	0	2	6	21	29
Cibola	underserved	4,944	1	4,945	12	3	87	318	420
Colfax		30		30	0	2	1	5	8
Curry		47	1	48	0	6	6	21	33
De Baca	underserved	7		7	0	4	4	15	23
Dona Ana	partially	345	15	360	0	9	38	141	188
Eddy		85	12	97	0	1	6	38	45
Grant		51	1	52	0	7	3	17	27
Guadalupe	underserved	8		8	0	3	4	9	16
Harding	underserved			0	0	2	0	4	6
Hidalgo	underserved	3		3	0	7	3	17	27
Lea	underserved	57	7	64	0	1	6	38	45
Lincoln		242	3	245	0	3	7	19	29
Los Alamos		21		21	2	5	12	51	70
Luna	underserved	62	1	63	0	16	18	74	108
McKinley		25,221		25,221	9	0	8	60	77
Mora	underserved	15		15	0	5	3	9	17
Otero	underserved	2,062	2	2,064	1	1	24	89	115
Quay	underserved	18	1	19	0	0	1	2	3
Rio Arriba	partially	2,366	10	2,376	3	7	11	62	83
Roosevelt		55		55	0	4	6	18	28
Sandoval		7,347	9	7,356	10	5	93	347	455
San Juan		19,940	8	19,948	3	1	14	69	87
San Miguel		145	3	148	1	7	12	53	73
Santa Fe	partially	1,480	25	1,505	11	8	96	345	460
Sierra	underserved	33		33	0	11	15	60	86
Socorro	underserved	1,016	3	1,019	2	4	84	303	393
Taos		663		663	2	5	11	58	76
Torrance	underserved	98		98	1	5	79	255	340
Union	underserved	3		3	0	0	1	3	4
Valencia		658	5	663	10	5	93	347	455
Total		**78,140**	**178**	**78,318**	**78**	**148**	**845**	**3,222**	**4,293**

TABLE 13 A: COUNTY AREA ONLY - HOME HEALTH

COUNTIES		POPULATION			HOME HEALTH
RECIPIENT RESIDENCE AREA	HRSA DESIGNATION	NATIVE AMERICANS	NON NATIVE AMERICANS	TOTAL	AGENCIES
Bernalillo	not established	11,030	68	11,098	9
Catron	not established	27		27	
Chaves	not established	61	3	64	5
Cibola	not established	4,944	1	4,945	
Colfax	not established	30		30	
Curry	not established	47	1	48	3
De Baca	not established	7		7	
Dona Ana	not established	345	15	360	11
Eddy	not established	85	12	97	6
Grant	not established	51	1	52	2
Guadalupe	not established	8		8	
Harding	not established			0	
Hidalgo	not established	3		3	
Lea	not established	57	7	64	3
Lincoln	not established	242	3	245	1
Los Alamos	not established	21		21	1
Luna	not established	62	1	63	1
McKinley	not established	25,221		25,221	2
Mora	not established	15		15	2
Otero	not established	2,062	2	2,064	2
Quay	not established	18	1	19	1
Rio Arriba	not established	2,366	10	2,376	1
Roosevelt	not established	55		55	1
Sandoval	not established	7,347	9	7,356	
San Juan	not established	19,940	8	19,948	5
San Miguel	not established	145	3	148	2
Santa Fe	not established	1,480	25	1,505	1
Sierra	not established	33		33	1
Socorro	not established	1,016	3	1,019	1
Taos	not established	663		663	1
Torrance	not established	98		98	
Union	not established	3		3	1
Valencia	not established	658	5	663	1
Total		**78,140**	**178**	**78,318**	**64**

TABLE 13 B: HEALTHCARE SERVICE AREA - HOME HEALTH

COUNTIES		POPULATION			HOME HEALTH
RECIPIENT RESIDENCE AREA	HRSA DESIGNATION	NATIVE AMERICANS	NON NATIVE AMERICANS	TOTAL	AGENCIES
Bernalillo	not established	11,030	68	11,098	10
Catron	not established	27		27	3
Chaves	not established	61	3	64	7
Cibola	not established	4,944	1	4,945	11
Colfax	not established	30		30	2
Curry	not established	47	1	48	4
De Baca	not established	7		7	3
Dona Ana	not established	345	15	360	11
Eddy	not established	85	12	97	9
Grant	not established	51	1	52	3
Guadalupe	not established	8		8	3
Harding	not established			0	4
Hidalgo	not established	3		3	3
Lea	not established	57	7	64	9
Lincoln	not established	242	3	245	6
Los Alamos	not established	21		21	3
Luna	not established	62	1	63	14
McKinley	not established	25,221		25,221	2
Mora	not established	15		15	4
Otero	not established	2,062	2	2,064	3
Quay	not established	18	1	19	1
Rio Arriba	not established	2,366	10	2,376	2
Roosevelt	not established	55		55	4
Sandoval	not established	7,347	9	7,356	10
San Juan	not established	19,940	8	19,948	5
San Miguel	not established	145	3	148	3
Santa Fe	not established	1,480	25	1,505	10
Sierra	not established	33		33	12
Socorro	not established	1,016	3	1,019	11
Taos	not established	663		663	2
Torrance	not established	98		98	9
Union	not established	3		3	1
Valencia	not established	658	5	663	10
Total		**78,140**	**178**	**78,318**	**194**

Summary

This Access Monitoring Review Plan analyzed access to providers of healthcare services in 2015 for New Mexico Medicaid FFS recipients.

The Medicaid provider rates for practitioners were compared with the Medicare rates applicable to New Mexico for essentially the same time period.

HSD/MAD analyzed access issues that have been reported to the Medicaid program by recipients who may be seeking assistance in locating providers.

HSD/MAD analyzed the number of providers in six distinct healthcare service categories in relation to the number of recipients in their geographical health care service areas.

The analysis indicates nearly all (99.9%) Medicaid FFS recipients are Native Americans who have not opted-in to the Centennial Care program. This population is split nearly in half by adults (52% age 18 and over) and children (42% age 17 and under).

HSD/MAD reviewed the Merritt Hawkins report "A Review of Physician-to-Population Ratios" (http://www.merritthawkins.com/pdf/a-review-of-physician-to-population-ratios.pdf) which reports the number of physicians required per 100,000 population from four different sources:

- Graduate Medical Education National Advisory Committee
- David Goodman, MD., JAMA
- Hicks & Glenn, Journal of Health Care Management
- Solucient (now Thompson Healthcare)

MAD also reviewed the CMS guidelines and standards in miles and driving time for accessing providers within Medicaid managed care programs.

Under all these standards and with these comparisons it appears that the New Mexico Medicaid program fee-for-service population has access to medical services when considering services available in neighboring counties making up the Healthcare Service Areas and the presence and location of IHS and other Tribal Healthcare Facilities. There is a shortage of healthcare providers over all in rural areas, particularly for very specialized physician services, but the access for Medicaid recipients appears comparable to other populations. This is largely due to the presence of IHS and Tribal Healthcare Facilities in critical areas to meet the needs of the Native American population. HSD/MAD will work with IHS and Tribal Leaders to obtain a more detailed

understanding from the experience of Native American recipients, Indian Health Services, and other Tribal Healthcare providers regarding perceptions about access (or lack of) to providers, to specific services, and for referrals.

Further analyses of access to medical and healthcare services for the NM FFS population indicate the following:

Access to Medical Services:

- 98.1% of the FFS population resides within the 11 counties that have at least one or more IHS or tribal healthcare facilities and one or more FQHCs. When looking at the wider Healthcare Service Area, access to Medicaid healthcare providers is significantly enhanced.
- 20 counties do not have IHS or tribal healthcare facilities within the county area. However, these counties do have one or more FQHCs. 1.7% of the FFS population resides within these 18 counties. Again, when looking at the wider Healthcare Service Area, access to Medicaid healthcare providers is increased.
- The remaining 2 counties that have neither IHS or tribal health care facilities nor an FQHC are Union County with 3 Medicaid FFS recipients and Los Alamos County with 21 FFS recipients. Union County is served by a hospital with outpatient care services. Los Alamos County is not an underserved county so recipients have access to other providers.
- When looking at the wider Healthcare Service Area, there is no county in New Mexico that does not have at least one FQHC and/or one IHS or tribal health care facility.

Access to Behavioral Health Services:

- The study related to behavioral health only included IHS and tribal facilities as well as FQHCs if these providers bill for behavioral health services.
- There is one county in New Mexico, Harding county, that has no behavioral health providers of any kind. However, no FFS recipients reside in that county.

Access to Dental Services:

- There are 3 counties in New Mexico that do not have dental services available from either an IHS or tribal facility, an FQHC, or a dental practice or individual dentist. The FFS population in these counties is just 22 recipients. When the wider dental Healthcare Services Area is considered, that is, access in a nearby county, there is no county in New Mexico that does not have least one FQHC and/or one IHS or tribal health care facility or dental practice or individual dentist.

Access to Home Health Services:

- There are 9 counties in New Mexico without a Home Health Agency. Most of the home health services in New Mexico are delivered to the older population which is enrolled in Medicare and, therefore, enrolled in managed care rather than in the Medicaid FFS program. Use of Home Health Agency services in the fee for service program is very light even in areas where home health services are readily available, due to the nature of the fee for service population.
- There are 12,474 FFS recipients in these counties. 7,356 recipients are in Sandoval County which is in the urban corridor area, with the largest population essentially being a suburb of the Albuquerque area.
- When the wider Healthcare Service Area is considered, there is no county in New Mexico that does not have at least one Home Health Agency available to recipients residing in that county. There are, however, potential areas in New Mexico that are in more isolated parts of some counties for which it would be difficult to obtain home health services because of the isolated locations. However, this would be a comparable issue for all populations living in those isolated areas, not just the Medicaid fee for service recipients.

As stated earlier, most fee for service recipients, even in counties with low populations that are rural in nature, tend to live in or close to the population center of the county even when a town is small. When healthcare providers are available in those small population centers, they tend to see Medicaid recipients and non-Medicaid recipients alike as it is difficult to operate a healthcare practice or business of any kind in those areas without including the Medicaid population. In such areas, it is the small number of practitioners in these areas -- rather than comparability, i.e. an unwillingness of a provider to serve Medicaid recipients -- that may be an issue. The IHS facilities, other tribal healthcare facilities, FQHCs, rural health clinics, and hospital based rural health clinics are essential in assuring access to healthcare services in New Mexico.

Lastly, one program that shows promise in providing better access to healthcare for rural recipients is ***telehealth***. In 2015, telehealth services were utilized for the Medicaid FFS recipients in Bernalillo, Cibola, Dona Ana, McKinley, Otero, and Sandoval counties. Four Indian Health Service or tribal healthcare facilities utilized telehealth services as well. The most common use of telehealth services was for behavioral health. Expanding telehealth services across the state will most certainly strengthen the FFS recipients’ access to services.

Given that Native Americans are the primary users of the Medicaid FFS program, New Mexico's access goals for Medicaid FFS are to:

1. Ensure that Non-IHS/Non-Tribal providers are sufficient to accommodate referrals from IHS and Tribal Facilities.
2. Continue to develop the state wide network that makes services by telemedicine readily available to IHS and Tribal Facility settings.
3. Help assure that IHS and Tribal Facilities are billing for all services that Medicaid can cover.
4. Continue to collaborate with our tribal partners and IHS on finding solutions to Workforce shortages and other access issues, including the development of telehealth capabilities.

Notes on Public Comments

To facilitate public comment, suggestions, and recommendations, the proposed format and content of the Access Monitoring Review Plan for calendar year 2015 and the federal requirement as stated in 42 CFR § 447.203 may be found on the Department's website at:

http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx.

Public comments will be received through September 26, 2016.

If you do not have internet access, a written copy of the proposed information in this supplement and on the HSD website may be requested by contacting MAD in Santa Fe at 505-827-6252.

Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to madrules@state.nm.us. Written, electronic and recorded comments will be given the same consideration as oral testimony. All comments must be received no later than 5:00 p.m. MDT, September 26, 2016.

Written or e-mailed comments are preferred because they become part of the record associated with these changes.

Interested persons may address written comments to:

Human Services Department
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the MAD in Santa Fe at 505-827-6252. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 505-827-3184. The Department requests at least 10 working days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Public Comments and Responses

1. Comments Received on Need for Tribal Consultation

Summary Comments: There were six comments related to the need for formal (face to face) Tribal Consultation.

Also, one verbal comment was made that stated it was hard to know what the purpose of the document is and that better communication with Native American entities would have made the purpose more clear.

RESPONSE:

The initial information that an access study would be performed to meet CMS requirements was provided at the Tribal Consultation on June 6, 2016.

A notification was provided to tribal leaders, IHS and other tribal health providers on August 25, and providing a web link to the document that was ready for review and comment. Those in a position to request formal face to face tribal consultation (the tribal governors) did not make a request for formal Tribal Consultation.

A public meeting was held on a September 20, 2016 at which Native American representatives and providers made comment.

A special conference call with Native American representatives, IHS, tribal healthcare facilities, and tribal leaders was held on August 28, 2016 for the purpose of discussing the content of the Access Monitoring Plan which also resulted in comments to the Department.

Further discussion on the comments previously received occurred during another special conference call on September 28, 2016, which also included discussion on how to work more closely in the future to obtain more specific and detailed information on the access issues faced by Native Americans and in making referrals from IHS and other tribal healthcare providers to non-tribal providers.

The Department agrees that working more closely with tribal representatives and their health care providers and in more detail should occur.

In order that we may have more current data and a monitoring plan that serves as a more current base line, the Department believes an updated version of the Access Monitoring Plan should be done with the following changes:

a. The time period should change to January 2016 through June 2016. CMS required the initial plan to be for calendar year 2015 which is what was reflected in this study. THE

DEPARTMENT would have preferred using 2016 information and would still like to update, revise, and expand the study using 2016 information.

b. The comments received in writing, verbally, and in conference calls will be incorporated to the extent possible. Again, the Department believes using 2016 information would be the most useful to the Department, to IHS and tribal healthcare facilities, and to tribal leaders. As the Department discusses this plan and potential changes with CMS, the Department will put forth this suggestion.

c. Using 2016 data, a revised version or format will be sent out for additional comments and will service as a preview document prior to working with Native Americans entities in formulating a process to work closely with Native American entities on a revised and updated plan. As part of a new version of the plan, MAD would solicit comments from each tribal facility, government, and IHS.

d. After revisions are made as necessary, it could be determined at that time if additional tribal consultation is considered necessary.

e. In the most recent conference call with Native American representatives, it appeared that there was agreement with the approach described above.

2. Observations and Comments on Access to Providers

IHS representatives commented that they have had some service units say that some of the Behavioral Health providers don't take Medicaid patients, and one in particular accepts Medicaid in Taos and not in Santa Fe. Also, one service unit reported that some providers limit the number of Medicaid slots that they will allow in favor of the better paying commercial patients. Another service unit is having difficulty finding a Child Psychiatrist that takes Medicaid.

They also commented that the lack of access to In-patient and Urgent Care Services doesn't seem to be separately addressed in the document and that is one of the biggest concerns for the Native Communities. The commenter noted that while CMS doesn't require that as part of the plan, there have been recent cuts to In-Patient payments and thus they should be analyzed under 447.203.6.

One verbal comment noted that there is a shortage of home health agencies in some areas where they would be useful to Native Americans.

RESPONSE:

The number of BH Providers in this Plan was determined by the actual number registered in our (MMIS) database.

The process to produce a more current, revised, and updated plan as described above includes a process to obtain more detail on specific access issues for Native Americans.

The Department has specifically noted the comment on home health agencies.

3. Observations on Counting Providers

Summary: Several comments were made on how to better count IHS and tribal healthcare providers and questioned some of the counts of IHS and tribal facilities in the draft available for review.

One commenter said that "All IHS/Tribal facilities provide some behavioral health services, they may not all be billing or billable" and that some residential treatment centers were not included.

The commenter went on to say "IHS/Tribal facilities do not have 49 facilities that provide Obstetrical services, including labor and delivery. Maybe separate out labor and delivery?" and "Table 8A and B would give a more accurate picture if the Outpatient and Hospital/ER services were in separate columns."

RESPONSE:

Several changes in the text of the document and information on the number of IHS and tribal providers were made for this version.

A new list of all the enrolled IHS and tribal healthcare providers was created to assure all facilities were counted but never double counted.

MAD only counted a tribal or IHS facility as rendering BH services if they had billed the revenue code 0919.

In this Plan we only analyzed the services categories specified by CMS. The Department may look at additional categories as suggested in future versions of the plan.

An updated plan using 2016 data, as described above, would include a process to obtain more detail on specific access issues for Native Americans and would establish a base line for comparison to determine the effect that the rate reductions may have on access and provider participation.

Because of the comments, outpatient hospital clinics (separate from hospital emergency rooms) were counted and placed more appropriately in the clinic column in the current plan.

Another revision to the current plan is that IHS and tribal facility obstetrical providers were only counted if they provide for labor and delivery, and not on the basis of just providing prenatal care.

4. Observations and Comments on the Fee Schedule Comparison

One commenter asked for clarification: "On Pages 9-11 of the document there are several services where Medicaid pays less than Medicare. Are there plans to address those differences? One service unit reported that some providers limit the number of Medicaid slots that they will allow in favor of the better paying commercial patients and another reported that one of their behavioral health providers will take Medicaid at their Taos location but not at their Santa Fe location."

Summary comment: One organization commented that the plan should include "an analysis of actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service. This includes a percentage comparison of payment rates to other public and private health insurer payments, including Medicaid managed care rates. This data and comparison is not provided in the Access Monitoring Review Plan, even though it could be estimated. Certainly, HSD knows its managed care payment rates. In addition, it could estimate Medicaid rates compared to private insurance. "

RESPONSE:

The chart in the document was used to determine which rates should not be reduced. It is not being used at this time to determine which rates should be increased.

The Department reported the comparison to Medicare but that is the information available. The Department does not have detailed information on other payers and does not believe an estimate would be possible or accurate.

5. Observations and Comments on Billing and Payment Issues

One comment asked "Can we add that we should work jointly on addressing why the services that are currently being provided aren't being billed or aren't billable?"

RESPONSE:

The Department believes that is an issue that needs to be handled separately, but we agree it is very important and needs to be done.

6. Other General Observations and Comments

One pueblo commented "The 13 areas for review per CMS guidance does provide a snapshot of the Facilities, population, type of providers and locations of existing and selected 2015 services available to the FFS population. The tables on selected types of services such as primary care, specialty, behavioral health, dental and home health show provider access by distance, facilities, organizations and locations by regional or counties.

RESPONSE:

Thank you for your comment.

The pueblo also commented that they are currently "aware of the covered services currently approved under the New Mexico State Medicaid Plan. The Pueblo has an outpatient clinic on site operated by the IHS and also provides dental and community health services. As such, the State covered services are limited in the actual access to comprehensive health services that the tribe provides to ALL its members."

RESPONSE:

This is helpful information. Other commenters have also stated the need to review the services being provided by tribal facilities to determine if there are services being billed that are not currently being billed because of lack of instruction or processes. The Medicaid program will look into these issues.

The pueblo also commented: "ABILITY TO PAY: Any and all facilities identified may exist in various service delivery areas and designations however, these facilities namely IHS and tribally operated facilities are limited by yearly funding and funded approximately 62% of need. The limited funding is exhibited by limited staffing, facility expansion, level of care and accreditation requirements and overall ability to meet health needs. In addition, care is normally limited to .primary care and all tertiary care like inpatient, trauma, cancer, heart, surgery, intensive care is referred to non-IHS/tribal facilities. This is where the ability to pay affect access to care as Natives has a choice to remain FFS, opt out of MCO assignment, Purchased Referred Care by IHS is limited, and some providers do not accept Medicare like rates under contract. Therefore the FFS population may require an additional survey on the ability to pay as an 'access' measure."

RESPONSE:

This is helpful information. The initial data was related only to the service areas that were required by CMS, but criteria can be defined to include other services and issues as well. MAD does recognize this as an issue also.

Another comment was: “Most IHS and tribal facilities do not provide elder care, long term care, hospice and services that are under State Approved Medicaid services. The Plan does not appear to look at this service as an access issue based on the Plan description. Based on State FFS date this appears to be a huge cost and such data may assist in further enhancing the proposed Plan.”

RESPONSE:

This is helpful information. The initial plan was related only to the service areas that were required by CMS, but criteria can be defined to include other services and issues as well in future versions of the plan.

A question was asked: “Medicaid vs Medicare costs comparisons. It is unknown if the costs used to compare Medicaid and Medicaid costs are FFS ONLY costs or overall Medicaid costs inclusive of MCO payments. A clarification on this would be helpful. Only FFS costs should be used.”

RESPONSE:

Only FFS costs were used.

A pueblo also commented: “Transportation has always been an access issue due to rural and frontier areas of where FFS members live. The transportation services available are sporadic and even if available some members do not have the ability to pay for minimal costs.”

RESPONSE:

This is helpful information. THE DEPARTMENT recognizes this as an issue also.

The pueblo also commented: “It is the Pueblo's recommendation that the Social Determinants of Health be used as a measure of 'access monitoring' as there are other metrics that affect health care. These determinants at times are more compelling than availability of medical facilities and staffing.”

RESPONSE:

THE DEPARTMENT agrees with this observation. However, it would be a much different study than the access plan which is what was required by CMS at this time. Thanks for the comment

The pueblo also commented: “Application of Fee For Service. The AIR should remain for tribal and contracted providers. It is a positive action to reimburse a tribal facility on services based on costs reports. Non-emergency transports, personal care, caregivers, counselors being paid at a reasonable rate will enhance basic medical needs never seen nor reimbursed by traditional medical facilities.”

RESPONSE:

We appreciate the comment.

The pueblo also stated: “As always, keep in mind the AI/AN health care is authorized under federal laws and federal protections and the State is NOT educated on how the federal laws protect and provide the health care framework in Native lands. States wants to simplify and streamline services for ALL state residents without the knowledge of federal laws trumping state laws and having an effect of 'access' to care.”

RESPONSE:

We hope that beginning to work together on compiling information like this will help bridge the knowledge gaps. We appreciate the observation.

The pueblo stated “The Monitoring Plan on FFS services is a good start on reviewing access to care. Thank You for this opportunity to comment and best regards.”

RESPONSE:

We appreciate your comments.

7. Comments in Support of Continuing the Development of the Plan:

An Indian Hospital Board stated they are “happy to hear that New Mexico Medical Assistance Division is seeking acknowledgement from [tribal health providers] regarding the Access Monitoring Review Plan” and submitted the following comment: The Indian Hospital Board “is

adamant supporters of having our Native American Medicaid recipients have access to their healthcare. The review plan will be advantageous to [tribal health providers] as to needs assessments of the community. The Fee for Service review based on the locality and accessibility will provide a better understanding of the remote location of our facility.

RESPONSE:

Thank you for your comments. We agree that the Access Plan will be beneficial.

8. Written Comments Regarding Telehealth:

Comments were received from a managed care organization:

"We believe that Telehealth is a good solution but will have limitations due to technology and internet challenges in the Native American areas."

"The providers are available but may not be in the geographic location that is opportune. We want to ensure there will be no mandate on MCO's to change this because we do not have control to dictate that a provider relocate or expand their practice where it may not be fiscally sustainable to do so."

"This is a challenging area and population due to scarce resources and providers in these areas. As noted there are some counties with no dentist and home health services so any opportunities to penetrate those areas with internet to reach this population would be a positive move but would not fix the whole issue."

RESPONSE:

Thank you for your comments. We agree that there are geographical challenges. This Plan focuses only on Fee-For-Service and not how services should be rendered through managed care.

9. Written comments on the Scope of the Plan.

Summaries:

One organization commented extensively on how it is not possible to monitor the services, especially behavioral health services, when the scope of the plan is the fee for service program. However, they acknowledged that the CMS requirement applies to FFS at this time.

The comment included observations that there was not enough specificity in the plan about the specific behavioral health services being monitored, stating that most behavioral health

services are not rendered by MD, DO, or PhD providers.

The comment included a question about the statement "Not all BH services are included in this line." The commenter questions if the Monitoring Review Plan for Fee for Service Recipients can effectively monitor the delivery of services, especially with regard to behavioral health services, stating the plan's "description of behavioral health services is either too narrow, vague or woefully incomplete so that it is not possible to know what behavioral health services are being measured."

RESPONSE:

For this document, HSD/MAD followed the CMS requirement that required only FFS information. The Department is continuing to monitor access to services in managed care but that is outside the scope of this document.

There is a misunderstanding in the statement that not all behavioral health services were included. That statement appears in the broad comparison of the Medicaid fee schedule to that of Medicare and is not meant to imply that all behavioral health services or providers were not included in the plan overall.

Medicare does not cover all the behavioral health services and providers that are covered under Medicare, so the rates of those services and providers were not included in the comparison with Medicare.

However, the plan does include all the BH service practitioners on Table 11 A and 11 B. Because of the different kinds of behavioral health providers, the providers are counted separately as (1) individual practitioners, (2) group practices, (3) Behavioral Health Agencies, Community Mental Health Centers and Core Service Agencies, (4) Freestanding Psychiatric Hospitals and Units, and (5) Behavioral Health in the Schools.

10. Comments and Observations New Mexico Workforce Shortages

Summary: One organization provided information on New Mexico's serious workforce shortages and stated that this topic does not receive due attention in the draft Access Monitoring Review Plan.

RESPONSE:

The Department is aware of the workforce shortages and in charts throughout the plan attempted to indicate how a county is classified. However, the Department did not believe this plan was the place to cite detailed statistics regarding each county. Rather, the task was to look specifically at the FFS population in the Medicaid program and to focus on that

access. Since the FFS population is almost exclusively Native Americans and the workforce shortages are not specific to Native Americans, detailed statistics were not included in the plan. Also, the task was more one of comparability between the Medicaid FFS population and the general population and the workforce shortages data is not specific to the Medicaid population and thus does not provide further information on the comparability of access.

11. **Comment on the Content and the Scope of the Plan**

Summary: One organization commented that: " . . . a key data source is Medicaid expenditure data to show how much is spent on patients and healthcare providers in each geographic region, by category of eligibility, and by service type. This data is likely available through the State's payment database, but it is not being compiled or analyzed in an effort to improve access to care. The data would provide more specific information about where Medicaid patients are actually accessing services, whether they are obtaining primary care, dental care, behavioral health services, specialty care and emergency care at the amounts that should be expected for patients to indicate that there is access to care, and whether there are disparities in the services Medicaid patients are obtaining compared to private insurance holders.

Summary: The organization noted that "The draft plan does not discuss patient needs or demands for care –even at a surface level. Patient characteristics and healthcare needs vary among geographic location, with some areas having higher rates of diabetes, asthma, heart disease, cancer, chronic lower respiratory disease and cerebrovascular disease. HSD/MAD should have compiled this data, along with data specific to the healthcare needs and disparate outcomes that are experienced by Native American populations. The extent of the demand for services could also be evaluated by obtaining information about the average wait-times for services and by surveying providers that serve Medicaid patients."

Summary: The organization commented that in developing the Access Review Monitoring Plan, New Mexico did not consult with the state's Medicaid Advisory Council (MAC) and that this requirement would have assured that the committee, comprised of stakeholders and healthcare providers, would have provided input into the data sources and methods used by the State to measure access to care. HSD/MAD did not include the MAC in the development of the plan, and only sought feedback after developing a fully formed draft of the plan, in the form of public comments that are due on September 26, 2016.

Summary: The organization noted "There is very little discussion about whether beneficiary needs are being met, the availability of care, utilization changes in an area, or the characteristics of the population."

RESPONSE:

The Department views the initial plan as important to begin to establish a base line for measuring access to care for the FFS population. It is not clear that expenditure data for each region would be useful in that goal.

Though not included in the final study, the Department did actually identify all of the providers who are seeing Native American recipients, and the payments to these providers as well as their geographical distribution. While the Department did not include that document in this plan, some conclusions were drawn from that study. The Department perceives it will be very useful information in working with Native Americans, IHS, tribal healthcare providers, and tribal leaders as described in the response to the first topic, above.

The Department believes it was necessary to provide a model for public comment. The Department anticipates updating the document and will consider all the comments in making such updates as well as providing for future opportunities to receive comments. The Department believes that CMS provided excellent instructions and models to consider as a starting point. The Department views this plan as an ongoing project, undergoing revisions and updates and therefore is trying to provide an initial baseline to work with from which to develop more detailed data. It was not intended at this point to be an exhaustive study, but rather the first step and basic in developing information and processes.

The Department has initiated processes to try to determine whether providers are taking new recipients and possible wait time involved. That information, however, is not available at this time for FFS recipients.

The Department believes that over time that CMS requirements and the Department's plan will become more detailed. However, the Department is not under the impression that a study on the disease states of the FFS population is required at this time. Certainly, however, as the plan evolves this may become an important aspect of the document.

12. Comments on Call Center Statistics

Summary: One verbal comment described significant difficulty in understanding the call center statistics, including how there could be so many calls about eligibility because it would seem to be one of the most difficult questions to discuss by phone. The comment included questions on how many calls were dropped and reported that it is difficult to call the county offices and other HSD entities.

RESPONSE:

The Department made changes to the wording in this section to help with the understanding. The Call Center statistics are for all recipients and for just FFS recipients which is one of the reasons the volume of calls is so high in proportion to the FFS population described in the plan.

The counts are actual calls and the number of different individuals calling is not available. The call center is the primary source of information for most recipients. It does not include statistics for calls made to county offices.