Mercer

Government Human Services Consulting

# Provider Rate Benchmarking Study

## Preliminary Benchmarking – Phase 2

**State of New Mexico**
**Medical Assistance Division**

August 5, 2022

# Contents

## Section 1

# Executive Summary

This report is the second in a series of reports that address different aspects of this study. This is a subsequent report to the Phase 1 report dated March 9, 2022, which covered professional and clinic services.

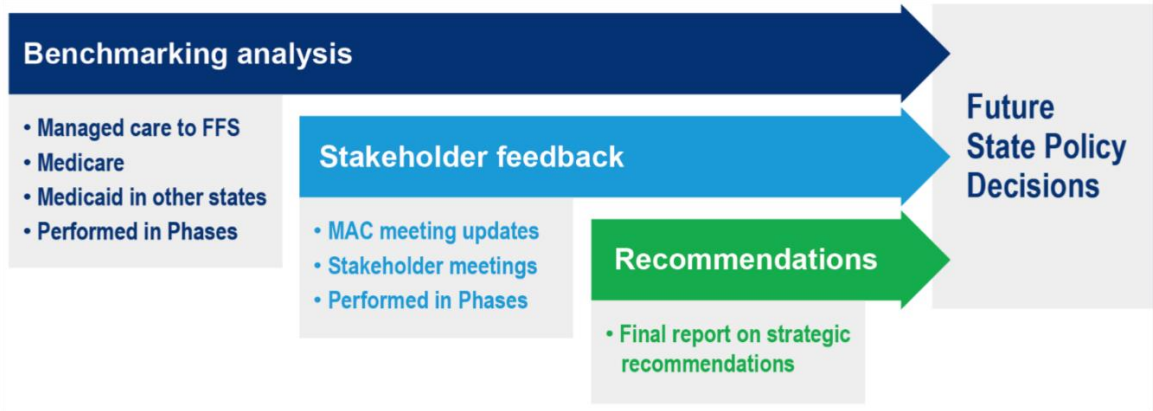
## Project Overview

As a critical payer for health care services, the State of New Mexico Human Services Department, Medical Assistance Division (HSD) is undertaking a comprehensive review of its provider reimbursement levels and methodologies in support of the following goals:

- To ensure access to high-quality care for Medicaid members through appropriate reimbursement of health care services.
- To attract and retain health care providers to New Mexico.
- To establish a methodology, process, and schedule for conducting routine rate reviews as part of normal future operations and fiscal planning.

HSD has requested that Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, perform a comprehensive study of the Medicaid reimbursement to providers for non-pharmacy services. To do so, Mercer is summarizing and benchmarking Medicaid provider reimbursement levels in both managed care and fee-for-service (FFS) environments, gathering feedback from interested stakeholders, and identifying areas to improve and modernize existing payment methodologies. The study will conclude with a final report that provides observations and strategic recommendations for ongoing evaluation and updating of provider reimbursement.

**Figure 1.**




HSD and Mercer considered current federal and state-level initiatives in designing the study, identifying the following service categories as critical focus areas:

1. **Home- and community-based services (HCBS)**, including services offered in the managed care community benefit authorized through the 1115 waiver and those in the 1915(c) waiver

programs serving individuals with intellectual disabilities, and developmental disabilities (DD). These services qualify for enhanced federal funding through American Rescue Plan Act[1] of 2021, Section 9817, and are included in HSD's proposed spending plan activities to "enhance, expand, or strengthen" HCBS under Medicaid.

2. **Maternal and child health**, including professional and hospital services for prenatal, delivery, and postpartum/newborn care. Medicaid currently pays for over 70% of births in New Mexico and has elected to exercise the option outlined in the American Rescue Plan Act[2] to extend post-partum coverage from 60 days to 12 months.

3. **Primary care**, to provide meaningful data on the Medicaid expenditures for primary care services to HSD's Primary Care Council, which was established by House Bill 67[3] during the 2021 legislative session. This includes the rates for federally qualified health centers (FQHCs), which support the delivery of primary care and related services.

To align with these priorities and provide timely information to HSD, the comprehensive review is split into two phases:

- Phase 1 includes most professional service types in addition to FQHCs and rural health centers (RHCs). This will capture the HCBS and primary care services as well as maternal and child health services rendered by practitioners.
- Phase 2 includes facility services, such as those provided by hospitals and nursing facilities.

This report represents the completion of the benchmarking analysis for the Phase 2 service areas.

**Figure 2: Phase 2 Service Areas**


Following the release of this report, HSD and Mercer will be conducting stakeholder outreach efforts to collect input on provider reimbursement methodologies for each of the service areas covered in this review. Mercer performed a similar benchmarking review for the Phase 1 services. Findings included in the initial benchmarking reports may be revised based upon the input collected through these stakeholder outreach efforts.

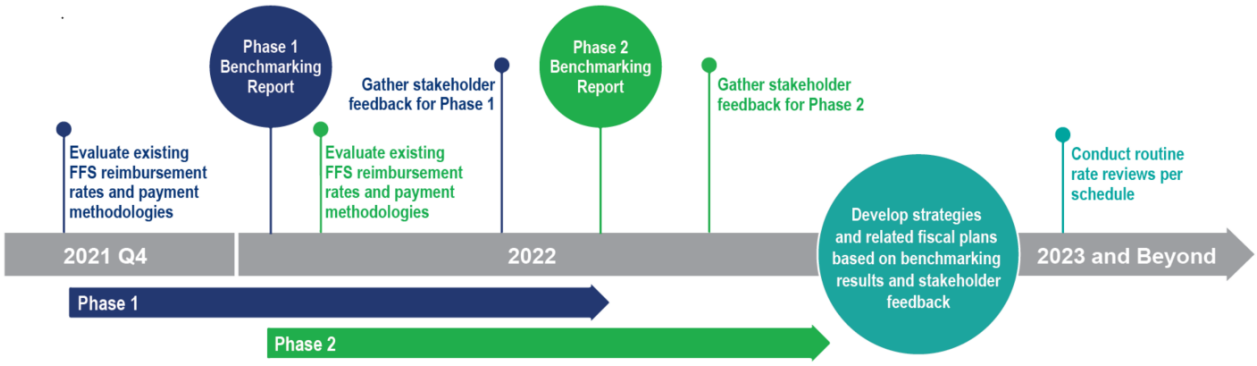
Mercer will use benchmarking results, stakeholder input, and other reimbursement methodology evaluation criteria to identify areas for improvement and/or modernization and to inform the HSD

[1] New Mexico Human Services Department. *Spending Plan for the Implementation of the American Rescue Plan Act of 2021, Section 9817.* Available at https://www.hsd.state.nm.us/wp-content/uploads/NM-HCBS-ARPA-Spending-Plan_07122021-2.pdf [Accessed January 2022]
[2] American Rescue Plan Act of 2021, H.R.1319, § 9812 and § 9822
[3] New Mexico Legislature. *Primary Care Council Act, House Bill 67.* Available at https://www.nmlegis.gov/Sessions/21%20Regular/final/HB0067.pdf [Accessed January 2022]

Reimbursement Strategy. The final report will synthesize this information and provide recommendations to HSD. In response to the Coronavirus Disease 2019 (COVID-19) pandemic and associated public health emergency, New Mexico added special provisions for telehealth services in 2020. Mercer recognizes that this will impact future health care delivery in New Mexico and will include this consideration when developing future recommendations.

The planned timeline of the Provider Rate Benchmarking Study is outlined below.

**Figure 3: Targeted Study Timeline**




# Summary of Results

Phase 2 service areas accounted for approximately $2.0 billion in New Mexico Medicaid service expenditures in calendar year (CY) 2019, where $1.8 billion of the $2.0 billion (90%) were for services provided through the managed care program. Mercer examined how provider reimbursement levels in managed care compares to FFS, and how the FFS provider reimbursement levels compare to Medicare and select other state Medicaid programs where available.

Although the managed care organizations (MCOs) are not required to align with FFS fee schedules and negotiate rates with contracted providers, Mercer found that MCO reimbursement closely compares with FFS in many cases. There was some variation by service, most notably inpatient services at psychiatric and rehabilitation hospitals, which may be related to differences in reimbursement methodologies between managed care and the FFS payment, or different handling of gross receipts tax (GRT). Mercer will seek feedback from MCOs and providers during the stakeholder engagement activities to better understand drivers of these patterns.

This Phase 2 benchmarking analysis excludes the Indian Health Services and those delivered through the Program of the All-Inclusive Care for the Elderly (PACE) for the following reasons:

- Medicaid claims at Indian Health Services providers are 100% federally matched and are reimbursed using an all-inclusive rate often referred to as the OMB rate. This rate is set annually by the federal Indian Health Services department and varies for inpatient and outpatient hospital visits. Since state Medicaid programs do not set the OMB rates, they have not been included in this benchmarking report.
- The PACE program provides comprehensive long-term services and supports (LTSS) for Medicaid, Medicare, dual-eligible, or private pay members. PACE enrollees are able to receive care at home or in a PACE center instead of in a nursing home. To be eligible for

PACE, an individual must be 55 years or older, be eligible for nursing home care, and live in a PACE organization service area. States reimburse PACE Medicaid enrollees using an all-inclusive per member per month (PMPM) rate that is not directly based on service utilization. The institutional claims for PACE members were excluded from this benchmarking report because the submitted encounter claims data represents this PMPM rate and does not reflect the individual service payments.

Mercer compared New Mexico's payments to estimated Medicare payments, where possible. We were able to do so for inpatient hospital and outpatient hospital service areas; but most of the other service areas are not covered by Medicare or the additional data necessary for Medicare pricing is not available. Based on the compared services, New Mexico FFS reimbursement levels were lower than corresponding Medicare rates for most service areas where benchmarking was possible. However, New Mexico reimbursement is above the estimated Medicare reimbursement for inpatient psychiatric hospitals and rehabilitation hospitals. For inpatient psychiatric and rehabilitation hospitals, this is likely because the current FFS reimbursement is based on a percentage of charges where a hospital's billed charges can be high and difficult to predict, resulting in higher FFS payment levels.

The New Mexico payment rates for most services in Phase 2 are facility-specific, therefore, the comparison to other states is limited. When possible, we have presented the range of payment rates for each service to provide context regarding New Mexico's payment levels as compared to Arizona, Colorado, Louisiana, and Washington. In Section 5 of this report, we describe additional limitations and considerations that influence the comparisons of New Mexico's payment levels to the selected benchmarks.

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

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

| | | CY2019 | | CY2021 |
|---|---|---|---|---|
| **Phase 2 Service Area** | **Service Subgroups** | **Total Medicaid Expenditures[1]** | **Managed Care Percent of FFSE[2]** | **NM FFS Percent of Medicare[3]** |
| **ALL** | **ALL** | **$1,991.2** | **99%** | **N/A** |
| Inpatient Hospital | General Acute Hospitals | $708.1 | 117% | 72% |
| | Critical Access Hospitals | $15.8 | 125% | 77% |
| | Psychiatric Hospitals | $46.2 | 54% | 164% |
| | Rehabilitation Hospitals | $81.9 | 67% | 154% |
| Outpatient Hospital | General Acute Hospitals | $513.8 | 81% | 89% |
| | Critical Access Hospitals | $50.4 | 132% | 66% |
| | Psychiatric Hospitals | $3.2 | 70% | 268% |
| | Rehabilitation Hospitals | $8.1 | 98% | 142% |
| Nursing Facility/ | Private - Low Level of Care | $214.7 | 111% | 84% |
| | State - Low Level of Care | $30.0 | 99% | 91% |

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

| | | CY2019 | | CY2021 |
|---|---|---|---|---|
| **Phase 2 Service Area** | **Service Subgroups** | **Total Medicaid Expenditures[1]** | **Managed Care Percent of FFSE[2]** | **NM FFS Percent of Medicare[3]** |
| Hospice | Private - High Level of Care | $21.2 | 114% | 82% |
| | State - High Level of Care | $1.9 | 97% | 161% |
| | Hospice | $22.9 | 92% | N/A |
| Residential Treatment Centers | ARTC Psychiatric | $25.9 | 114% | N/A |
| | RTC - Youth | $4.4 | 153% | N/A |
| | Group Home | $0.6 | 116% | N/A |
| | ARTC Chemical Dependency | $0.1 | 89% | N/A |
| | RTC - Other | $17.3 | N/A | N/A |
| Other Institutional | Dialysis | $18.2 | 262% | N/A |
| | Home Health Agency | $10.0 | 107% | N/A |
| | Nursing Agency, Private Duty | $7.1 | N/A | N/A |
| | Ambulatory Surgical Centers | $2.2 | 164% | 64% |
| | Intermediate Care Facility | $0.8 | N/A | N/A |
| Excluded Services | Indian Health Services | $177.1 | N/A | N/A |
| | PACE | $9.2 | N/A | N/A |

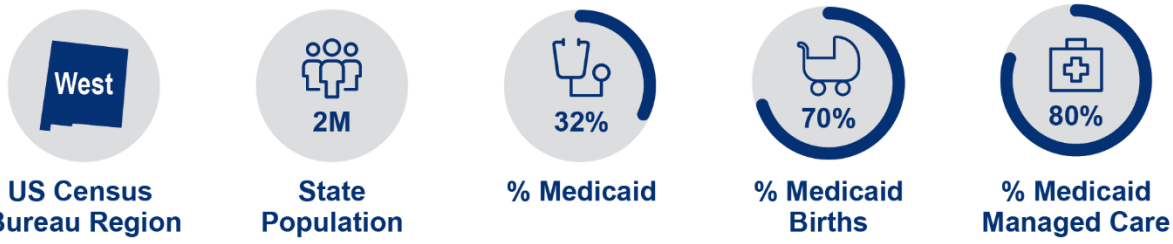
*1. CY2019 Total Medicaid Expenditures includes managed care encounters and FFS claims after exclusions. See Data Sources and Time Period for the impact and list of exclusions applied to the claims data. Totals differ due to rounding.*
*2. Includes services with available managed care expenditures and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

## Section 2

# Overview of Medicaid in New Mexico

Over one million New Mexicans (50% of the state population) receive benefits from one or more state social programs, including Medicaid. Within the social and healthcare programs that New Mexico offers, Medicaid plays a central role in the delivery of health services to members and covers among the largest proportion of the state's population in the country. Since the CY2019 time period used for this analysis, the Medicaid proportion in New Mexico has grown substantially, in part due to the COVID-19 public health emergency. HSD projects that Medicaid enrollment will represent more than 44% of the New Mexico population in fiscal year 2023.[5]

**Figure 4: CY2019 Key characteristics of New Mexico**




Medicaid's significant role as a purchaser of health care services in New Mexico creates a large responsibility for the state to ensure accessibility of appropriate care for New Mexicans.

## Managed Care Overview

New Mexico operates an integrated, comprehensive Medicaid program called Centennial Care authorized through an 1115 Demonstration waiver. Today, three MCOs provide a full array of physical health, behavioral health, and LTSS for their members. New Mexico initiated managed care in 1997, adding managed LTSS in 2008. As an early expansion state, New Mexico included the Patient Protection and Affordable Care Act new adult group (known as the "Other Adult Group") in 2014.

Participation in managed care is mandatory for most eligible populations with the notable exception of the Native American population. The Native American population accounts for approximately 90% of the New Mexico Medicaid members receiving full benefits through the FFS program. New Mexico continues to provide coverage outside of managed care for certain populations and the services authorized under three 1915(c) HCBS waivers for members with Intermediate Care Facility (ICF) level of care. HSD reimburses services for these programs under FFS with ancillary services reimbursed under managed care. Populations that are not eligible for managed care include:

[5] HSD overview and budget request for FY 2023. Available online: https://www.hsd.state.nm.us/2021/09/02/30833/

- Qualified Medicare Beneficiaries
- Specified Low-Income Medicare Beneficiaries
- Qualified Individuals
- Qualified Disabled Working Individuals
- Non-citizens only eligible for emergency medical services
- Program of All-Inclusive Care for the Elderly (PACE)
- Individuals who receive care in an ICF for Individuals with intellectual or developmental disabilities (ICF/IID)
- Individuals eligible for family planning services only

Currently, managed care represents nearly 80% of overall Medicaid program expenditures in New Mexico.

## Historical Program Expenditures for Phase 2 Services

HSD directly manages the reimbursement levels and methodologies used in FFS, but much of the Medicaid program operates through a managed care delivery model, in which MCOs establish their own payment terms with contracted provider networks, and in some cases their own reimbursement methodologies. In order to develop a complete picture of Medicaid provider reimbursement in New Mexico, Mercer has included both delivery systems in this comprehensive rate evaluation. FFS is the sole delivery system for the ICF/IID services, while managed care represents the primary delivery system for the remaining service areas in Phase 2. Accordingly, Mercer's analysis relies on FFS data to understand utilization patterns for the ICF/IID services and encounter data to understand utilization patterns and MCO payment levels for the remaining services. Table 2 displays the total expenditures for each service category, separated by managed care and FFS.

**Table 2: Overview of Managed Care and FFS Expenditures by Service Area ($ in Millions)**

| | | CY2019 | | |
|---|---|---|---|---|
| **Phase 2 Service Area** | **Service Subgroups** | **Total Medicaid Expenditures** | **Total Managed Care Expenditures** | **Total FFS Expenditures** |
| **ALL** | **ALL** | **$1,991.2** | **$1,800.2** | **$191.0** |
| Inpatient Hospital | General Acute Hospitals | $708.1 | $644.1 | $64.0 |
| | Critical Access Hospitals | $15.8 | $14.4 | $1.4 |
| | Psychiatric Hospitals | $46.2 | $43.4 | $2.8 |
| | Rehabilitation Hospitals | $81.9 | $79.8 | $2.1 |
| Outpatient Hospital | General Acute Hospitals | $513.8 | $492.9 | $20.8 |
| | Critical Access Hospitals | $50.4 | $47.3 | $3.1 |
| | Psychiatric Hospitals | $3.2 | $3.1 | $0.2 |
| | Rehabilitation Hospitals | $8.1 | $8.1 | $0.0 |
| | Private - Low Level of Care | $214.7 | $214.2 | $0.6 |

| | | CY2019 | | |
|---|---|---|---|---|
| **Phase 2 Service Area** | **Service Subgroups** | **Total Medicaid Expenditures** | **Total Managed Care Expenditures** | **Total FFS Expenditures** |
| Nursing Facility/ Hospice | State - Low Level of Care | $30.0 | $30.0 | $0 |
| | Private - High Level of Care | $21.2 | $21.2 | $0 |
| | State - High Level of Care | $1.9 | $1.9 | $0 |
| | Hospice | $22.9 | $22.7 | $0.2 |
| Residential Treatment Centers | ARTC Psychiatric | $25.9 | $25.7 | $0.2 |
| | RTC - Youth | $4.4 | $4.4 | $0.0 |
| | Group Home | $0.6 | $0.6 | $0 |
| | ARTC Chemical Dependency | $0.1 | $0.1 | $0 |
| | RTC - Other | $17.3 | $17.3 | $0 |
| Other Institutional | Dialysis | $18.2 | $17.8 | $0.4 |
| | Home Health Agency | $10.0 | $10.0 | $0 |
| | Nursing Agency, Private Duty | $7.1 | $7.1 | $0 |
| | Ambulatory Surgical Centers | $2.2 | $2.2 | $0 |
| | Intermediate Care Facilities | $0.8 | $0 | $0.8 |
| Excluded Services | Indian Health Services | $177.1 | $91.9 | $85.2 |
| | PACE | $9.2 | $0 | $9.2 |

*1. Managed care encounters and FFS claims are shown after claims exclusions. See Data Sources and Time Period for the impact and list of exclusions applied to the claims data. Totals differ due to rounding.*

For purposes of this benchmarking study, Mercer included only the claims that could be benchmarked to Medicare or other state Medicaid programs to produce meaningful results at the detail level. This limitation primarily applies to the following service areas:

- **Inpatient Hospital**: Payers reimburse inpatient claims eligible for outlier payments, stays for out-of-state hospitals, transfers and 1-day stays differently than a typical inpatient discharge and use of these claims would skew the results presented in the *Results* section by Medicare Severity Diagnosis Related Group (MS-DRG) later in this report.
- **Outpatient Hospital:** Medicare packages some services into a bundle linked to the significant procedure on the claim. In these cases, the claim shows a $0 payment for the packaged service. In addition, there are outpatient services that are paid based on revenue code or other fields on the claim besides the procedure code. We did not present the data for these services in the *Results* section, as they would skew the results presented by procedure code.

We provide additional information for these data exclusions in Appendix A and further explanation in the *Results* section of the report.

## Section 3

# Evaluation Approach

Mercer's approach to the comprehensive provider rate evaluation of the New Mexico Medicaid program includes a review of both the managed care payments and FFS rates. Managed care reimbursement is generally negotiated between the MCOs and the providers in their network. However, because the majority of services in the program are delivered through managed care, understanding those reimbursement dynamics is critical to a complete understanding of Medicaid provider reimbursement in New Mexico. Mercer reviewed the reimbursement for institutional services in Phase 2 of the study, where some could be compared to a FFSE amount, Medicare or other state Medicaid programs; however, this was not possible for all service areas presented in this report for the following reasons:

- Certain codes are managed care only services without a FFSE rate available for benchmarking (i.e., revenue code 0194 for residential treatment centers [RTCs]).
- Fields needed for Medicare pricing are unavailable in the New Mexico claims, such as:
  - The Health Insurance Prospective Payment System (HIPPS) rate codes. These indicate specific patient characteristics (or case-mix groups) to make payment determinations under several prospective payment systems.
  - Member demographic data, such as weight. This data is used in the calculation of Medicare dialysis reimbursement.
- The other state Medicaid programs used for FFS rate benchmarking may not use the same reimbursement methodology as New Mexico (for example, Arizona, Colorado, and Washington pay inpatient hospital services using the All Patients Refined Diagnosis Related Groups [APR-DRGs] and New Mexico uses Medicare's DRG system).

For services where information was available for benchmarking, Mercer:

- Compared average New Mexico Medicaid managed care payment levels with average FFSEs.
- Compared New Mexico's published FFS reimbursement levels to Medicare and other state Medicaid programs (i.e., FFS rate benchmarking).

Each of the comparisons has a tailored approach to ensure that HSD gets the most useful information possible from the available data. The comparison of averaged managed care payment levels to the state's FFS includes a significant amount of nuance regarding how reimbursement is applied, going beyond the information available from a published fee schedule using a field from the Medicaid Management Information Systems (MMIS) that re-prices each managed care encounter claim to show the amount that would have been paid by FFS. Mercer refers to this FFS payment amount as the FFSE throughout the analysis, and that value captures detail such as the application of the GRT. This field is used to benchmark against the average managed care reimbursement for the inpatient hospital and outpatient hospital service areas, representing 65% of the analyzed managed care expenditures. Since the FFSE is calculated in the MMIS system using fields on the claims data, there are instances where the field was not available in the MMIS system due to missing data in the claim submissions. For example, MCOs

report a different revenue code than the code used for New Mexico FFS payment for nursing facility high/low level of care stays. For these cases, Mercer has calculated the FFS reimbursement levels using the CY2019 FFS fee schedule rates to best align with the Managed Care paid amounts. Mercer refers to these payments as the FFS Mercer Calculated amount throughout the analysis. This value will not capture the additional amount paid for GRT. This methodology was used for nursing facility, hospice, RTCs, and other institutional service areas, representing 35% of the analyzed managed care expenditures.

It is important to note that the managed care payment amount and the FFSE for a service can vary across claims for multiple reasons, as outlined below.

- FFSE amounts may vary due to:
  - Whether a provider is subject to GRT
  - Differences in GRT by location
  - Changes in the fee schedule rate over time
- Managed care payment amounts may vary due to:
  - Negotiated contract rate differences across providers with the same MCO
  - Contract rate differences across MCOs
  - Contractual differences in how GRT is handled
  - Changes to a negotiated contract rate over time
  - Differing reimbursement methodologies compared to FFS
  - Differing levels of patient pay liability for individuals requiring certain institutional or residential long-term care

In this report, we compare the average managed care payment and the corresponding average FFSE (or FFS Mercer Calculated amount) across all the managed care encounter claims for a service during CY2019.

For the FFS rate benchmarking portion of the evaluation, Mercer compared published fee schedule rates between New Mexico FFS rates and the selected benchmarks of Medicare FFS rates and comparable state Medicaid FFS programs, taking care to note any significant methodological differences that could influence interpretation of results. Section 4 provides additional detail on the selected benchmark states. Mercer used the New Mexico FFS fee schedule rates available as of November 3, 2021 for the benchmarking analysis.

To ensure an accurate comparison between New Mexico Managed Care, New Mexico FFS and Medicare payments for inpatient hospital and outpatient hospital services, Mercer applied the following exclusions to the encounter claims data:

- Visits eligible for outlier payments
- One-day inpatient hospital stays
- Transfers from one hospital to another

- Services provided by out-of-state hospitals
- Packaged services

We provide additional information regarding these exclusions in the *Results* section for each service area.

## Service Area and Service Subgroups

Mercer collaborated with HSD to identify five service areas as part of the Phase 2 benchmarking analysis. Mercer selected the specific service areas based on the FFS reimbursement methodology, provider types, as well as HSD's focus areas. The service areas are divided into more detailed subgroups based on industry standard groupings or additional areas of HSD interest. The table below outlines the selected service areas, service subgroups, and the criteria used to categorize the services. Refer to Appendix B of the report for the associated fee schedule and online source for each service subgroup.

Throughout this report, the total results shown for the service group and subgroup represent the average New Mexico managed care experience during the CY2019 time period. We provide additional detail in the supplemental Excel™ file titled "Provider Rate Benchmarking Study P2 - Detail" dated April 29, 2022.

**Table 3: Criteria for each Service Area and Subgroup in Phase 2**

| Phase 2 Service Area | Service Subgroups | Identification Criteria |
|---|---|---|
| Inpatient Hospital | General Acute Hospitals | Claim Type = I and Provider Type = 201 |
| | Critical Access Hospitals | Claim Type = I and CAH Provider (See Appendix C for list of CAH providers) |
| | Psychiatric Hospitals | Claim Type = I and Provider Type = 204 or 205 |
| | Rehabilitation Hospitals | Claim Type = I and Provider Type = 202 or 203 |
| Outpatient Hospital | General Acute Hospitals | Claim Type = O and Provider Type = 201 |
| | Critical Access Hospitals | Claim Type = O and CAH Provider (See Appendix C for list of CAH providers) |
| | Psychiatric Hospitals | Claim Type = O and Provider Type = 204 or 205 |
| | Rehabilitation Hospitals | Claim Type = O and Provider Type = 202 or 203 |
| Nursing Facility/ Hospice | Private - Low Level of Care | Claim Type = N and Provider Type = 211 and Low Level of Care Revenue Code (varies by MCO) |
| | State - Low Level of Care | Claim Type = N and Provider Type = 212 and Low Level of Care Revenue Code (varies by MCO) |
| | Private - High Level of Care | Claim Type = N and Provider Type = 211 and High Level of Care Revenue Code (varies by MCO) |
| | State - High Level of Care | Claim Type = N and Provider Type = 212 and High Level of Care Revenue Code (varies by MCO) |
| | Hospice | Claim Type = H and Provider Type = 632 |
| | ARTC Psychiatric - Youth | Claim Type = N and Provider Type = 216 and Revenue Code = 1001 |

| Phase 2 Service Area | Service Subgroups | Identification Criteria |
|---|---|---|
| Residential Treatment Centers | RTC - Youth | Claim Type = N and Provider Type = 217 and Revenue Code = 0190 |
| | Group Home - Youth | Claim Type = N and Provider Type = 219 and Revenue Code = 1005 |
| | ARTC Chemical Dependency - Youth | Claim Type = N and Provider Type = 216 and Revenue Code = 1002 |
| | RTC - Other | Claim Type = N and Provider Type = 216, 217, or 219 and Revenue Code <> 1001, 0190, 1005, or 1002 |
| Other Institutional | Dialysis | Claim Type = O and Provider Type = 447 |
| | Home Health Agency | Claim Type = V and Provider Type = 361 |
| | Nursing Agency, Private Duty | Claim Type = V and Provider Type = 324 |
| | Ambulatory Surgical Centers | Claim Type = O and Provider Type = 664 |
| | Intermediate Care Facility | Claim Type = N and Provider Type = 215 |
| Excluded Services | Indian Health Services | Claim Type = I or O and Provider Type = 221 |
| | PACE | Claim Type = O and Provider Type = 705 |

# Data Sources and Time Period

Mercer used the encounter and FFS claims data for services provided from January 1, 2019 through December 31, 2019 (CY2019). We used the utilization in this data period to compare managed care payment levels to the FFSE in CY2019 as well as to adjust (or weight) the CY2021 FFS benchmark relationships. Mercer considered using more recent data, for example, CY2020 dates of service. However, later periods included notable fluctuations in service utilization and expenditures as a result of the COVID-19 pandemic and associated public health emergency. In Mercer's judgment, the CY2019 period provided the most recent available complete, stable picture of future Medicaid utilization and therefore will form the strongest basis for understanding market dynamics and potential recommendations.

The following sections provide a description about the encounter and FFS data and how they were utilized in Mercer's benchmarking analysis.

## Encounter and FFS Claims Data

Mercer receives claim-level encounter and FFS data from New Mexico after it is processed through the state's MMIS. New Mexico's MMIS applies a series of data processing edits to submitted encounter data, designed to check for data quality and integrity, and append certain other information. Mercer reviewed the encounter and FFS data for reasonableness and performed additional data reliance queries on the data; however, we did not audit the data. We completed data validation queries, including obtaining the most recent file layouts and data dictionaries, control total validation to confirm successful data transmission, and referential integrity for common data fields between separate data sets.

Mercer used FFS claims data to summarize the utilization experience for ICF/IID services, and encounter data for all other service areas.

In the encounter claims data, Mercer used the MCO paid amount as the managed care provider reimbursement and the “C_TOT_REIMB_AMT”, a field created by the MMIS system, as the FFSE paid amount. The “C_TOT_REIMB_AMT” is a computed field based on the allowed charge amount for a claim plus/minus all base rate changes such as GRT or third party liability. MCOs are required to submit encounters for services provided through subcontracted vendors using amounts that would have otherwise been paid if the service were not subcapitated. Patient pay liability amounts are not available in the claim-level encounter and FFS data, and are therefore, excluded from the managed care expenditures analyzed in this report.

Mercer applied the logic described in the “Service Area and Service Subgroups” in Section 3, Table 3 of the report to categorize the encounter and FFS data into the applicable service area and service subgroups.

Mercer has made the following exclusions to the encounter and FFS claims data. The removal of these claims reduces the overall expenditures included in the benchmarking analysis by 8%.

- Zero paid encounters – Identified as denied encounter lines on a claim.
- Duplicate claims – Identified through a series of standardized edits.
- Claims for members deemed not eligible for managed care on date of service – Identified from State Capitation Roster eligibility data.
- Claims with member copayment amounts.
- Claims with other Third Party Liability paid amounts.

## Additional Provider Payments

Encounter and FFS claims data do not capture all reimbursement made to New Mexico providers. State directed payments in the managed care delivery system and supplemental payments in the FFS delivery system are not included in the benchmark analysis. The FFS supplemental payments are typically paid in aggregate to a provider and not by service. There are a few State directed payments that operate similarly, however there are others that direct the MCOs to increase the reimbursement rate for each service or claim to a certain provider by the directed percentage. Additional detail on these arrangements is summarized below for informational purposes.

### State Directed Payments

Since 2019, HSD has implemented state directed payments approved by Centers for Medicare & Medicaid Services (CMS) under 42 CFR §438.6(c) to instruct MCOs to increase provider reimbursement to specific provider classes for specific services or to issue payments to providers based on meeting selected quality measures. These increases are not made to the FFS rates. Below is a table showing the estimated impact of the state directed payments to the New Mexico CY2019 Managed Care expenditure levels (not already reflected in the CY2019 Managed Care expenditures in Table 2 earlier in this report), in addition to the estimated CY2022 magnitude of all state directed payments by Service Area.

### Table 4: Summary of New Mexico State Directed Payment Impacts by Service Area ($ in Millions)[6]

| | CY 2019[7] | CY 2022 |
|---|---|---|
| **Service Area** | **Estimated Increase to Managed Care Expenditures** | **Estimated Magnitude ($M)** |
| Inpatient Hospital | 14% | $195.7 |
| Outpatient Hospital | 22% | $189.5 |
| Nursing Facility and Hospice | 46% | $168.9 |
| Residential Treatment Centers | 0% | $0 |
| Other Institutional | 0% | $0 |

Below is the list of the state directed payments affecting services included in the Phase 2 benchmarking analysis.

### Table 5: Phase 2 State Directed Payments[8]

| Impacted Benchmark Service Areas | Impacted Provider Class | Type of Directed Payment |
|---|---|---|
| **Health Care Quality Surcharge (Effective since January 1, 2020)[9]** | | |
| Nursing Facility and Hospice | Nursing facilities with less than 60 beds; 60 or more beds and less than 90,000 annual Medicaid bed days; and 60 or more beds and more than 90,000 annual Medicaid bed days. | Uniform percent increase to all nursing facilities using the market basket index (MBI) factor, per diem add-on for each respective provider class. In addition, provides quality payments to each nursing facility for achieving performance targets across quality measures. |
| **Nursing Facility Value Based Purchasing Payment (Effective since January 1, 2020)** | | |
| Nursing Facility and Hospice | Nursing Facilities that meet the following criteria: a Medicaid certified facility with Medicaid utilization, contracted with at least one MCO, submits Minimum Data Sets to HSD's data vendor, and has a signed data use agreement with the data vendor. | $4,500,000 will be available to nursing facilities in foundational, secondary, and per diem add-on payments based on Medicaid bed days and quality scores. Achievement of these payments is calculated by HSD and its data vendor. |

[6] Figured leveraged from Mercer's state directed payment preprint support for CMS approval.
[7] The Not-For-Profit and Government Owned Hospital directed payment was effective October 1, 2019 and was partially reflected in the CY2019 Managed Care experience used in this report.
[8] https://www.hsd.state.nm.us/lookingforinformation/medical-assistance-division/
[9] Effective July 1, 2019 per SB 246, but implemented on January 1, 2020 due to timing of CMS approvals.

| Impacted Benchmark Service Areas | Impacted Provider Class | Type of Directed Payment |
|---|---|---|
| **Temporary Fee Increases – Nursing Facility (Effective January 1, 2022 through June 30, 2022, *pending CMS approval*)** | | |
| Nursing Facility and Hospice | All nursing facilities. | Uniform percent increase of 8.1% to all nursing facilities. |
| **Community Tribal Hospital (Effective since January 1, 2020)** | | |
| Inpatient Hospital and Outpatient Hospital | Community hospitals that serve a disproportionate share of Medicaid enrollees and Native American enrollees as measured relative to their total Medicaid utilization as defined in the approved preprint for the respective contract year. See Appendix C for list of impacted providers. | Uniform percentage increases to contracted rates between the classes of covered hospitals and the Medicaid MCOs for inpatient and outpatient hospital services. |
| **University of New Mexico Hospital Uniform Percentage Increase and Quality Payments (Effective since January 1, 2020)** | | |
| Inpatient Hospital and Outpatient Hospital | The eligible class of providers is defined as a hospital that, pursuant to a lease agreement, has assumed a New Mexico county's perpetual contractual obligation to the United States government, through the Indian Health Service, to provide guaranteed access to care for Native Americans. | Rate increase for inpatient and outpatient hospital services with a portion at-risk for meeting specified performance metrics. |
| **For-Profit and Government Owned Hospitals (Effective since January 1, 2020)** | | |
| Inpatient Hospital and Outpatient Hospital | The uniform percentage increase applies to for-profit/investor owned and government owned hospitals. See Appendix C for list of impacted providers. | Uniform percentage increase of approximately 2.0% to contracted rates between the class of covered hospitals and the Medicaid MCOs for inpatient and outpatient hospital services. |
| **Not-For-Profit and Government Owned Hospitals (Effective since October 1, 2019)** | | |
| Inpatient Hospital and Outpatient Hospital | The uniform percentage increase applies to not-for-profit community hospitals. See Appendix C for list of impacted providers. | Uniform percentage increase of approximately 3.8% to contracted rates between the class of covered hospitals and the Medicaid MCOs for inpatient and outpatient hospital services. |

| Impacted Benchmark Service Areas | Impacted Provider Class | Type of Directed Payment |
|---|---|---|
| **Safety Net Care Hospital Minimum Fee Schedule (Effective since March 1, 2014)** | | |
| Inpatient Hospital | Safety Net Care Pool (SNCP) hospitals. See Appendix C for list of impacted providers. | Minimum fee schedule based on State Plan approved rates for inpatient services. |
| **Hospital Access Program (Effective since January 1, 2020)** | | |
| Inpatient Hospital and Outpatient Hospital | SNCP hospitals. See Appendix C for list of impacted providers. | A uniform dollar increase to contracted rates between the class of covered hospitals and the MCOs. |
| **Trauma Hospital (Effective since July 1, 2020)** | | |
| Inpatient Hospital and Outpatient Hospital | Level 1, Level 2, Level 3, and Level 4 trauma centers. See Appendix C for list of impacted providers. | A uniform percentage increase to contracted rates between the classes of covered hospitals and the Medicaid MCO for trauma hospital services. Level 1 – 0.9%, Level 2 – N/A, Level 3 – 13.3%, Level 4 – 37.0%. |
| **Temporary Fee Increases – Hospital (Effective January 1, 2022 through June 30, 2022)** | | |
| Inpatient Hospital and Outpatient Hospital | Frontier/Rural and Urban hospitals. | A uniform dollar increase to contracted rates between the classes of covered hospitals and the MCOs. |

### Supplemental Payments

Authorized through the New Mexico Medicaid State Plan,[10] there are supplemental payments made to providers outside of the traditional FFS claims payment process. These payments are made quarterly or annually and detailed further in the State Plan. These payments are not made through the managed care delivery system. Below is the list of the supplemental payments impacting services included in the Phase 2 benchmarking analysis, but note that this list may not capture all supplemental payments relevant to the Phase 2 services. Refer to the State Plan for further information.

### Indirect Medical Education (IME)

This supplemental payment is intended to help cover the cost of residency programs. Each acute care hospital that qualifies as a teaching hospital will receive an IME payment adjustment, which covers the increased operating or patient care costs that are associated with approved intern and resident programs. The IME payment adjustment is subject to available state and federal funding,

[10] New Mexico Human Services Department. *New Mexico Medicaid State Plan.* Available at https://www.hsd.state.nm.us/new-mexico-medicaid-state-plan/ [Accessed January 2022]

as determined by the department and shall not exceed any amounts specified in the Medicaid State Plan.

### Graduate Medical Education (GME)

This supplemental payment is intended to help cover the cost of residency programs. Payment to hospitals for GME expense is made on a prospective basis and will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents in the various categories who worked at the hospital during the preceding year, and subject to an upper limit on total payments. The GME payment is subject to available state and federal funding, as determined by the department, and shall not exceed any amounts specified in the Medicaid State Plan.

### Disproportionate Share Hospitals (DSH)

This supplemental payment is intended to offset uncompensated care costs for hospitals serving a disproportionate number of Medicaid and other indigent patients. HSD allocates the available DSH funds to three separate payment pools, paying qualifying hospitals based on the number of discharges. DSH payments are subject to available state and federal funding.

### Targeted Access Payments (TAPs)

This supplemental payment is intended to adjust reimbursement made to hospitals in cases of inappropriate brief admissions and non-medically warranted days. Safety-Net Care Pool hospitals with Medicaid fee-for-service utilization during the Public Health Emergency are eligible to receive TAPs.

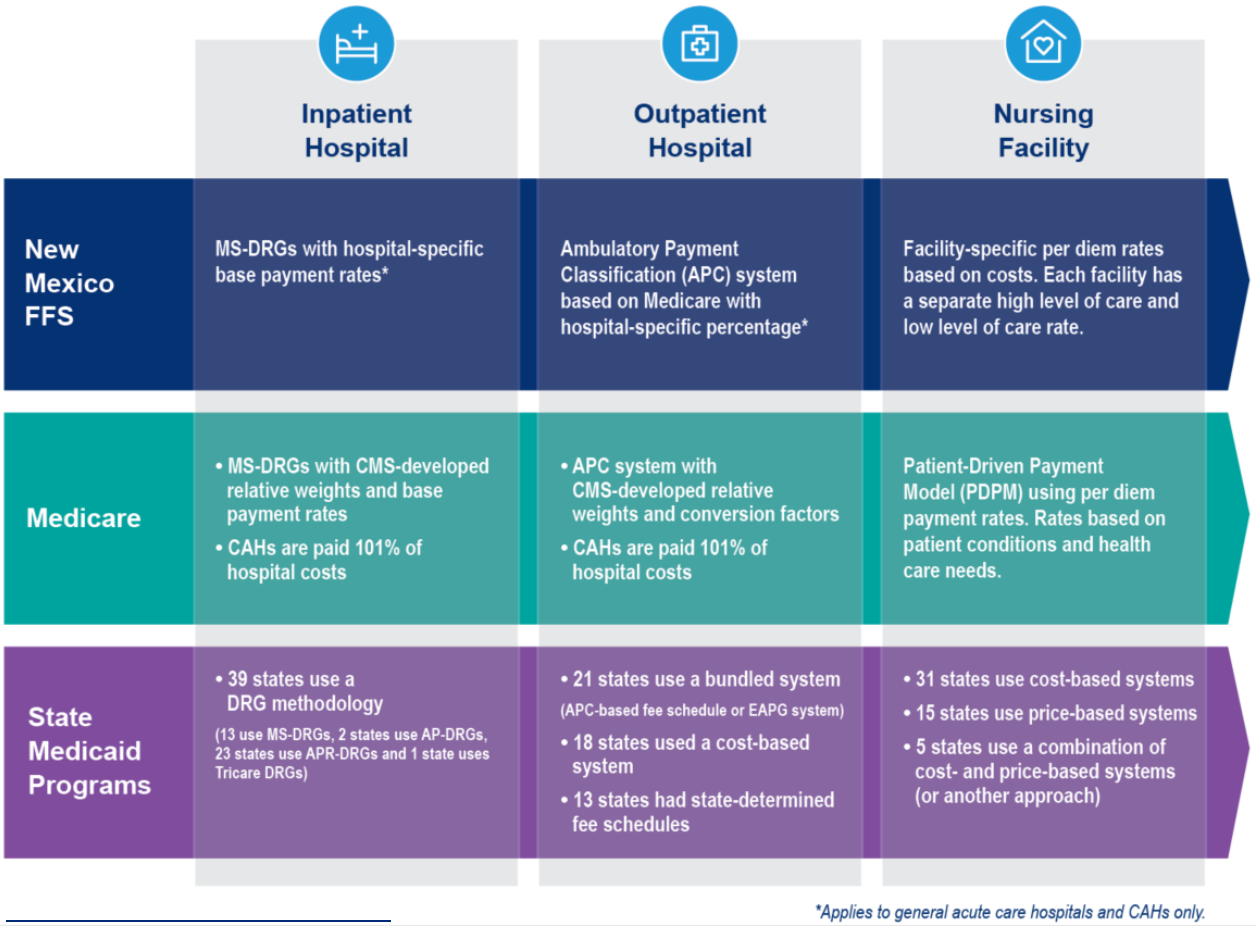
# Section 4
# Selected Benchmarks

## Overview of Methodologies for Medicare and Medicaid Nationwide

For each of the service areas presented in this report, Medicare and other state Medicaid programs may use reimbursement methodologies that differ from New Mexico. In some cases, Mercer has determined reasonable comparisons among the payers or states, but in other cases, it is not feasible to benchmark the New Mexico FFS payment levels.

Inpatient hospital, outpatient hospital and nursing facilities account for a majority of New Mexico Medicaid expenditures in this phase of the study. We have summarized the methodologies for these services in the figure below.

**Figure 5. Overview of Reimbursement Methodologies for Key Service Areas[11]**




[11] MACPAC, State Medicaid Payment Policies reflecting 2018 Inpatient Hospital policies, 2015 Outpatient Hospital policies, 2018/2019 Nursing Facility policies. Available online:
https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/
https://www.macpac.gov/publication/state-medicaid-payment-policies-for-outpatient-hospital-services/
https://www.macpac.gov/publication/nursing-facility-payment-policies/

## New Mexico Medicare FFS

CMS is the largest payer of health care services in the country.[12] CMS establishes reimbursement methodologies, maintaining and updating the pricing inputs routinely for the Medicare program. Medicare rates are frequently a required comparison of Medicaid reimbursement for CMS review and approval, such as through Upper Payment Limit (UPL) requirements or for approval of directed payments to providers under Medicaid managed care. Therefore, Medicare serves as an important benchmark comparison to evaluate New Mexico's reimbursement rates in Medicaid.

Medicare primarily covers hospital inpatient and outpatient, preventive and medically necessary services, skilled nursing facility, hospice, and pharmacy care for people over age 65 or with certain disabilities. Importantly, Medicare does not cover long-term custodial care in a nursing home, dental office care or many services billed using a Healthcare Common Procedure Coding System code. Additionally, Medicare is not a large payer for maternal and child health services given the population covered by Medicare.

For Phase 2, Mercer used Medicare payment rates as a benchmark for inpatient hospital, outpatient hospital and hospice, and estimated the facility costs for nursing facility services using Medicare cost reports. Unlike the Phase 1 service areas, the Medicare reimbursement methodology differs for each of the Phase 2 service areas. See the figure above in addition to the *Results* section for additional details on the Medicare reimbursement methodology by Service Area. Unless otherwise specified, the Medicare rates reflect the CY2021 rates for New Mexico.

## Medicaid – Other States

In addition to Medicare, Mercer used other state Medicaid reimbursement rates for benchmark comparisons where possible. Mercer used the published FFS fee schedule rates for each state. These fee schedules may not include other sources of provider reimbursement, such as directed payments and supplemental payments.

States were selected for comparison based on several considerations:

- Does the other state have fee schedules similarly structured to New Mexico and readily accessible?
- Is the state geographically close to New Mexico?
- How much of the state's population is covered by Medicaid?
- What type of delivery system does the state use?

Based on these considerations, Mercer and HSD selected four states as additional benchmarks for both Phase 1 and Phase 2 service areas. The figures below represent the state profiles from CY2019 as reported by the Kaiser Family Foundation. See Appendix D for additional demographic information on New Mexico and the other selected benchmark states and the data sources used.

[12] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet [Accessed January 2022]

**Figure 6: CY2019 Key Characteristics for Benchmark States**

| | US Census Bureau Region | State Population | % Medicaid | % Medicaid Births | % Medicaid Managed Care |
|---|---|---|---|---|---|
| NM | West | 2M | 32% | 70% | 80% |
| AZ | West | 7M | 21% | 50% | 85% |
| CO | West | 5M | 17% | 45% | 10% |
| LA | South | 4.5M | 30% | 65% | 90% |
| WA | West | 7.5M | 20% | 50% | 85% |

The most distinguishing characteristic of the four selected benchmark states is the percentage of the population using managed care ("% Medicaid Managed Care"). Colorado predominantly uses FFS for Medicaid payments, therefore, Colorado's FFS fee schedule accurately reflects actual Medicaid payments to providers in the state. The other three benchmark states (Arizona, Louisiana, and Washington) predominantly use managed care for Medicaid payments. Medicaid managed care payments can vary significantly from FFS rates in some states given the ability for MCOs to negotiate payment rates.[13] The current variations between managed care payments and the FFS fee schedule rates in Arizona, Louisiana, and Washington are unknown.

## Arizona

Arizona's Medicaid program predominantly operates through a managed care delivery system. Therefore, providers are paid through MCO negotiated rates which may differ from the published FFS rates. The rates used in this analysis are publicly available on the Arizona State Medicaid website and were effective as of October 1, 2021. See Appendix B for additional details. See the *Results* section for additional details on the Arizona reimbursement methodologies by Service Area.

## Colorado

Colorado's Medicaid program predominately operates through a FFS system. The rates used in this analysis are publicly available on the Colorado State Medicaid website and were effective as of July 1, 2021 for Ambulatory Surgical Centers (ASC), dialysis, and nursing facility, and effective as of October 1, 2021 for hospice, and RTCs. See Appendix B for additional details. See the *Results* section for additional details on the Colorado reimbursement methodologies by Service Area.

## Louisiana

Louisiana's Medicaid program predominantly operates through a managed care delivery system. Therefore, providers are paid through MCO negotiated rates which may differ from the published

[13] https://www.gao.gov/assets/gao-14-533.pdf

FFS rates. Rates were effective in 2021 or earlier. The rates used in this analysis are publicly available on the Louisiana State Medicaid website. See Appendix B for additional details. See the *Results* section for additional details on the Louisiana reimbursement methodologies by Service Area.

## Washington

Washington's Medicaid program predominantly operates through a managed care delivery system. Therefore, providers are paid through MCO negotiated rates which may differ from the published FFS rates. The rates used in this analysis are publicly available on the Washington State Medicaid website and were effective in 2021. See Appendix B for additional details. See the *Results* section for additional details on the Washington reimbursement methodologies by Service Area.

# Section 5
# Results

Mercer presents the results of the Phase 2 benchmarking by service category, sharing results for both the comparison of managed care to FFS reimbursement levels and the comparison of FFS rates to other available benchmarks. Based on the analysis, Mercer observed that the average managed care reimbursement is generally on track with the FFSE amounts, where managed care pays 99% of FFSE amounts overall across all Phase 2 services. However, Mercer observed some variation by service, most notably:

- For inpatient services provided by psychiatric and rehabilitation hospitals, New Mexico pays a percentage of charges under FFS but the MCOs appear to reimburse differently, resulting in lower payments as compared to the FFSE amounts.
- For RTCs, New Mexico pays all facilities the same FFS rate based on the type of facility/treatment, but the MCOs appear to reimburse individual facilities at different rates, resulting in larger variation in payments as compared to the FFSE amounts.
- New Mexico pays dialysis services based on the revenue code under FFS, but the MCOs appear to reimburse differently, resulting in higher payments as compared to the FFSE amounts.

Mercer will seek feedback from MCOs and providers during the stakeholder engagement activities to better understand drivers of these patterns.

Mercer's results include benchmark comparisons wherever they could be practically performed at the detail level, which includes the majority of expenditures for each of the Phase 2 service types. As outlined in Section 4 and in more detail for applicable service areas below, due to coverage differences, significant differences in methodology, or data limitations, there were certain claims that could not be compared to Medicare, and others that could not be benchmarked at all. In addition, there are other types of payments in the New Mexico system in which Phase 2 providers are paid in ways that do not directly link to specific claims; primarily the state directed payments in managed care and supplemental payments in FFS, and those payments are also excluded from these results. Thus, Mercer presents benchmarking results in this section that are valid when considered for the particular claims evaluated; however, if all payment streams to providers were considered, conclusions regarding overall reimbursement relationships may be different. In each section below, we provide some detail on the non-benchmarked payment volume and the implications for Mercer's conclusions.

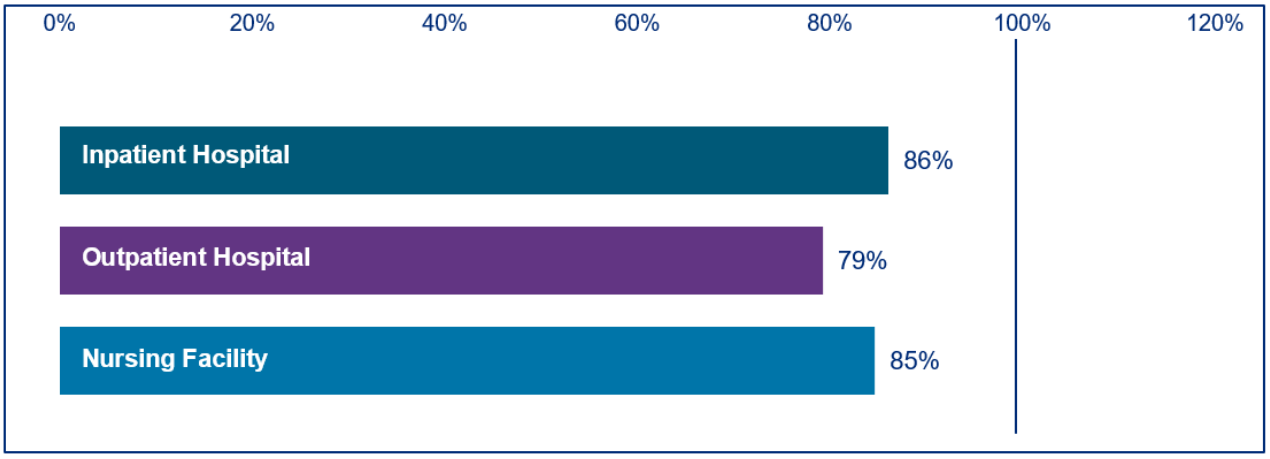
In addition to the quantitative benchmarking, we also discuss the methodologies used in New Mexico as well as Medicare and the other selected benchmark states. In each of the sections below, we will discuss these findings in more detail for each service group.

For the rehabilitation, psychiatric, nursing facility and hospice service areas, the structure of the program may vary widely from state-to-state and therefore the level of detail available for benchmarking may also vary. In these cases, we have presented the information using ranges or other relevant information. We outline the specific approach in each category below.

In Figure 7, we illustrate the overall results for the CY2021 New Mexico FFS fee schedules compared to the presented benchmarks for the inpatient hospital, outpatient hospital, and nursing facility services. Overall for these service areas, New Mexico Medicaid pays approximately 97% of FFS reimbursement levels through its managed care program.

In addition to the managed care expenditures available for benchmarking for inpatient hospital, outpatient hospital and nursing facility services, we have included the estimated increase in managed care expenditures resulting from HSD's directed payment programs in Figure 7 below. As described in Section 3 of this report, the directed payments are paid to providers outside of the encounter claims and are not already reflected in the CY2019 Managed Care expenditures. For example for inpatient hospital services, the directed payments increase the overall managed care expenditures by approximately 14%, which may bring the total managed care payments above FFS levels and closer to Medicare payments for this service area. However, it is important to recognize that the directed payment amounts vary by facility.

**Figure 7: Overall New Mexico Medicaid FFS Relativity to Medicare[1]**




| Service Area | MC/FFSE | NM Medicaid FFS Percent of Medicare[2] | CY2019 Estimated Increase to Managed Care Expenditures[3] |
|---|---|---|---|
| **Subtotal** | **97%** | **83%** | **N/A** |
| Inpatient Hospital | 100% | 86% | 14% |
| Outpatient Hospital | 86% | 79% | 22% |
| Nursing Facility | 110% | 85% | 46% |

*1. Mercer calculated Medicare payments for inpatient general acute care services using the MS-DRG pricing formula and Medicare OPPS rates for outpatient general acute care services. For the other subgroups, the Medicare payment calculations are estimates using hospital-level per diems or cost-to-charge ratios (CCRs) and may not reflect precise Medicare payments.*
*2. For nursing facilities, Mercer compared the NM Medicaid FFS payments to the estimated facility costs (based on facility costs reported in Medicare cost reports). See further description below.*
*3. The amount of directed payments vary by facility and apply to managed care only. These directed payment amounts are not reflected in the Total Managed Care Expenditures presented in Table 2 earlier in this report and are paid in addition to managed care capitation payments.*

The supporting Excel™ file titled “Provider Rate Benchmarking Study P2 - Detail” dated April 29, 2022 includes additional detail to support the summary of results that includes the following information:

- Top 20 MS-DRG codes (by Managed Care expenditures) for General Acute Hospitals and Critical Access Hospitals for inpatient hospital services.
- Top 20 ICD-10 diagnosis codes (by Managed Care expenditures) for Psychiatric Hospitals and Rehabilitation Hospitals for inpatient hospital services.
- Minimum, median, and maximum per diem rates for New Mexico FFSE and the selected benchmarks for Psychiatric and Rehabilitation Hospitals for inpatient hospital services.
- Top 20 procedure codes (by Managed Care expenditures) for General Acute Hospitals, Critical Access Hospitals, Psychiatric Hospitals, and Rehabilitation Hospitals for outpatient hospital services.
- New Mexico FFS provider specific rates for nursing facilities and minimum, median, and maximum per diem rates for New Mexico FFS and the selected benchmarks for nursing facility services.
- New Mexico FFS provider specific rates for hospice facilities and minimum, median, and maximum rates for New Mexico FFS and the selected benchmarks for hospice services.

# Inpatient Hospital

| Medicare | AZ | CO | LA | WA |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |

The managed care expenditures for inpatient hospital services in New Mexico account for 34% of the institutional services analyzed in Phase 2 of the study. Medicare and most state Medicaid programs reimburse hospitals for inpatient services using diagnosis related groups (DRGs), a classification system adopted by Medicare in 1983. Since the initial implementation, payers have developed various types of DRG systems, which are classification systems that group inpatient discharges for payment purposes. The three listed below are used most commonly:

- **Medicare Severity Diagnosis Related Groups (MS-DRGs):** System with approximately 750 DRGs, classifying inpatient discharges based on the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay. In a small number of MS-DRGs, classification is also based on the age, sex, and discharge status of the patient.[14] MS-DRGs were developed primarily to support Medicare payments.
- **All Patient DRGs (AP-DRGs):** An expansion of the MS-DRG system to be more representative of non-Medicare populations such as pediatric patients.
- **3M All Patient Refined DRGs (APR-DRGs):** This version further expands the AP-DRGs to incorporate severity of illness subclasses for each DRG. This system reflects all payer

[14] Centers for Medicare & Medicaid Services MS-DRG Classifications and Software
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

populations and has four severity of illness categories for each DRG to bring more precision to the payment amount for each inpatient discharge. There are approximately 1,330 APR-DRGs.

Under these DRG methodologies, payers reimburse hospitals a fixed amount per discharge, with outlier payments for especially costly cases. Based on a 2018 MACPAC report, 39 states pay for inpatient Medicaid discharges using a DRG methodology: 13 use MS-DRGs, 2 states use AP-DRGs, 23 states use APR-DRGs and one state uses Tricare DRGs (Georgia).[15] As of February 2021, 3M indicates that 27 state Medicaid programs use APR-DRGs to pay hospitals in addition to 12 commercial payers and Medicaid managed care organizations.[16]

New Mexico uses MS-DRGs to pay for inpatient hospital services delivered in a general acute or critical access hospital (CAH), and reimbursement for psychiatric and rehabilitation services delivered in a hospital is based on a percentage of charges. Most of the inpatient hospital services are for managed care members, except those for the populations that are not required to enroll or ineligible for managed care as listed in Section 3.

The reimbursement approach for Medicare is consistent with New Mexico for some of the inpatient hospital services (e.g., general acute care hospitals) but not all categories (e.g., psychiatric and rehabilitation). Therefore, we have benchmarked the payment levels where appropriate in the following sections. In addition, the selected state Medicaid benchmarks do not follow the same approach as New Mexico and could not be directly compared to the New Mexico FFS payment rates for inpatient services. Arizona, Colorado, and Washington use APR-DRGs for inpatient hospital reimbursement and Louisiana pays hospitals using per diems.

As described earlier in this report, Mercer excluded certain inpatient hospital stays from the Phase 2 analysis since they are paid differently than a typical inpatient discharge under FFS and would skew the benchmarking results. We provide additional information for each of these exclusions below.

- **Outlier Stays**: Inpatient discharges paid using the outlier payment policy represent 2% of all New Mexico discharges in CY2019 and 25% of total inpatient hospital expenditures. Inpatient visits are eligible for a New Mexico outlier payment under FFS when a patient meets one of these specified thresholds.
  - State teaching hospital: Outlier payments are made for inpatient stays exceeding $125,000 in billed charges, or the length of stay is 75 calendar days or more.
  - Disproportionate share hospitals: Outlier payments are made for children up to age six where an inpatient stay exceeds $100,000 in billed charges, or the length of stay is 75 calendar days or more.
  - All hospitals: Outlier payments are made for infants under age one when an inpatient stay exceeds $100,000 in billed charges, or the length of stay is 75 calendar days or more.

  The NMAC indicates that outlier cases are paid at an amount equal to 85% of the hospital's standardized cost, and the State Plan indicates these cases are paid 90% of the hospital's standardized cost. Based on HSD input, outlier stays are reimbursed at 90% of the hospital's standardized costs. Standardized costs equal the hospital's allowable billed charges multiplied

[15] MACPAC, State Medicaid Payment Policies for Inpatient Hospital Services, https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/

[16] https://www.3m.com/3M/en_US/health-information-systems-us/drive-value-based-care/patient-classification-methodologies/apr-drgs/

by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report. The outlier policies under managed care may differ from those under FFS.

For FY2021, Medicare implemented an outlier threshold of $29,051, targeting outlier payments equal to 5.11% of operating DRG payments and 5.363% of capital payments.[17]

- **Out-of-State Hospitals:** Inpatient discharges to these hospitals represent 6% of total New Mexico discharges in CY2019 and 3% of total inpatient hospital expenditures. Under Medicare, each state uses a different set of wage indices to determine inpatient hospital Medicare payments. The results presented in this report reflect direct comparisons of New Mexico Medicaid's payment levels to New Mexico *Medicare* payment levels, therefore, we did not include discharges for out-of-state hospitals.
- **Transfers and 1-day Stays**: Inpatient discharges for transfers represent 8% of total discharges and 18% of inpatient hospital expenditures, while hospital 1-day stays represent 21% of total New Mexico discharges in CY2019 and 8% of total inpatient hospital expenditures. New Mexico and Medicare both pay these types of inpatient visits differently than a typical inpatient discharge eligible for a full DRG payment. In New Mexico FFS, transfers are paid the lower of the standardized costs or the appropriate DRG payment for the visit; and Medicare pays a per diem rate if the length of stay is shorter than identified for the associated DRG.

For typical inpatient hospital discharges, we do not expect that these claims would strongly influence the benchmarking results, however, these payments and policies may affect the methodology recommendations provided to HSD in the Final Report of this study.

## General Acute Hospitals

General hospitals account for 79% of all inpatient hospital services evaluated in the benchmarking analysis. In CY2019, New Mexico general acute hospitals provided over 37,000 inpatient discharges across 670 MS-DRGs, with 10 hospitals providing a majority (89%) of all general acute inpatient hospital stays. The managed care reimbursement for these services correspond to 117% of the FFSE reimbursement levels, across all MS-DRGs.

Overall, New Mexico pays 72% of estimated Medicare payments. For the five DRGs with the most expenditures in CY2019, New Mexico is paying between 54% and 104% of Medicare.

[17] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates, Federal Register / Vol. 85, No. 182 / Friday, September 18, 2020 / Rules and Regulations, page 59040.

**Table 6: Relativities for the Selected Benchmarks for Top Five MS-DRGs (Based on Expenditures)**

| Top MS-DRGs | CY2019 | | CY2021 |
|---|---|---|---|
| | Number of Discharges | MC/FFSE | NM Medicaid FFS Percent of Medicare |
| **All MS-DRGs** | **37,077** | **117%** | **72%** |
| 871: Septicemia or Severe Sepsis W/O MV >96 Hours W MCC | 1,035 | 126% | 86% |
| 885: Psychoses | 1,766 | 97% | 73% |
| 189: Pulmonary Edema & Respiratory Failure | 726 | 114% | 104% |
| 807: Vaginal Delivery W/O Sterilization/D&C W/O CC/MCC | 3,262 | 107% | 54% |
| 853: Infectious & Parasitic Diseases W O.R. Procedure W MCC | 156 | 126% | 88% |

The MS-DRGs displayed in the table above represent those with the most managed care expenditures; however, the three most frequently used MS-DRGs were inpatient stays related to newborns and deliveries, where each MS-DRG has more than 2,000 discharges in CY2019 (accounting for 24% of all inpatient stays for general acute care hospitals).

- MS-DRG 795: Normal Newborn
- MS-DRG 807: Vaginal Delivery W/O Sterilization/D&C W/O CC/MCC
- MS-DRG 794: Neonate W Other Significant Problems

For these discharges, New Mexico's FFSE payments are 15% to 69% of Medicare's estimated payments. Given that the MS-DRG system was developed for the Medicare population, the payments under MS-DRGs does not reflect as much cost precision for maternal and pediatric services.

Overall, New Mexico managed care payments for general acute care hospitals are above FFSE levels, but both managed care and FFSE payments are lower than Medicare.

## Critical Access Hospitals

CAHs account for 4% of managed care expenditures in New Mexico for CY2019. Five of the 10 CAHs accounted for over 85% of CY2019 inpatient hospital discharges and inpatient hospital expenditures. The managed care reimbursement to these hospitals corresponds to 125% of the FFSE reimbursement levels.

Under Medicare, CAHs are paid 101% of provider costs for inpatient hospital services. Mercer obtained the aggregated hospital-specific Medicare payment per diems from Medicare Cost Reports (as available in the Medicare Hospital Cost Report Information System [HCRIS] database) and applied these per diems to the actual New Mexico Medicaid covered days to

estimate Medicare payments for CAH inpatient stays.[18] Based on this calculation, New Mexico pays 77% of estimated Medicare payments to CAHs for inpatient hospital services.

Consistent with the general acute care hospitals:

- HSD pays for inpatient services delivered by CAHs in New Mexico using MS-DRGs
- The 3 most frequently used MS-DRGs for CAHs are:
  - MS-DRG 795: Normal Newborn
  - MS-DRG 807: Vaginal Delivery W/O Sterilization/D&C W/O CC/MCC
  - MS-DRG 794: Neonate W Other Significant Problems

## Rehabilitation Hospitals

Inpatient rehabilitation hospitals account for 7% of inpatient hospital services (40% of psych/rehab services) with $24.8 million in managed care payments. The managed care payments to these 11 rehabilitation hospitals is 67% of the FFSE reimbursement levels, which suggests the MCOs may use different reimbursement methodologies from FFS, which is based on a percentage of charges. Mercer will inquire about the methodology for rehabilitation service reimbursement in the stakeholder outreach portion of the study.

Medicare pays inpatient rehabilitation facilities for each discharge using a prospective payment system (PPS) that relies on various patient characteristic fields that were not available to Mercer (e.g., HIPPS codes); therefore, we could not calculate precise Medicare payments for these services. The PPS applies the patient assessment information to classify patients into distinct groups based on clinical characteristics and expected resource needs, with separate payments for each group, including the application of case and facility level adjustments.[19]

Similar to the approach used for CAHs above, Mercer used the aggregated hospital-specific Medicare payment per diems from Medicare Cost Reports from HCRIS for each rehabilitation hospital to estimate Medicare payments for the rehabilitation days delivered in New Mexico in CY2019. We estimated that New Mexico FFS payment levels are approximately 154% of Medicare payments based on this calculation. However, it should be noted that this Medicare payment estimate does not account for the patient characteristic or acuity adjustments so does not have the same level of precision as the Medicare rehabilitation PPS payments.

The other benchmark states use various structures to reimburse for rehabilitation services, but all use facility-specific per diem rates. For example, Colorado has per diem rates with four stepdown levels and Washington has facility-specific per diem rates with floors/ceilings. For purposes of this comparison to other states' 2021 payment rates, Mercer compared the CY2019 New Mexico FFS minimum, median and maximum payments on a per diem basis (trended to the midpoint of CY2021) to the other benchmark states and found that New Mexico pays above all of these comparison states.[20] The table below shows the rehabilitation hospital benchmarking results for Medicare and each state, separated by the minimum, median, and maximum rate. Mercer will

[18] Cost Reports obtained from HCRIS database, July 2020 reflecting hospital fiscal year end (FYE) 2018 or 2019 hospital costs, based on the SFY 2021 UPL demonstration template provided by Myers & Stauffer.
[19] CMS.gov, Inpatient Rehabilitation Facility PPS, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS
[20] There is no published New Mexico FFS fee schedule for Rehabilitation Hospitals because each claim is paid on a percent of charges. Therefore, Mercer relied on the per diems from the CY 2019 encounter data trended to CY 2021 using the Consumer Price Index to compare to the CY 2021 rate levels in other states.

inquire about the MCO methodologies for Rehabilitation Hospital reimbursement in the stakeholder outreach portion of the study.

**Table 7: Summary of Rehabilitation Hospitals Benchmarking Results**

| Rate Statistic | CY 2019 MC/FFSE | CY2021: NM FFS Percent of Benchmark FFS Rates | | | | |
|---|---|---|---|---|---|---|
| | | Medicare | AZ | CO | LA | WA |
| Minimum Rate | 71% | 107% | 114% | 132% | 135% | 103% |
| Median Rate | 45% | 157% | 264% | 142% | 313% | 206% |
| Maximum Rate | 47% | 167% | 546% | 190% | 647% | 282% |

## Psychiatric Hospitals

Services delivered by psychiatric hospitals in New Mexico account for 10% of inpatient services in CY2019 (60% of psych/rehab services) with $36.5 million in managed care payments. Total managed care payments correspond to approximately 54% of FFSE levels, which suggests the MCOs may use different reimbursement methodologies from FFS (based on a percentage of charges). Mercer will inquire about the methodology for psychiatric service reimbursement in the stakeholder outreach portion of the study.

Medicare pays inpatient psychiatric facilities for each day of service using a PPS based on the sum of the national average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an inpatient facility, adjusted for budget neutrality. For purposes of this study, Mercer replicated the Medicare payment calculations for inpatient psychiatric hospital services. We estimated that New Mexico FFS payment levels are approximately 164% of Medicare payments based on this calculation.

The other benchmark states pay for psychiatric services under FFS using per diem rates, but the rate structure varies. Arizona and Louisiana use one rate for most psychiatric services with some variation by revenue code or facility, Colorado has facility-specific per diem rates with stepdown levels and Washington has facility-specific per diem rates with floors/ceilings. For purposes of this comparison to other states' 2021 payment rates, Mercer compared the New Mexico FFS minimum, median and maximum payments on a per diem basis (trended to the midpoint of CY2021) to the other benchmark states and found that New Mexico pays higher than all of these comparison states.[21] The table below shows the psychiatric hospital benchmarking results for Medicare and each state, separated by the minimum, median, and maximum rate.

**Table 8: Summary of Psychiatric Hospitals Benchmarking Results**

| Rate Statistic | CY2019 MC/FFSE | CY2021: NM FFS Percent of Benchmark FFS Rates | | | | |
|---|---|---|---|---|---|---|
| | | Medicare | AZ | CO | LA | WA |
| Minimum Rate | 90% | 82% | 99% | 140% | 94% | 94% |
| Median Rate | 71% | 136% | 174% | 207% | 160% | 148% |
| Maximum Rate | 20% | 376% | 541% | 668% | 437% | 198% |

[21] There is no published New Mexico FFS fee schedule for Psychiatric Hospitals because each claim is paid on a percent of charges. Therefore, Mercer relied on the per diems from the CY 2019 encounter data trended to CY 2021 using the Consumer Price Index to compare to the CY 2021 rate levels in other states.

# Outpatient Hospital

| Medicare | AZ | CO | LA | WA |
|---|---|---|---|---|
| ✓ | X | X | X | X |

The managed care expenditures for outpatient hospital services in New Mexico account for 31% of the institutional services analyzed in Phase 2 of the study. While state Medicaid agencies have flexibility in determining the payment rates for covered Medicaid services delivered in an outpatient hospital, there are a few commonly adopted methodologies utilized by states. Based on Mercer's research and a MACPAC publication of Medicaid payment policies, states generally use one of the following:

- **Ambulatory Payment Classification (APC) system**: An Outpatient Prospective Payment System (OPPS) that classifies procedure codes into categories based on similar costs and clinical characteristics for payment purposes. This is a service-based system.
- **Enhanced Ambulatory Patient Group (EAPG) system**: An OPPS visit-based system that categorizes patients based on resource use, cost and clinical characteristics for payment purposes. This is a comprehensive system that can apply to services delivered in hospitals, freestanding ASCs, renal dialysis centers and other outpatient settings and services.
- **Cost-based system**: Payment rates are typically a percentage of charges, developed based on hospital cost reports. Some states establish the cost-based rates on a prospective basis, while others do so retrospectively (i.e., cost settling at the end of each year).
- **Fee Schedule**: A state-developed fee schedule that may be based on Medicare cost reports or commercial customary charges.

The APC and EAPG approaches are considered bundled payment systems where the Medicaid agency pays for the major or significant surgery, but the ancillary services needed to conduct the surgery are "bundled" (or "packaged") into the major surgery payment.

According to the 2015 MACPAC study, 14 states use an APC-based fee schedule and seven use an EAPG system. In addition, 18 states used a cost-based system and 13 states had state-determined fee schedules at the time of publication; however, five of these states noted that they planned to move to APC or EAPG systems.

New Mexico generally follows Medicare's APC-like system, assigning a fixed OPPS rate to each procedure code. Provider payment equals a percent of the OPPS rate which varies by hospital. It is worth noting these specific considerations:

- HSD updated the hospital percentages on July 1, 2019 as published on the HSD website. In the managed care comparison to the FFSE below, we are presenting the results for the CY2019 time period, which includes the hospital rate changes midway through the year.
- For select procedure codes, New Mexico uses state-specific Medicaid rates. For example, Medicare "packages" the payment for procedure code G0378 (Hospital observation per hour) into the significant procedure on the claim (i.e., Medicare payment = $0), but New Mexico pays for this procedure code separately based on the units billed (i.e., published New Mexico rate is $28.28 per unit).

- For laboratory services:
  - Codes that are on the federal Clinical Diagnostic Lab Code list are paid at 94% of the federal Medicare schedule for New Mexico. The hospital percentages applied to the published OPPS rates are not used for these codes.
  - There are other laboratory codes where the hospital percentages apply for calculation of the New Mexico FFS payment, if they are not considered "packaged".

As described earlier in this report, Mercer excluded certain outpatient hospital services from the Phase 2 analysis since they are paid differently and would skew the benchmarking results. Specifically, for purposes of this benchmarking analysis, we excluded:

- **"Packaged" services**: These services represent 48% of total New Mexico outpatient hospital line items in CY2019 and 13% of total outpatient hospital expenditures. These are services that are packaged by Medicare meaning that the payment for select services is bundled into the payment for the significant procedure on the claim, resulting in a $0 payment to the packaged service. New Mexico pays for some of these procedure codes, however, Medicare does not; therefore, we did not include these procedure codes in the benchmarking analysis given that there is no reasonable rate comparison.
- **Services Paid with Other Methodology**: These services represent 15% of total New Mexico outpatient hospital line items in CY2019 and 26% of total outpatient hospital expenditures. The APC methodology is a service-based system with payment rates associated with each procedure code. States may have policies to pay based on revenue code or other fields on the claim besides the procedure code. The majority of the services that fall under this exclusion are for Managed Care outpatient line items with no reported procedure codes. In these instances, there are no FFSE payments calculated for the service. The revenue codes for these claims are primarily for recovery room, pharmacy services, medical supplies, or anesthesia services. Given that this varies by state and payer, and the FFSE is not populated for many of these services, we did not benchmark the data for these items.
- **Out-of-State Hospitals:** Outpatient discharges to these hospitals represent 1% of total New Mexico outpatient hospital line items in CY2019 and 2% of total outpatient hospital expenditures. Under Medicare, each state uses a different adjustment factor to determine outpatient hospital Medicare payments. The results presented in this report reflect direct comparisons of New Mexico Medicaid's payment levels to New Mexico *Medicare* payment levels, therefore, we did not include the services for out-of-state hospitals.

These services are exceptions to the standardized APC-based reimbursement methodology and would skew the benchmarking results for outpatient hospital services at the detail level; however, these payments and policies may affect the methodology recommendations provided to HSD in the Final Report of this study.

New Mexico reimbursement for psychiatric and rehabilitation services delivered in a hospital is based on a percentage of charges, with the exception of partial hospitalization services. See the Psychiatric Hospitals section below for additional information.

Most of the outpatient hospital services are for managed care members, except those for the populations that are not required to enroll or ineligible for managed care as listed in Section 3. Medicare's reimbursement approach is similar to New Mexico for the general acute care

hospitals, but not for CAHs, psychiatric or rehabilitation hospitals. Therefore, we have benchmarked the payment levels where appropriate in the following sections.

In addition, the selected state Medicaid benchmarks do not follow the same approach as New Mexico and as a result could not be directly compared to the New Mexico FFS payment rates. Colorado and Louisiana pay for outpatient hospital services based on costs and Washington uses an EAPG system. Arizona's fee schedule is based on the Medicare OPPS fee schedule; however, the state has developed additional bundled payments for select services and applied peer group factors to differentiate emergency department payments among hospital types (e.g., Urban, Large Rural, Small Rural, CAHs, Public, Free-standing Children's, Large Pediatric and University-affiliated Teaching Hospitals). Therefore, the rates cannot be compared to New Mexico by procedure code.

## General Acute Hospitals

General hospitals account for 84% of all outpatient hospital expenditures evaluated in the benchmarking analysis. In CY2019, the highest paid outpatient services were for emergency department visits and outpatient clinic visits, where 10 hospitals provided a majority (80%) of all general acute outpatient services. The managed care reimbursement for these services corresponds to 81% of the FFSE reimbursement levels, across all outpatient hospital procedure codes. This overall average relativity of managed care to FFSE appears to be primarily driven by differentials in the MCO unit billing for one procedure code – 90378 (RSV MAB IM 50MG). This service should be billed in 50 mg increments per the code definition; however, based on the results it appears that the MCOs may be billing in 1 mg increments, as shown in the table below. Mercer will inquire about the MCO reporting of procedure code 90378 units in the stakeholder outreach portion of the study.

**Table 9: Overview of Results for Procedure Code 90378**

| Procedure Code | CY2019: New Mexico Encounter Data | | | |
|---|---|---|---|---|
| | Billed Units | Managed Care Payments | FFSE | MC/FFSE |
| 90378 (RSV MAB IM 50MG) | 51,045 | $1,599,709 | $59,468,031 | 3% |

Excluding this service from the managed care/FFSE comparison, the managed care reimbursement for all other services corresponds to 98% of the FFSE reimbursement level.

To determine how New Mexico FFS payments for outpatient hospital services compare to Medicare, Mercer identified the Medicare national rate for each procedure code and applied the hospital wage index to estimate NM Medicare payments for each service. Overall, we estimated that New Mexico pays 89% of outpatient Medicare payments for the mix of services provided in New Mexico in CY2019. For the five procedure codes with the most expenditures in CY2019, New Mexico is paying between 80% and 106% of Medicare as shown below.

**Table 10: Relativities for the Selected Benchmarks for Top Five Procedure Codes (Based on Expenditures)**

| Top Procedure Codes | CY2019 | | CY2021 |
|---|---|---|---|
| | Number of Units | MC/FFSE | NM Medicaid FFS Percent of Medicare |
| **All Procedure Codes** | **2,675,081** | **81%** | **89%** |
| 99284: EMERGENCY DEPT VISIT | 99,841 | 93% | 82% |
| 99283: EMERGENCY DEPT VISIT | 122,128 | 104% | 80% |
| G0463: HOSPITAL OUTPT CLINIC VISIT | 165,786 | 109% | 91% |
| 99285: EMERGENCY DEPT VISIT | 45,043 | 93% | 84% |
| 74177: CT ABD & PELV W/CONTRAST | 18,935 | 95% | 106% |

## Critical Access Hospitals

CAHs account for 14% of the outpatient managed care expenditures in New Mexico for CY2019 where the top three procedure codes are for emergency department services. The managed care reimbursement to these hospitals corresponds to 132% of the FFSE reimbursement levels.

Under Medicare, CAHs are paid 101% of provider costs for outpatient hospital services. Mercer obtained the aggregated hospital-specific Medicare cost-to-charge ratios (CCRs) from Medicare Cost Reports (as available in the HCRIS database) and applied these CCRs to the actual New Mexico Medicaid billed charges to estimate Medicare payments for CAH outpatient services equal to 101% of costs.[22] Based on this calculation, New Mexico pays 66% of estimated Medicare payments to CAHs for outpatient hospital services.

Many other state programs pay CAHs consistent with general acute care hospitals, but may apply a peer group factor to account for the higher costs of delivering care given that CAHs do not achieve the same economies of scale.

In the table below, we present the top five procedure codes that contribute 5% of all CAH units of service and 29% of managed care expenditures in CY2019.

[22] Cost Reports obtained from HCRIS database, June 2019 reflecting hospital fiscal year end (FYE) 2018 or 2019 hospital costs, based on the SFY2021 Outpatient Hospital UPL demonstration template provided by Myers & Stauffer.

**Table 11: Relativities for the Selected Benchmarks for Top Five Procedure Codes (Based on Expenditures)**

| Top Procedure Codes | CY2019 | | CY2021 |
|---|---|---|---|
| | Number of Units | MC/FFSE | NM Medicaid FFS Percent of Medicare |
| **All Procedure Codes** | **810,869** | **132%** | **66%** |
| 99284: EMERGENCY DEPT VISIT | 11,887 | 118% | 79% |
| 99283: EMERGENCY DEPT VISIT | 14,964 | 130% | 79% |
| 99285: EMERGENCY DEPT VISIT | 4,617 | 117% | 74% |
| 74177: CT ABD & PELV W/CONTRAST | 2,087 | 161% | 23% |
| 87633: RESP VIRUS 12-25 TARGETS | 2,154 | 113% | 146% |

## Psychiatric Hospitals

Outpatient services delivered by psychiatric hospitals in New Mexico account for less than 1% of outpatient hospital expenditures in CY2019 with $2.4 million in managed care payments analyzed. Most of these expenditures are for partial hospitalization services. Partial hospitalization is a structured program to treat mental illness and substance abuse and is a step down from 24-hour care in a psychiatric hospital setting (inpatient treatment). These services are provided by psychiatric hospitals on an outpatient basis, where clients participate in the scheduled treatment sessions during the day and return home at night.

Total managed care payments correspond to approximately 70% of FFSE levels. Under FFS, New Mexico pays for partial hospitalization services using a per diem rate and all other psychiatric hospital services using a percentage of charges. As shown in Table 12 below, the managed care and FFSE reimbursement levels are close to 100% for partial hospitalization, but the overall category result of 70% is driven by the other psychiatric services. As part of the stakeholder outreach portion of the study, Mercer will also seek to better understand the reimbursement approach used by the MCOs for outpatient psychiatric services.

For purposes of this study, Mercer estimated Medicare payments for outpatient psychiatric services using the same approach described above for CAHs and rehabilitation hospitals. We used the aggregated hospital-specific Medicare CCRs from Medicare Cost Reports from HCRIS for each psychiatric hospital to estimate Medicare payments for the psychiatric units of service delivered in New Mexico in CY2019. We estimated that New Mexico FFS payment levels are approximately 282% of Medicare payments based on this calculation. It should be noted that this is a high-level estimate and does not provide service-level precision given that the aggregate hospital CCR is applied to every procedure code to calculate Medicare payments.

The top five procedure codes (Based on Expenditures) reported for psychiatric hospitals are:

- S0201: PARTIAL HOSPITALIZATION SERVICES, <25 HR
- 99285: EMERGENCY DEPT VISIT
- 99283: EMERGENCY DEPT VISIT
- G0378: HOSPITAL OBSERVATION PER HR

- 90853: GROUP PSYCHOTHERAPY

## Rehabilitation Hospitals

Outpatient rehabilitation hospitals account for less than 1% of outpatient hospital services with $1.4 million in managed care payments analyzed. Most of the services provided in this category are outpatient therapies. The managed care payments to the four rehabilitation hospitals billing services in CY2019 is 98% of the FFSE reimbursement levels.

Medicare pays outpatient rehabilitation therapies, which account for a significant portion of the services provided by outpatient rehabilitation hospitals in New Mexico, using the Medicare physician fee schedule. Mercer relied upon the CY2021 Medicare physician fee schedule rates by procedure code (consistent with the Phase 1 benchmarking report). We estimated that New Mexico FFS payment levels are approximately 142% of Medicare payments for these services.

In the table below, we present the top five procedure codes that contribute 64% of all rehabilitation units of service and 53% of managed care expenditures in CY2019.

**Table 12: Relativities for the Selected Benchmarks for Top Five Procedure Codes (Based on Expenditures)**

| | CY2019 | | CY2021 |
|---|---|---|---|
| Top Procedure Codes | Number of Units | MC/FFSE | NM Medicaid FFS Percent of Medicare |
| **All Procedure Codes** | **30,981** | **98.0%** | **142%** |
| 97110: THERAPEUTIC EXERCISES | 9,934 | 92.1% | 124% |
| 64493: INJ PARAVERT F JNT L/S 1 LEV | 238 | 84.3% | 460% |
| G0463: HOSPITAL OUTPT CLINIC VISIT | 1,704 | 94.7% | N/A |
| 97112: NEUROMUSCULAR REEDUCATION | 4,322 | 89.1% | 113% |
| 97113: AQUATIC THERAPY/EXERCISES | 3,610 | 95.0% | 111% |

# Nursing Facility and Hospice

| Medicare | AZ | CO | LA | WA |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |

Nursing facilities and hospice services (both in-home and facility) represent a sizable portion (27%) of the overall New Mexico Medicaid expenditures analyzed in Phase 2 of the study. Medicaid programs typically reimburse nursing facility and hospice services using an all-inclusive daily rate. The New Mexico FFS rates for nursing facilities and hospice are facility-specific and New Mexico pays for these services under FFS using the nursing facility and hospice fee schedules. The facility-specific rates are typically based on facility costs so can vary widely by facility. Nursing facility stays in the New Mexico FFS program are limited to short-term skilled-nursing facility stays only. Members requiring long-term nursing facility stays are required to be enrolled with an MCO and receive care in the Managed Care program.

New Mexico Medicaid reimburses nursing facilities using a two-tiered payment system based on the care needs of the patient. Each facility has a separate high level of care and low level of care rate. The high level of care rates are typically around 50% higher than the low level of care rates for the same facility. There are two types of nursing facilities in New Mexico, state-owned and operated nursing facilities and private nursing facilities. The state-owned and operated nursing facilities have higher reimbursement rates than the private facilities and have been reviewed separately.

In 2019, Medicare transitioned its nursing facility reimbursement to the Patient-Driven Payment Model (PDPM). The PDPM reimburses skilled nursing facilities (SNFs) based on patient conditions and health care needs rather than the volume of services provided. Generally, the Medicaid population served in nursing facilities is a different demographic than those served from the Medicare only population, where Medicaid includes individuals with more complex medical needs, higher utilization of therapy services and longer lengths of stay. PDPM was designed to support the shorter lengths of stay associated with Medicare's coverage limits for SNFs and does not accommodate longer-term and fluctuating therapy needs that are more common for the Medicaid population.

Medicare and the selected benchmark states reimburse nursing facility and hospice using either facility-specific, patient-specific or geographic-specific rates, therefore, direct comparison to New Mexico's facility specific rates is not possible. As such, Mercer reviewed the minimum rate, median rate, and maximum rate paid to nursing facility and hospice facilities in each selected benchmark state for the comparison to New Mexico, where available.

The detail required to reprice Medicaid nursing facility claims data using the Medicare nursing facility methodology was not available on the New Mexico managed care claims data. Since it was not possible to recalculate the Medicare payments for nursing facility services, we estimated the facility costs using Medicare cost report data for another data point, as payment rates are typically tied to the provider's cost to deliver service. For the purposes of this benchmarking study, we are comparing the minimum, median, and maximum facility cost per diems calculated as part of New Mexico's nursing facility UPL demonstration to the New Mexico Medicaid FFS fee schedule rates.[23]

## Nursing Facility

A majority of the overall nursing facility and hospice expenditures in the managed care program are for the Private-Owned Nursing Facility - Low Level of Care (PNF, Low) category (74%), while State-Owned Nursing Facility - Low Level of Care (SNF, Low) represents 10%, Private-Owned Nursing Facility - High Level of Care (PNF, High) represents 7%, and State-Owned Nursing Facility - High Level of Care (SNF, High) represents 1% of the nursing facility and hospice managed care expenditures.

Mercer identified a challenge with comparing the managed care NF payment rates and FFS payment rates because of the absence of key information, most notably the MCO contracted NF rate. Mercer has access to MCO payment amounts in the encounter data, but those are net of patient liability, copays, and third party liability. Copays and third party liability are available on the encounter, but patient liability is not. To compare, Mercer calculated FFS reimbursement amounts by subtracting the available copays and TPL amounts from the fee schedule amount, but this

[23] Based on the SFY 2021 Nursing Facility UPL demonstration template provided by Myers & Stauffer.

leaves a difference in the treatment of patient liability. Aggregate level data suggests that MCO gross NF payment may be approximately 10% higher with the value of patient liability included, which means the relativities presented here may be understated by approximately 10%.

While there is some variability between providers, the majority of facilities have higher MCO reimbursement than the FFS calculated reimbursement with total managed care payments equal to 110% of the FFS calculated reimbursement. The table below shows the number of Medicaid nursing facility days and FFS calculated relativity for each nursing facility type.

**Table 13: Nursing Facility FFS Calculated Relativities**

| | CY2019 | |
|---|---|---|
| **Nursing Facility Type** | **Number of NF Days** | **MC/FFS Calculated** |
| **Nursing Facility Total** | **1,345,350** | **110%** |
| *Low Level of Care* | | |
| Private-Owned Nursing Facility | 1,178,250 | 111% |
| State-Owned Nursing Facility | 95,490 | 99% |
| *High Level of Care* | | |
| Private-Owned Nursing Facility | 68,194 | 114% |
| State-Owned Nursing Facility | 3,416 | 97% |

Under Medicare, nursing facility payments vary by provider and patient characteristics. Mercer obtained the aggregated nursing facility-specific cost per diems from Medicare Cost Reports and applied these per diems to the actual New Mexico Medicaid covered days to estimate facility costs for nursing facility stays.[24] Based on this calculation and a comparison to the median facility rates, New Mexico pays 84% of estimated facility costs to PNF (Low), 91% of estimated facility costs to SNF (Low), 82% of estimated facility costs to PNF (High), and 161% of estimated facility costs to SNF (High).

The table below shows the benchmarking results, separated by the minimum, median, and maximum rate for each nursing facility type.

[24] Cost Reports obtained from HCRIS database, July 2020 reflecting facility fiscal year end (FYE) 2019 costs, based on the SFY 2021 UPL demonstration template provided by Myers & Stauffer.

**Table 14: Summary of Nursing Facility Benchmarking Results**

| | CY2021: NM FFS Percent of Benchmark FFS Rates | | | | |
|---|---|---|---|---|---|
| **Rate Statistic** | **Estimated Facility Costs[1]** | **AZ** | **CO** | **LA[2]** | **WA** |
| **Private-Owned Nursing Facility – Low Level of Care** | | | | | |
| Minimum Rate | 87% | 87% | 85% | N/A | 79% |
| Median Rate | 84% | 108% | 83% | N/A | 82% |
| Maximum Rate | 42% | 121% | 73% | N/A | 25% |
| **State-Owned Nursing Facility – Low Level of Care** | | | | | |
| Minimum Rate | 122% | 180% | 176% | N/A | 163% |
| Median Rate | 91% | 203% | 157% | N/A | 154% |
| Maximum Rate | 47% | 223% | 135% | N/A | 45% |
| **Private-Owned Nursing Facility – High Level of Care** | | | | | |
| Minimum Rate | 155% | 79% | 100% | N/A | 93% |
| Median Rate | 82% | 125% | 125% | N/A | 123% |
| Maximum Rate | 41% | 135% | 106% | N/A | 35% |
| **State-Owned Nursing Facility – High Level of Care** | | | | | |
| Minimum Rate | 200% | 235% | 298% | N/A | 277% |
| Median Rate | 161% | 257% | 257% | N/A | 253% |
| Maximum Rate | 140% | 268% | 209% | N/A | 70% |

*1. The Estimated Facility Costs benchmark represents the cost per diems from each nursing facility's 2019 Medicare Cost Report (excluding Medicaid provider tax costs).*
*2. Nursing Facility is a covered benefit in the Louisiana Medicaid program, however the provider-specific rates are not publicly available on the Louisiana Medicaid website; therefore, Louisiana was excluded as a benchmark for this category.*

A small portion of nursing facility services are not reimbursed using per diem rates. These services are related to skilled maintenance therapies (physical therapy, speech therapy, and occupational therapy) and reflect 0.01% of the managed care nursing facility and hospice expenditures.

## Hospice

The hospice category represents 8% of the nursing facility and hospice managed care expenditures, and the average managed care payments are 92% of the FFS calculated reimbursement. While there is some variability between providers, the majority of facilities have lower MCO reimbursement than the FFS calculated reimbursement.

Hospice rates vary by setting for New Mexico FFS and each of the selected benchmarks. The New Mexico FFS rates are provider-specific and Table 15 below shows the minimum, median, and maximum rate for each hospice setting.

**Table 15: Summary of New Mexico CY2021 FFS Hospice Rates by Setting**

| | CY2021: NM FFS Rates | | |
|---|---|---|---|
| **Hospice Setting** | **Minimum** | **Median** | **Maximum** |
| General Inpatient Care | $937.15 | $988.50 | $1,069.30 |
| Inpatient Respite Care | $439.88 | $462.91 | $499.14 |
| Routine Home Care (Days 1-60) | $177.68 | $187.85 | $203.86 |
| Routine Home Care (Days 61+) | $140.42 | $148.46 | $161.11 |
| Continuous Home Care | $52.10 | $55.57 | $61.03 |
| Service Intensity Add-On | $13.02 | $13.89 | $15.26 |

In addition to these hospice specific rates, hospice care provided at a nursing facility is reimbursed at 95% of the nursing facility fee schedule rate.

Since the hospice rates are facility-specific, there is significant variability between New Mexico payments and the selected benchmarks. The median New Mexico FFS rates are generally lower than the median Medicare, Arizona, Colorado, and Washington rates. Table 16 below shows the benchmarking results for Medicare and each state for the median hospice rates.

**Table 16: Summary of Hospice Benchmarking Results**

| | CY2021: Median NM FFS Percent of Median Benchmark FFS Rates | | | | |
|---|---|---|---|---|---|
| **Hospice Setting** | **Medicare** | **AZ** | **CO** | **LA** | **WA** |
| General Inpatient Care | 97% | 93% | 83% | 102% | 87% |
| Inpatient Respite Care | 103% | 94% | 83% | 102% | 92% |
| Routine Home Care (Days 1-60) | 97% | 93% | 83% | 106% | 87% |
| Routine Home Care (Days 61+) | 97% | 93% | 83% | 106% | 87% |
| Continuous Home Care | 97% | 92% | 82% | 107% | 85% |
| Service Intensity Add-On | N/A[1] | 92% | 20%[2] | N/A[1] | 85% |

*1. Medicare and Louisiana did not have a Service Intensity Add-On rate in their posted fee schedules.*
*2. The Service Intensity Add-On rate for Colorado is only applicable for the final seven days of life and is not directly comparable to the New Mexico rate.*

# Residential Treatment Centers

| Medicare | AZ | CO | LA | WA |
|---|---|---|---|---|
| X | ✓ | ✓ | ✓ | X |

RTC services represent a small portion (5%) of the overall New Mexico Medicaid expenditures analyzed in Phase 2 of the study. Medicaid programs typically reimburse RTC services using a daily rate. The average managed care payments in New Mexico are 118% of the FFS calculated reimbursement. New Mexico pays for these services under FFS using the Behavioral Health fee schedules. The New Mexico FFS rates vary by type of RTC stay, with higher rates for youth psychiatric and chemical dependency at Accredited Residential Treatment Center (ARTC) than youth RTC and youth group homes. Adult Accredited Residential Treatment Centers (AARTC)

were implemented in New Mexico at the end of 2019 to treat adults with Substance Use Disorders. AARTCs do not have specific fee schedule rates and are reimbursed based on reported cost data for each individual provider.

Since RTCs are traditionally for children and youth, they are not a Medicare covered benefit.

The Arizona behavioral health inpatient fee schedule has per diem rates for secure and non-secure RTC facilities and secure and non-secure RTC-detoxification facilities. For the purpose of this benchmark study, we have used the average of the secure and non-secure rates in Arizona to compare to the New Mexico youth RTC rate and New Mexico ARTC chemical dependency rate.

Colorado has a separate qualified residential treatment program facility fee schedule. For the purpose of this benchmark study, this rate is being compared to the New Mexico youth RTC rate. Colorado also has a separate psychiatric residential treatment facility fee schedule. For the purpose of this benchmark study, this rate is being compared to the New Mexico ARTC psychiatric rate.

Louisiana does not have a specific RTC fee schedule but has alcohol/drug and psychiatric health facility services that are paid on a per diem basis. These rates are found in the Louisiana specialized behavioral health services fee schedule. For the purpose of this benchmark study, we are comparing these rates to the New Mexico youth chemical dependency and psychiatric ARTC rates.

RTC appears to be a covered benefit in the Washington Medicaid program, however the rates are not publicly available on the Washington Medicaid website; therefore, Washington was excluded as a benchmark for this category.

The New Mexico FFS rates are lower than Arizona, Colorado, and Louisiana for youth ARTC psychiatric but higher than Colorado for group home and higher than Louisiana for youth ARTC chemical dependency. Table 17 below shows the benchmarking results for RTCs.

**Table 17: Summary of RTC Benchmarking Results**

| Service Subgroup | CY2019 MC/FFS Calculated | Selected CY2021 Medicaid FFS Benchmarks |
|---|---|---|
| **Total**<br>*(64% of total expenditures)* | **118%** | **N/A** |
| Youth ARTC – Psychiatric<br>*(53% of total expenditures)* | 114% | 47% (CO)<br>77% (LA) |
| Group Home<br>*(9% of total expenditures)* | 153% | 57% (AZ)<br>194% (CO) |
| Youth RTC<br>*(1% of total expenditures)* | 116% | N/A |
| Youth ARTC – Chemical Dependency<br>*(0.2% of total expenditures)* | 89% | 49% (AZ)<br>156% (LA) |

A portion of the Managed Care expenditures (36%) billed at RTC providers are billed using revenue codes that do not have a corresponding New Mexico FFS rate and thus are not included in the benchmark comparison. As part of the stakeholder outreach portion of the study, Mercer will also seek to better understand the reimbursement approach used by the MCOs for these RTC services.

# Other Institutional

Other institutional services represent a small portion (3%) of the overall New Mexico Medicaid expenditures analyzed in Phase 2 of the study but represents a variety of specialized services like ASC, Dialysis Clinics, and (ICF/IID). The reimbursement levels and methodologies for each of these services varies and are described in additional detail in each of the sections below.

## Dialysis

Dialysis represents 49% of the Other Institutional expenditures and 1.7% of overall Managed Care expenditures analyzed in Phase 2, with the average managed care reimbursement being 262% of the FFS calculated reimbursement. New Mexico FFS reimburses dialysis using the dialysis fee schedule which has regional-specific rates for each of the various revenue codes associated with dialysis treatments. The New Mexico FFS fee schedule rates have been in effect since 2019. New Mexico set rates for specific dialysis treatments and claims are paid using these rates in addition to any ancillary services, such as Erythropoietin using the professional fee schedule rate. It appears that the MCOs do not follow the FFS reimbursement methodology, with Mercer observing MCOs reimbursing some providers at 100% of billed charges which is significantly higher than the FFS reimbursement levels.

Medicare covers dialysis treatments, however the Medicare rates are unavailable as they are determined based on patient characteristics, such as weight, and Mercer does not have access to this information for the New Mexico claims. Arizona and Washington have a similar reimbursement structure to New Mexico, however, New Mexico covers a larger range of treatments than both of these states. Colorado covers the same treatments as New Mexico, however they use one rate for all treatments that varies by region instead of varying rates by treatment like New Mexico does.

The New Mexico FFS rates are region specific and Table 18 below shows the minimum, median, and maximum rate for each dialysis treatment type.

**Table 18: Summary of New Mexico CY2021 FFS Dialysis Rates**

| | CY2021: NM FFS Rates | | |
|---|---|---|---|
| **Dialysis Treatment** | **Minimum** | **Median** | **Maximum** |
| Hemodialysis | $140.20 | $142.95 | $150.28 |
| Peritoneal Dialysis | $140.20 | $142.95 | $150.28 |
| Continuous ambulatory peritoneal dialysis | $61.69 | $62.89 | $66.12 |
| Continuous cycling peritoneal dialysis | $62.89 | $62.89 | $62.89 |
| Ultrafiltration | $142.95 | $142.95 | $142.95 |
| Hemodialysis | $140.20 | $142.95 | $150.28 |

While New Mexico FFS dialysis rates are region-specific, there is not significant variability by region. The median New Mexico FFS rates are higher than Arizona but lower than Colorado, and Washington rates. Table 19 below shows the benchmarking results for Medicare and each state for the median dialysis rates.

**Table 19: Summary of Dialysis Benchmarking Results**

| | CY2021: Median NM FFS Percent of Median Benchmark FFS Rates | | | | |
|---|---|---|---|---|---|
| **Dialysis Treatment** | **Medicare** | **AZ** | **CO** | **LA[1]** | **WA** |
| Hemodialysis | N/A | 111% | 72% | N/A | 71% |
| Peritoneal Dialysis | N/A | N/A | 72% | N/A | 71% |
| Continuous ambulatory peritoneal dialysis | N/A | 114% | 31% | N/A | 73% |
| Continuous cycling peritoneal dialysis | N/A | 114% | 31% | N/A | 73% |
| Ultrafiltration | N/A | N/A | 72% | N/A | N/A |
| Hemodialysis | N/A | 111% | 72% | N/A | 71% |

*1. Dialysis is a covered benefit in the Louisiana Medicaid program, however the rates are not publicly available on the Louisiana Medicaid website; therefore, Louisiana was excluded as a benchmark for this category.*

## Home Health Agencies

Home Health Agencies represent 25% of the Other Institutional expenditures and 0.9% of overall Managed Care expenditures analyzed in Phase 2 with the average managed care reimbursement being 107% of the FFS calculated reimbursement. New Mexico FFS reimburses Home Health Agencies on a percentage of claims billed charges which varies by provider. It is unclear how the MCOs reimburse for these services, and while overall Managed Care expenditures are relatively similar to FFS, there is significant variation by provider with managed care reimbursement ranging from 61% to 192% of FFS calculated reimbursement. Mercer will inquire about the MCO methodologies for Home Health Agency reimbursement in the stakeholder outreach portion of the study.

## Private Duty Nursing Agencies

Private Duty Nursing Agencies represent 20% of the Other Institutional expenditures and 0.7% of overall Managed Care expenditures analyzed in Phase 2. New Mexico does not reimburse private duty nursing services using institutional claim types in the FFS program therefore there is no FFS equivalent payment to compare to New Mexico MCO reimbursement. It is unclear how the MCOs reimburse for these services, there are some instances where the MCO reimbursement rate appears similar to the professional services paid using the same procedure codes, but there are instances where these are not similar.

## Ambulatory Surgical Centers

ASCs represent 3% of the Other Institutional expenditures and 0.1% of overall Managed Care expenditures analyzed in Phase 2. The average managed care reimbursement are 153% of the FFS Calculated reimbursement. There is significant variation by procedure code, with the MCOs

paying above 200% and 300% for some procedure codes. New Mexico pays for ASC services under FFS using the ASC fee schedule posted on the HSD website. Dental services ("D" procedure codes) are not listed on the New Mexico FFS fee schedule, however the MCOs are reporting paid claims with dental procedure codes at ASC facilities. It appears that the MCOs are reimbursing higher for dental services at ASCs compared to the professional dental setting.

In 2008, Medicare revised its payment methodology for ASC services, implementing a fee schedule based on the outpatient hospital APC OPPS. Under this system, Medicare pays ASCs a prospectively determined rate for covered procedures.

Colorado, Louisiana, and Washington reimburse ASC services similar to Medicare's ASC reimbursement model in effect prior to 2008 which groups procedure codes into one of nine payment groups, with all procedure codes within a group having the same fee schedule rate. Thus the comparison for New Mexico to these states at the procedure code level is not reliable.

The New Mexico FFS rates are lower than Medicare and Arizona but higher than Colorado, Louisiana, and Washington in aggregate across all ASC procedure codes. Table 20 below shows the benchmarking results for Medicare and the benchmark Medicaid programs.

**Table 20: Summary of ASC Benchmarking Results**

| Service Subgroup | CY2019 | Selected CY2021 Medicaid FFS Benchmarks | | | | |
|---|---|---|---|---|---|---|
| | MC/FFS Calculated | Medicare | AZ | CO[1] | LA[1] | WA[1] |
| Ambulatory Surgical Centers | 153% | 64% | 83% | 217% | 324% | 214% |

*1. CO, LA, and WA reimburse ASC on a group rate methodology which is different with how New Mexico reimburses ASC.*

## Intermediate Care Facilities

ICFs represent 2% of the Other Institutional expenditures and less than 0.1% of overall Managed Care expenditures analyzed in Phase 2. New Mexico reimburses ICFs using the ICF/IID fee schedule. These rates are provider-specific and vary based on the level of care. ICF services are offered only through FFS and not through Managed Care.

ICF services are not a Medicare covered benefit. While the other benchmark states offer ICF services as a covered benefit, fee schedule rates were not publicly available on each benchmark state's website.

The New Mexico FFS rates are provider specific and Table 21 below shows the minimum, median, and maximum rate for each level of care.

**Table 21: Summary of New Mexico CY2021 FFS ICF Rates**

| | CY2021: NM FFS Rate | | |
|---|---|---|---|
| Rate Statistic | Level I | Level II | Level III |
| Minimum Rate | $54.61 | $54.61 | $54.61 |
| Median Rate | $400.04 | $372.81 | $332.19 |
| Maximum Rate | $968.23 | $890.70 | $775.03 |

## Section 6

# Conclusion and Future Updates

The information presented in the previous sections of this report are intended to assist HSD with the evaluation of reimbursement methodologies and rate levels for all of the service areas in Phase 2 of the study. Mercer developed a similar benchmarking report for Phase 1 services, and the next step in the Study is for HSD and Mercer to conduct stakeholder outreach efforts to collect input on New Mexico provider reimbursement methodologies for each of the service areas. HSD plans to collect information for each service area to focus on the different provider groups delivering each set of services. The findings included in this report may be revised based upon the input collected through these outreach efforts.

Based on the information in the Phase 1 and Phase 2 benchmarking reports and stakeholder activities, Mercer will develop a final comprehensive report of strategic recommendations to HSD to inform future policy decisions. This final report will be provided to HSD after the completion of the stakeholder activities.

## Section 7

# Limitations and Data Reliance

In preparing this report, Mercer considered publicly available information and New Mexico Medicaid claim, reimbursement level and benefit design data and information supplied by HSD. New Mexico is solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In our opinion, the data used for the comprehensive rate evaluation is appropriate for the intended purpose. However, if the data and information are incomplete/inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Fee schedule rates for each of the service areas presented in this report are based on the published fee schedules available on the New Mexico HSD website, in addition to those that HSD provided to Mercer, at the time this report was developed. The Medicare fee schedules and the fee schedules for the benchmark states reflect those available publicly online. To the extent changes or clarifications are made to the fee schedules, the presented results may be impacted and need to be updated accordingly.

This methodology document assumes the reader is familiar with Medicaid programs and the associated delivery systems for reimbursement. This report should only be reviewed in its entirety.

## Appendix A

# Analyzed Expenditures Summary

| | | CY2019 | | |
|---|---|---|---|---|
| **Phase 2 Service Area** | **Service Subgroups** | **Total Medicaid Expenditures[1]** | **Total Managed Care Expenditures[2]** | **Total Analyzed Expenditures[2]** |
| **ALL** | **ALL** | **$1,991.2** | **$1,800.2** | **$1,045.5** |
| Inpatient Hospital | General Acute Hospitals | $708.1 | $644.1 | $284.5 |
| | Critical Access Hospitals | $15.8 | $14.4 | $14.4 |
| | Psychiatric Hospitals | $46.2 | $43.4 | $36.5 |
| | Rehabilitation Hospitals | $81.9 | $79.8 | $24.8 |
| Outpatient Hospital | General Acute Hospitals | $513.8 | $492.9 | $278.0 |
| | Critical Access Hospitals | $50.4 | $47.3 | $47.3 |
| | Psychiatric Hospitals | $3.2 | $3.1 | $2.4 |
| | Rehabilitation Hospitals | $8.1 | $8.1 | $1.4 |
| Nursing Facility/ Hospice | Private - Low Level of Care | $214.7 | $214.2 | $214.0 |
| | State - Low Level of Care | $30.0 | $30.0 | $29.9 |
| | Private - High Level of Care | $21.2 | $21.2 | $21.0 |
| | State - High Level of Care | $1.9 | $1.9 | $1.9 |
| | Hospice | $22.9 | $22.7 | $22.5 |
| Residential Treatment Centers | ARTC Psychiatric | $25.9 | $25.7 | $25.6 |
| | RTC - Youth | $4.4 | $4.4 | $4.3 |
| | Group Home | $0.6 | $0.6 | $0.6 |
| | ARTC Chemical Dependency | $0.1 | $0.1 | $0.1 |
| | RTC - Other | $17.3 | $17.3 | $0.0 |
| Other Institutional | Dialysis | $18.2 | $17.8 | $17.8 |
| | Home Health Agency | $10.0 | $10.0 | $9.2 |
| | Nursing Agency, Private Duty | $7.1 | $7.1 | $7.1 |
| | Ambulatory Surgical Centers | $2.2 | $2.2 | $1.2 |
| | Intermediate Care Facilities | $0.8 | $0.8 | $0.8 |
| Excluded Services | Indian Health Services | $177.1 | $91.9 | $0.0 |
| | PACE | $9.2 | $0 | $0.0 |

*1. CY2019 Total Medicaid Expenditures includes managed care encounters and FFS claims after exclusions. See Data Sources and Time Period for the impact and list of exclusions applied to the claims data. Totals differ due to rounding.*

*2. CY2019 Expenditures include FFS claims for the Intermediate Care Facilities Service Subgroup and managed care encounters for all other Service Subgroups.*

# Appendix B
# References

## Arizona

The Arizona rates used in the benchmarking analysis are publicly available on the Arizona State Medicaid website (http://www.azahcccs.gov). Arizona Health Care Cost Containment System. *AHCCCS Fee-For-Service Fee Schedules.* Available at https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/feeschedules.html [Accessed January 2022]

Arizona Department of Economic Security. *Arizona HCBS for I/DD Population. Arizona Health Care Cost Containment System (AHCCCS) 1115 Demonstration.* Available at https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/rates-authorizations-billing [Accessed January 2022]

## Colorado

The Colorado rates used in the benchmarking analysis are publicly available on the Colorado State Medicaid website (https://hcpf.colorado.gov). Colorado Department of Health Care Policy & Financing. *Provider Rates and Fee Schedule.* Available at https://hcpf.colorado.gov/provider-rates-fee-schedule [Accessed January 2022]

Colorado Department of Health Care Policy & Financing. *Colorado HCBS for I/DD Population. Developmental Disabilities Waiver. Support Living Services Waiver. Available at https://hcpf.colorado.gov/provider-rates-fee-schedule* [Accessed January 2022]

## Louisiana

The Louisiana rates used in the benchmarking analysis are publicly available on the Louisiana State Medicaid website (https://www.lamedicaid.com). Louisiana Department of Health. *Fee Index.* Available at https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm [Accessed January 2022]

Louisiana Department of Health. *Louisiana HCBS Waivers for I/DD Populations. New Opportunities Waiver. Residential Options Waiver. Supports Waiver.* Available at https://ldh.la.gov/page/283 [Accessed January 2022]

## New Mexico

New Mexico Human Services Department. *Public Information and Communications.* Available at https://www.hsd.state.nm.us/public-information-and-communications/centennial-care-2-0-current-2019-proposed-updates/centennial-care-2-0-2019-waiver-application/ [Accessed January 2022]

New Mexico Legislature. *Legislative Health & Human Services Committee*, July 6, 2021. Available at https://www.nmlegis.gov/handouts/LHHS%20070621%20Item%201%20FINAL%20HSD%20LHHS%20Interim2021_07_06.pdf [Accessed January 2022]

New Mexico Human Services Department. *Centennial Care 2.0 MCO Contract Amendment #5.* Amended and Restated, December 27, 2021 thru December 31, 2023. Available at https://www.hsd.state.nm.us/lookingforinformation/medical-assistance-division/ [Accessed January 2022]

New Mexico Human Services Department. *Fee for Service.* Available at https://www.hsd.state.nm.us/providers/fee-for-service/ [Accessed January 2022]

## Washington

The Washington rates used in the benchmarking analysis are publicly available on the Washington State Medicaid website (https://www.hca.wa.gov). Washington State Health Care Authority. *Provider billing guides and fee schedules.* Available at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules [Accessed January 2022]

Washington State Health Care Authority. *Washington HCBS Waivers for I/DD Populations. Core Waiver. Community Protection Waiver.* Available at https://www.dshs.wa.gov/ALTSA/management-services-division/office-rates-management/ [Accessed January 2022]

## Appendix C

# Hospital Appendix

| Critical Access Hospitals | |
|---|---|
| Cibola General Hospital | Miners Colfax Medical Center |
| Dan C Trigg Memorial Hospital | Nor-Lea General Hospital |
| Gila Regional Medical Center | Sierra Vista Hospital |
| Holy Cross Hospital | Socorro General Hospital |
| Lincoln County Medical Center | Union County General Hospital |

| Not-For-Profit Hospitals | |
|---|---|
| Artesia General Hospital | Presbyterian Santa Fe Medical Center |
| Dan C Trigg Memorial Hospital | Rehoboth McKinley Christian Health |
| Gerald Champion Regional Medical Center | San Juan Regional Medical Center |
| Holy Cross Hospital | San Juan Regional Rehab Hospital |
| Lincoln County Medical Center | Socorro General Hospital |
| Plains Regional Med Center-Clovis | St Vincent Hospital |
| Presbyterian Hospital | |

| For-Profit Hospitals | |
|---|---|
| Advanced Care Hospital of Southern NM | Lovelace UNM Rehabilitation Hospital |
| Albuquerque – AMG Specialty Hospital | Lovelace Westside Hospital |
| Alta Vista Regional Hospital | Lovelace Women's Hospital |
| Carlsbad Medical Center | Memorial Medical Center |
| Central Desert Behavioral Health Center | Mesilla Valley Hospital |
| Cibola General Hospital | Mimbres Memorial Hospital |
| Eastern NM Medical Center | Miners Colfax Medical Center |
| Gila Regional Medical Center | Mountainview Regional Medical Center |
| Guadalupe County Hospital | NM Rehabilitation Center PC |
| Haven Behavioral Senior Care of Albuquerque | Nor-Lea General Hospital |
| HealthSouth Rehabilitation Hospital | Peak Behavioral Health Services LLC |

| For-Profit Hospitals | |
|---|---|
| Kindred Healthcare Inc | Rehabilitation Hospital of Southern NM |
| Lea Regional Hospital LLC | Roosevelt General Hospital |
| Lea Regional Medical Center | Sierra Vista Hospital |
| Los Alamos Medical Center | UNM Sandoval Regional Medical Center |
| Lovelace Medical Center – Downtown | Union County General Hospital |
| Lovelace Regional Hospital – Roswell | |

| Safety Net Care Pool (SNCP) Hospitals[25] | |
|---|---|
| Alta Vista Regional Hospital | Mimbres Memorial Hospital |
| Artesia General Hospital | Miners Colfax Medical Center |
| Carlsbad Medical Center | Mountainview Regional Medical Center |
| Cibola General Hospital | Nor-Lea General Hospital |
| Dan C Trigg Memorial Hospital | Plains Regional Medical Center – Clovis |
| Eastern NM Medical Center | Presbyterian Espanola Hospital |
| Gerald Champion Regional Medical Center | Rehoboth McKinley Christian Health |
| Gila Regional Medical Center | Roosevelt General Hospital |
| Guadalupe County Hospital | San Juan Regional Medical Center |
| Holy Cross Hospital | Sierra Vista Hospital |
| Lea Regional Medical Center | Socorro General Hospital |
| Lincoln County Medical Center | St Vincent Hospital |
| Los Alamos Medical Center | Union County General Hospital |
| Lovelace Regional Hospital – Roswell | University of NM Hospital |
| Memorial Medical Center | |

| Trauma Hospitals |
|---|
| **Level 1** |
| University of NM Hospital |
| **Level 2** |
| None |

[25] Current amendment will add Three Crosses Hospital and Presbyterian Santa Fe Hospital as SNCP hospitals.

| Trauma Hospitals | |
|---|---|
| **Level 3** | |
| Carlsbad Medical Center | Mountainview Regional Medical Center |
| Eastern NM Medical Center | San Juan Regional Medical Center |
| Gerald Champion Regional Medical Center | St Vincent Hospital |
| **Level 4** | |
| Gila Regional Medical Center | Nor-Lea General Hospital |
| Memorial Medical Center | Sierra Vista Hospital |
| Miners Colfax Medical Center | Union County General Hospital |

| Community Tribal Hospitals | |
|---|---|
| **Class 1** | |
| Rehoboth McKinley Christian Hospital | San Juan Regional Medical Center |
| Cibola General Hospital | |
| **Class 2** | |
| Lincoln County Medical Center | UNM Sandoval Regional Medical Center |
| San Juan Regional Rehab Hospital | |

## Appendix D

# Selected Benchmark State Profiles

# Health Insurance Coverage — New Mexico

## U.S. Census Bureau Region — West

**Total Population: 2,053,200**

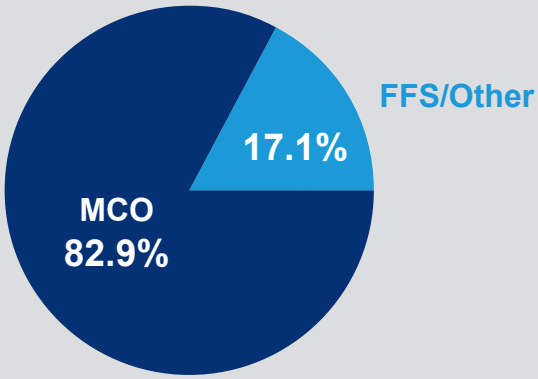
NM

| | Health Insurance Coverage Type | | | | |
|---|---|---|---|---|---|
| **Demographic** | **Employer** | **Medicare** | **Medicaid** | **Other Coverage** | **Uninsured** |
| Total Population | 36.6% | 15.0% | 32.7% | 5.9% | 9.8% |
| Elderly 65+ | 10.7% | 65.6% | 19.8% | 1.7% | 2.2% |
| Adults 19-64 | 47.7% | 2.2% | 28.0% | 7.7% | 14.4% |
| Children 0-18 | 33.1% | N/A | 55.6% | 5.8% | 5.5% |

*Source: KFF - State Health Facts (2019)*

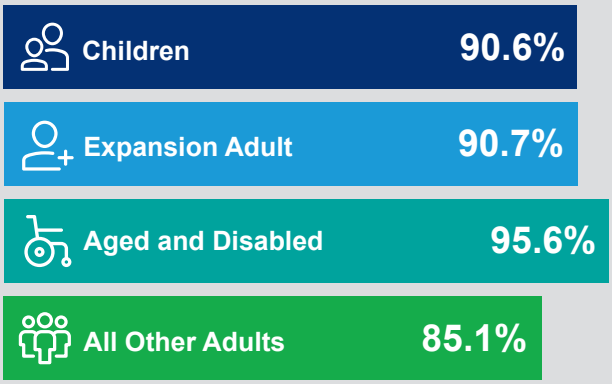
## Medicaid program Delivery Systems

### Enrollment by Delivery System



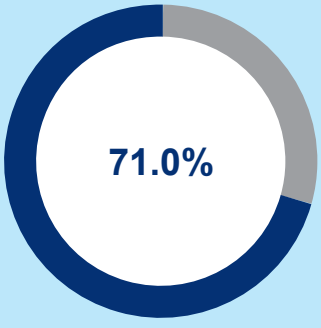

*Source: KFF - State Health Facts (2019)*

### Managed Care Enrollment by Eligibility Group




*Source: KFF - State Health Facts (July 1, 2021)*

## Births Financed by Medicaid




*Source: KFF - State Health Facts (2019)*

## Median Hourly Wages

| | |
|---|---|
| All Occupations | $17.97 |
| Healthcare Practitioners and Technical Occupations | $34.45 |
| Healthcare Support Occupations | $11.96 |

*Source: U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2020)*

# Health Insurance Coverage — Arizona

## U.S. Census Bureau Region — West

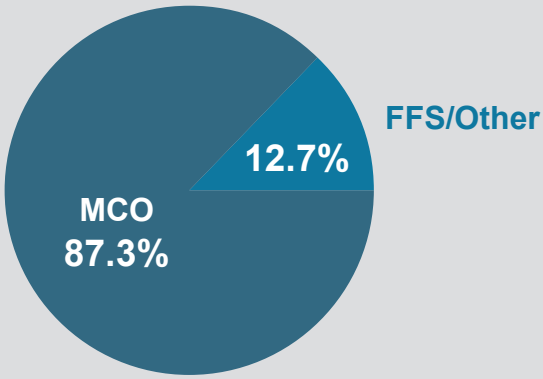
**Total Population: 7,467,800**


| | Health Insurance Coverage Type | | | | |
|---|---|---|---|---|---|
| **Demographic** | **Employer** | **Medicare** | **Medicaid** | **Other Coverage** | **Uninsured** |
| Total Population | 45.1% | 16.1% | 21.0% | 6.7% | 11.1% |
| Elderly 65+ | 7.6% | 77.1% | 13.0% | 0.8% | 1.4% |
| Adults 19-64 | 56.9% | 1.9% | 17.1% | 8.7% | 15.4% |
| Children 0-18 | 46.9% | N/A | 37.1% | 7.3% | 8.7% |

*Source: KFF - State Health Facts (2019)*

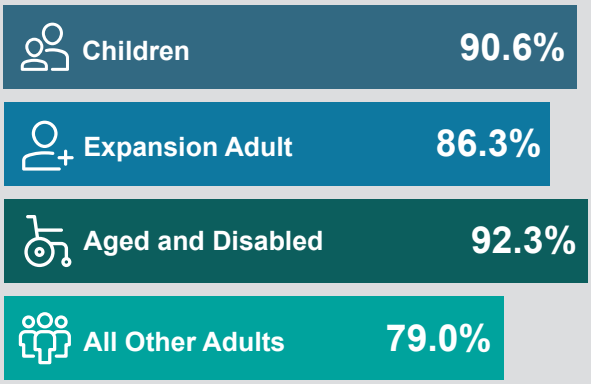
## Medicaid program Delivery Systems

### Enrollment by Delivery System



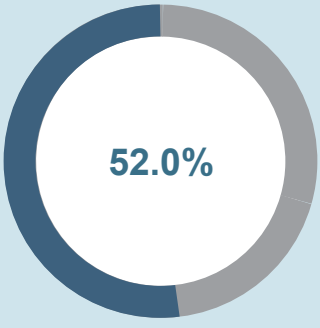

*Source: KFF - State Health Facts (2019)*

### Managed Care Enrollment by Eligibility Group




*Source: KFF - State Health Facts (July 1, 2021)*

## Births Financed by Medicaid




*Source: KFF - State Health Facts (2019)*

## Median Hourly Wages

| | |
|---|---|
| All Occupations | $19.35 |
| Healthcare Practitioners and Technical Occupations | $35.47 |
| Healthcare Support Occupations | $14.26 |

*Source: U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2020)*

# Health Insurance Coverage — Colorado

## U.S. Census Bureau Region — West

**Total Population: 5,737,200**

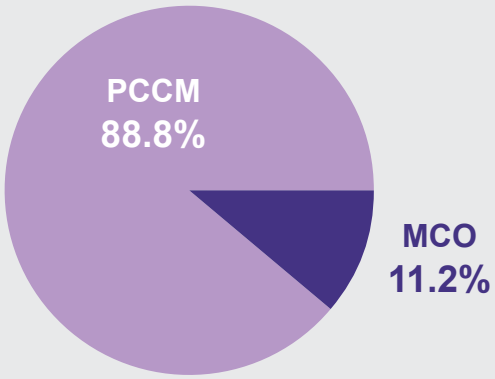
CO

| | Health Insurance Coverage Type | | | | |
|---|---|---|---|---|---|
| **Demographic** | **Employer** | **Medicare** | **Medicaid** | **Other Coverage** | **Uninsured** |
| **Total Population** | 53.4% | 12.8% | 16.8% | 9.2% | 7.8% |
| **Elderly 65+** | 6.8% | 80.7% | 11.6% | 0.6% | 0.3% |
| **Adults 19-64** | 64.2% | 1.3% | 12.7% | 11.3% | 10.5% |
| **Children 0-18** | 54.2% | N/A | 31.2% | 9.3% | 5.3% |

*Source: KFF - State Health Facts (2019)*

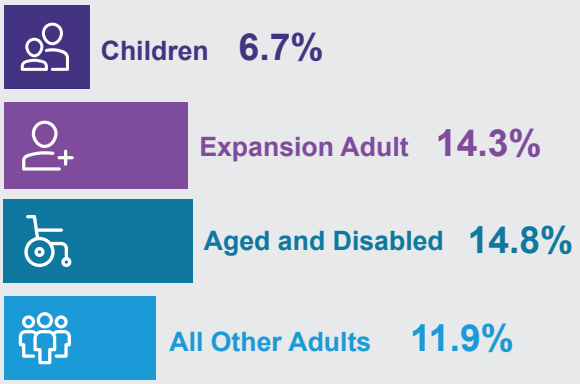
## Medicaid program Delivery Systems

### Enrollment by Delivery System



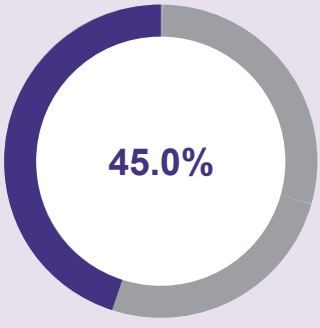

*Source: KFF - State Health Facts (2019)*

### Managed Care Enrollment by Eligibility Group




*Source: KFF - State Health Facts (July 1, 2021)*

## Births Financed by Medicaid




*Source: KFF - State Health Facts (2019)*

## Median Hourly Wages

| | |
|---|---|
| **All Occupations** | **$22.52** |
| **Healthcare Practitioners and Technical Occupations** | **$36.04** |
| **Healthcare Support Occupations** | **$16.02** |

*Source: U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2020)*

# Health Insurance Coverage — Louisiana

## U.S. Census Bureau Region — South

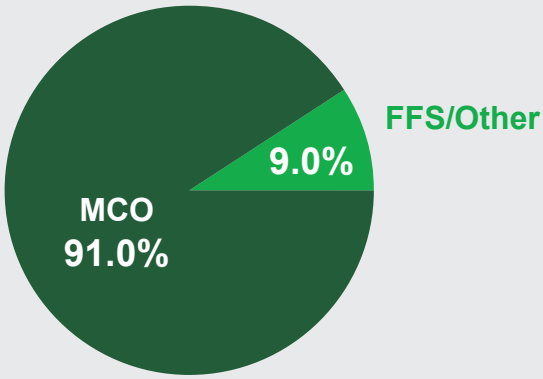
**Total Population: 4,547,900**


| | Health Insurance Coverage Type | | | | |
|---|---|---|---|---|---|
| **Demographic** | **Employer** | **Medicare** | **Medicaid** | **Other Coverage** | **Uninsured** |
| Total Population | 41.8% | 13.7% | 29.3% | 6.3% | 8.9% |
| Elderly 65+ | 7.9% | 72.9% | 16.6% | 1.2% | 1.3% |
| Adults 19-64 | 52.7% | 2.7% | 23.5% | 8.1% | 13.0% |
| Children 0-18 | 38.5% | N/A | 51.5% | 5.7% | 4.3% |

*Source: KFF - State Health Facts (2019)*

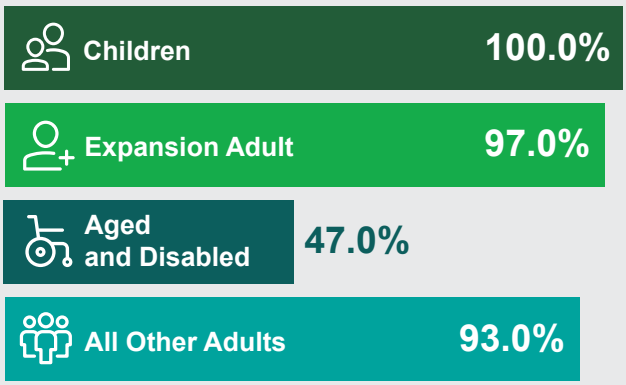
## Medicaid program Delivery Systems

### Enrollment by Delivery System



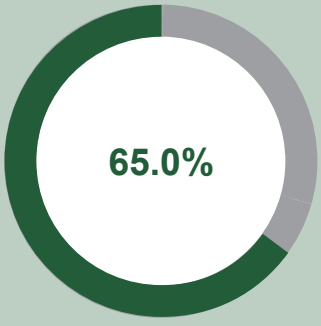

*Source: KFF - State Health Facts (2019)*

### Managed Care Enrollment by Eligibility Group




*Source: KFF - State Health Facts (July 1, 2021)*

## Births Financed by Medicaid




*Source: KFF - State Health Facts (2019)*

## Median Hourly Wages

| | |
|---|---|
| All Occupations | $17.53 |
| Healthcare Practitioners and Technical Occupations | $28.16 |
| Healthcare Support Occupations | $10.77 |

*Source: U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2020)*

# Health Insurance Coverage — Washington

## U.S. Census Bureau Region — West

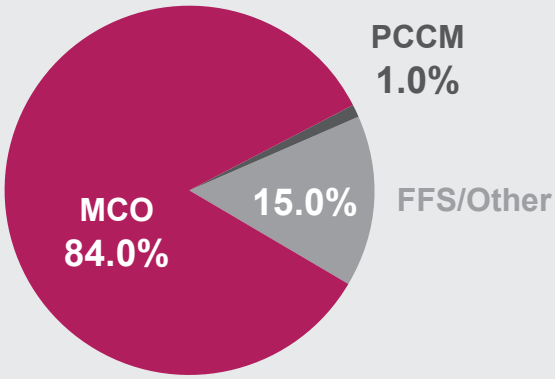
**Total Population: 7,596,300**


| | Health Insurance Coverage Type | | | | |
|---|---|---|---|---|---|
| **Demographic** | **Employer** | **Medicare** | **Medicaid** | **Other Coverage** | **Uninsured** |
| Total Population | 52.9% | 13.9% | 19.8% | 6.8% | 6.6% |
| Elderly 65+ | 1.4% | 87.6% | 11.0% | -0.2% | 0.2% |
| Adults 19-64 | 65.5% | 1.7% | 14.8% | 8.6% | 9.4% |
| Children 0-18 | 51.5% | N/A | 38.7% | 6.7% | 3.1% |

*Source: KFF - State Health Facts (2019)*

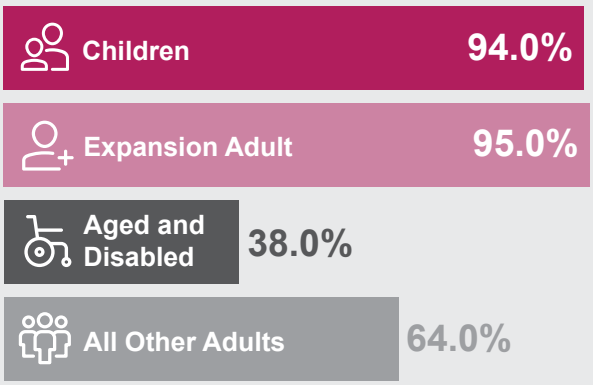
## Medicaid program Delivery Systems

### Enrollment by Delivery System



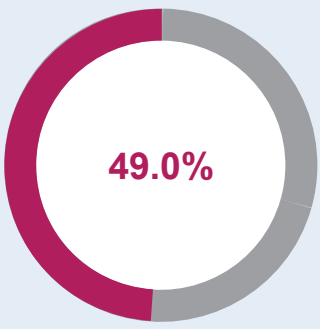

*Source: KFF - State Health Facts (2019)*

### Managed Care Enrollment by Eligibility Group




*Source: KFF - State Health Facts (July 1, 2021)*

## Births Financed by Medicaid




*Source: KFF - State Health Facts (2019)*

## Median Hourly Wages

| | |
|---|---|
| All Occupations | $24.81 |
| Healthcare Practitioners and Technical Occupations | $40.75 |
| Healthcare Support Occupations | $17.03 |

*Source: U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2020)*

## Appendix E

# Glossary of Acronyms

| Acronym | Meaning |
|---|---|
| **APR-DRG** | All Patients Refined Diagnosis Related Groups |
| **AP-DRG** | All Patient Diagnosis Related Groups |
| **APC** | Ambulatory Payment Classification |
| **ARTC** | Accredited Residential Treatment Center |
| **AARTC** | Adult Accredited Residential Treatment Centers |
| **ASC** | Ambulatory Surgical Centers |
| **CAH** | Critical Access Hospital |
| **CCR** | Cost-To-Charge Ratios |
| **CMS** | Centers for Medicare & Medicaid Services |
| **COVID-19** | Coronavirus Disease 2019 |
| **CY** | Calendar Year |
| **DD** | Developmental Disabilities |
| **DSH** | Disproportionate Share Hospitals |
| **EAPG** | Enhanced Ambulatory Patient Group |
| **FFS** | Fee-For-Service |
| **FFSE** | Fee-For-Service Equivalent |
| **FQHC** | Federally Qualified Health Center |
| **GME** | Graduate Medical Education |
| **GRT** | Gross Receipts Tax |
| **HCBS** | Home- And Community-Based Services |
| **HCRIS** | Hospital Cost Report Information System |
| **HSD** | State of New Mexico Human Services Department |
| **HIPPS** | Health Insurance Prospective Payment System |
| **ICF** | Intermediate Care Facility |
| **IID** | Individuals with Intellectual Disabilities |
| **IME** | Indirect Medical Education |
| **LTSS** | Long-Term Services And Supports |

| Acronym | Meaning |
|---|---|
| **MCO** | Managed Care Organization |
| **MBI** | Market Basket Index |
| **MMIS** | Medicaid Management Information Systems |
| **MS-DRG** | Medicare Severity Diagnosis Related Groups |
| **OPPS** | Outpatient Prospective Payment System |
| **PACE** | Program Of The All-Inclusive Care For The Elderly |
| **PDPM** | Patient-Driven Payment Model |
| **PMPM** | Per Member Per Month |
| **PPS** | Prospective Payment System |
| **RHC** | Rural Health Clinic |
| **RTC** | Residential Treatment Center |
| **SNCP** | Safety Net Care Pool |
| **SNF** | Skilled Nursing Facility |
| **UPL** | Upper Payment Limit |

**Mercer Health & Benefits LLC**
2325 East Camelback Road, Suite 600
Phoenix, AZ  85016
www.mercer-government.mercer.com