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Medicaid Network of Providers

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New Mexico's Medicaid Managed Care Program

- New Mexico's new Medicaid managed care program, Turquoise Care, replaced the state's prior managed care program, Centennial Care, on July 1st, 2024. Turquoise Care services are provided through managed-care organizations (MCOs), insurance companies that contract with providers and medical facilities to provide Medicaid-covered care to members. Presbyterian Health Plan and Blue Cross Blue Shield continued as MCOs in Turquoise Care while United Healthcare Community Plan and Molina Healthcare were added. Western Sky Community Care was dropped as an MCO.

- Turquoise Care is a Medicaid waiver, or a program the federal government permits the state to operate which pays for services that would not be available under a traditional Medicaid program, if the state can demonstrate the waiver is cost neutral. The waiver covers physical health, behavioral health, long-term care, and other services for about 745 thousand enrollees.

- Turquoise Care comprises most of the state's $10.2 billion Medicaid budget and is projected to spend roughly $7.3 billion in FY25, with the remainder of the Medicaid budget going towards fee for service, Medicaid waivers for people with developmental disabilities, and Medicare. The state pays the MCOs a set monthly fee per month—a capitation payment—for services. About 10 percent of this fee is for the administrative overhead associated with managing the program. About $1.5 billion of the program's revenue comes from the general fund, making it one of the biggest drivers of state spending and a keen area of interest for performance management.

- Given the number of people it serves and the large budget, Turquoise Care is the greatest lever available to the state to improve outcomes, especially when it comes to behavioral health and substance use disorders. However, as documented in numerous prior LFC reports and evaluations MCOs, along with the Health Care Authority, must expand provider networks to ensure adequate access to services.

- The Legislature invested significantly in the last few years to assist in building out provider networks by increasing provider rates for maternal and child health and physical health, hospital services, behavioral health, and federally qualified health clinics. The legislature also invested over $100 million to build more provider capacity and additional amounts for workforce development.

- With this additional funding, expanded provider networks and higher quality evidence-based services should be expected. There has been growth in the networks over the past years or so, but it has been slow and there is still reason to believe that many people cannot access appointments for routine care or behavioral health timely.

- To improve the availability of services the authority added several performance measures to the Turquoise Care contracts with the MCOs on top of already required federal measures. For example, the department is requiring MCOs to increase the number of enrollees receiving a behavioral health visit and increase the number of enrollees receiving telemedicine visits. However, these measures are limited and do not touch on quality or require services that are provided be evidence-based.

- In addition to these standards, the federal government recently released an updated rule on network adequacy standards for Medicaid managed care organizations (MCO). In addition to stricter time and distance standards, the new rule introduces mandatory standards for appointment availability. Medicaid enrollees must be able to schedule an appointment for routine primary care within 10 business days, specialty care within 15 business days, behavioral health services within 10 business days, and urgent care within 24 hours.