Mercer

Government Human Services Consulting

Provider Rate Benchmarking Study

Preliminary Benchmarking – Phase 1

State of New Mexico
Medical Assistance Division
March 9, 2022

Contents

Section 1
Executive Summary

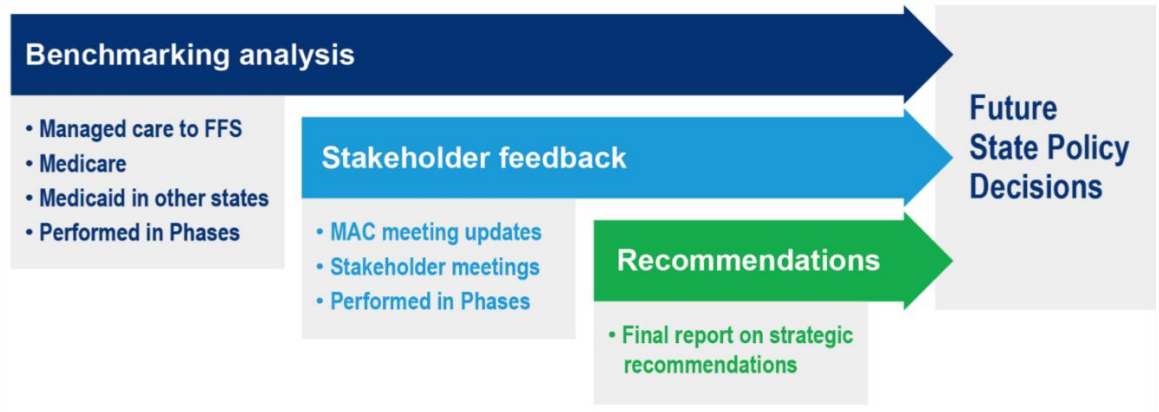
Project Overview

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 healthcare 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 (ID), 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.

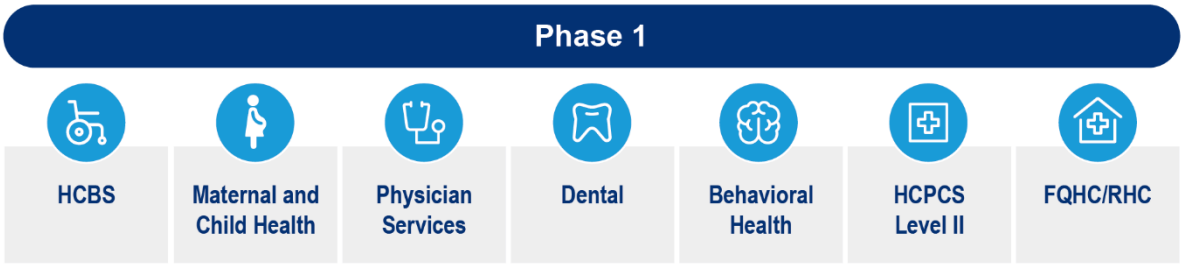
2. **Maternal and child health**, including professional and hospital services for prenatal, delivery, and postpartum/newborn care. Medicaid currently pays for over 70% of births in New Mexico and is electing to exercise the option outlined in the American Rescue Plan Act[2] to extend post-partum coverage 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 1 service areas.

Figure 2: Phase 1 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 will perform a similar benchmarking review for the Phase 2 services, which will also include a stakeholder feedback opportunity. Findings included in the initial benchmarking reports may be revised based upon the input collected through these outreach efforts.

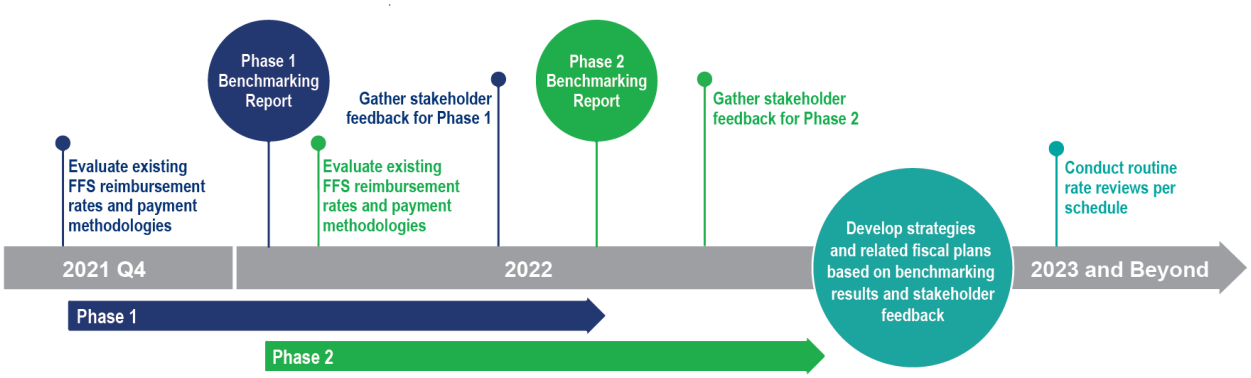
Mercer will use benchmarking results, stakeholder input, and other reimbursement methodology evaluation criteria to identify areas for improvement and/or modernization and to inform the HSD Reimbursement Strategy. The final report will synthesize this information and provide

[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]

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 1 service areas accounted for approximately $2.1 billion in New Mexico Medicaid service expenditures in calendar year (CY) 2019, where $1.6 billion of the $2.1 billion (around 75%) 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.

Although the managed care organizations (MCOs) are not required to align with FFS fee schedules and negotiate rates with contracted providers, Mercer found that their reimbursement closely compares with FFS in many cases. There was some variation by service, most notably anesthesia, which may be related to differences in the reported units of service (e.g., per visit versus per 15 minutes) between managed care and the FFS payment. Mercer frequently observed cases in managed care where Core Services Agencies, who coordinate care and provide a variety of behavioral health (BH) services, have higher reimbursement for similar services compared to other providers. In some cases, MCOs paid below FFS, such as many services billed by physicians, BH agencies, and dentists. Some of these differences may be related to different treatment of items such as the state's Gross Receipts Tax (GRT).[4] Mercer will seek feedback from MCOs and providers during the stakeholder engagement activities to better understand drivers of these patterns.

Unsurprisingly, New Mexico FFS reimbursement levels were consistently lower than corresponding Medicare rates. This observation is consistent with national studies[5] of physician

[4] Gross Receipts Tax is applicable to most businesses in New Mexico and varies from 5.125% to 9.4375% based on location. https://www.tax.newmexico.gov/governments/gross-receipts-tax/ [Accessed January 2022]

[5] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff [Accessed January 2022]

payments in Medicaid programs. New Mexico initiated a multi-phase strategy in 2019 to increase provider rates with an emphasis on aligning reimbursement with 90% of Medicare, where applicable, but has not updated them as Medicare rates have continued to change. This lowers the comparison to the current Medicare FFS rates. Compared to other states, New Mexico FFS rates tend to be lower than Arizona's levels and higher than rates in Colorado, Louisiana, and Washington. 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 and state Medicaid benchmarks.

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

		CY2019		CY2021	
Phase 1 Service Area	**Service Subgroups**	**Total Medicaid Expenditures[2]**	**Managed Care Percent of FFSE**	**NM FFS Percent of Medicare**	**NM FFS Percent of State Benchmarks[4]**
ALL	**ALL**	**$2,107.6**	**103%**	**88%**	**91% to 124%**
HCBS	1115 Waiver Community Benefit	$432.6	124%	88%	90% to 145%
	State Plan Case Management	$13.0	169%	89%	85% to 158%
	1915(c) Waiver Services[1]	$403.1	N/A[3]	N/A[3]	N/A[3]
Physician & Other Practitioners	Evaluation & Management	$213.4	101%	82%	106% to 149%
	Surgery	$80.5	107%	89%	85% to 149%
	Radiology/Laboratory/ Pathology	$69.7	100%	94%	88% to 120%
	Medicine	$64.0	100%	86%	79% to 139%
	Anesthesia	$14.0	30%[5]	86%	57% to 114%
HCPCS Level II	Other HCPCS Level II	$105.5	97%	82%	73% to 113%
	Non-Emergent Medical Transportation (NEMT)	$49.8	226%	N/A	46% to 159%
	Emergent Medical Transportation (EMT)	$42.7	106%	70%	77% to 172%
	Physician Administered Drugs	$41.8	101%	100%	97% to 103%
	Durable Medical Equipment	$22.8	117%	96%	72% to 114%
Maternal & Child Health	Maternity-Related	$46.6	87%	93%	80% to 139%
	Child Health & Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	$37.3	99%	112%	109% to 154%
	Newborn-Related Care	$18.5	104%	95%	101% to 140%
	Family Planning	$12.5	95%	104%	113% to 134%
Behavioral Health	General Behavioral Health	$138.0	100%	97%	101% to 152%

		CY2019		CY2021	
Phase 1 Service Area	**Service Subgroups**	**Total Medicaid Expenditures[2]**	**Managed Care Percent of FFSE**	**NM FFS Percent of Medicare**	**NM FFS Percent of State Benchmarks[4]**
	Opioid Treatment Program	$25.5	99%	N/A	105% to 392%
	Applied Behavioral Analysis	$19.6	98%	N/A	73% to 172%
Dental	Diagnostic/Preventive/ Other	$116.3	96%	N/A	79% to 109%
	Orthodontics	$13.3	94%	N/A	90% to 166%
FQHC/RHC	Federally Qualified Health Centers	$116.2	99%	N/A[3]	N/A[3]
	Rural Health Clinics	$11.0	107%	N/A[3]	N/A[3]

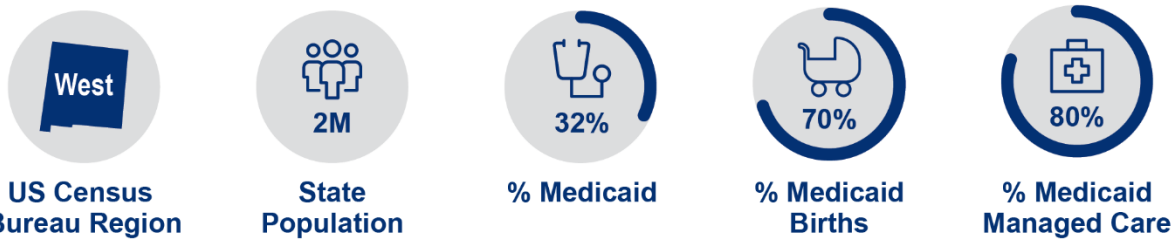
1. The Supports Waiver went into effect July 1, 2020, therefore, there is no claims experience in CY2019.
2. CY2019 Total Medicaid Expenditures includes managed care encounters and FFS claims after exclusions. See Data Sources and Time Period for the impact and list of exclusions applied to the claims data. Totals differ due to rounding.
3. Due to the types of services and reimbursement approaches in the 1915(c) Waivers and FQHC/RHC Service Areas, the relativities to the selected benchmarks are not displayed. See the Summary of Results section for additional detail.
4. This range reflects the comparison of NM's FFS rates to each of the benchmark states (AZ, CO, LA and WA). For example, a range of 90% to 145% indicates that NM rates compared to the highest benchmark state is 90%, and NM rates compared to the lowest benchmark state is 145%.
5. The calculation for this service area is influenced by discrepancies between the units reported in managed care and the FFS payment formula. See the Summary of Results section for additional detail regarding the Managed Care Percent of FFSE figure.

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.

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, BH, and long-term services and supports (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 is 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:

- 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
- Individuals who receive care in an ICF for Individuals with ID or DD
- Individuals eligible for family planning services only

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

FFS 1915(c) HCBS Waivers

In addition to the 1115 Demonstration waiver, New Mexico operates four 1915(c) HCBS waivers with services reimbursed under the FFS delivery system.

- **Developmentally Disabled Waiver** – Provides community services to individuals of any age with, IDs or DDs. The waiver offers a comprehensive service package, including case management, residential services, community integrated employment, customized community supports, respite, therapies for adults, adult nursing, and behavioral support.
- **Medically Fragile (MF) Waiver** – Provides services to MF[6] individuals of any age. Waiver includes services such as case management, home health aide, respite, skilled therapy for adults, behavior support consultation, and private duty nursing.
- **Mi Via Waiver** – Provides self-directed services to individuals of any age who are MF, with autism, IDs, or DDs. Under this waiver, members can manage their own services and supports within an approved budget to receive services such as customized community group supports, employment supports, home health aide services, homemaker/direct support services, respite, and in-home living supports.
- **Supports Waiver** – Serves as a bridge to provide limited supports to those on the waiting list for a waiver allocation. Effective July 1, 2020 services offered include community supports coordinator, customized community supports, employment supports, personal care, and respite.

Historical Program Expenditures for Phase 1 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. 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 1915(c) HCBS waiver services, while managed care represents the primary delivery system for the remaining service areas. Accordingly, Mercer's analysis relies on FFS data to understand

[6] A medically fragile condition is defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled nursing intervention is medically necessary. https://www.hsd.state.nm.us/lookingforinformation/medically-fragile/ [Accessed January 2022]

utilization patterns for the 1915(c) HCBS waiver services and encounter data to understand utilization patterns and MCO payment levels for the remaining services. Table 2 displays the total and analyzed expenditures for each service category.

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

		CY2019		
Phase 1 Service Area	**Service Subgroups**	**Total Medicaid Expenditures[2]**	**Benchmark Analysis Expenditures[3]**	**Proportion of Expenditures Analyzed**
ALL	**ALL**	**$2,107.6**	**$1,961.4**	**93.1%**
HCBS	1115 Waiver Community Benefit	$432.6	$432.6	100.0%
	State Plan Case Management	$13.0	$13.0	100.0%
	1915(c) Waiver Services *(FFS Only)[1]*	$403.1	$403.1	100.0%
Physician & Other Practitioners	Evaluation & Management	$213.4	$202.9	95.1%
	Surgery	$80.5	$74.9	93.1%
	Radiology/Laboratory/Pathology	$69.7	$66.6	95.7%
	Medicine	$64.0	$45.5	71.2%
	Anesthesia	$14.0	$13.0	93.2%
HCPCS Level II	Other HCPCS Level II	$105.5	$54.4	51.5%[4]
	NEMT	$49.8	$44.8	90.1%
	EMT	$42.7	$36.6	85.9%
	Physician Administered Drugs	$41.8	$39.9	95.5%
	Durable Medical Equipment	$22.8	$22.3	98.0%
Maternal and Child Health	Maternity-Related	$46.6	$42.2	90.5%
	Child Health and EPSDT	$37.3	$35.6	95.3%
	Newborn-Related Care	$18.5	$15.7	84.6%
	Family Planning	$12.5	$11.6	92.4%
Behavioral Health	General Behavioral Health	$138.0	$128.9	93.4%
	Opioid Treatment Program	$25.5	$25.3	99.0%
	Applied Behavioral Analysis	$19.6	$19.5	99.6%
Dental	Diagnostic/Preventive/Other	$116.3	$106.8	91.8%
	Orthodontics	$13.3	$11.2	84.2%
FQHC/RHC	Federally Qualified Health Centers	$116.2	$104.2	89.7%
	Rural Health Clinics	$11.0	$10.6	95.8%

1. The Supports Waiver went into effect July 1, 2020, therefore, there is no claims experience in CY2019.
2. 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.
3. CY2019 Benchmark Analysis Expenditures include FFS claims for the 1915(c) Waiver Services Service Subgroup and managed care encounters for all other Service Subgroups.
4. The Other HCPCS Level II expenditures not included in the benchmark analysis are related to Family Infant Toddler (FIT) program.

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. For both systems, 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 payment adjustments applied for certain provider types and the application of the GRT.

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:
  - Adjustments applied for certain provider types
  - 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

In this report, we compare the average managed care payment and the corresponding average FFSE 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 the New Mexico FFS published fee schedule and the selected benchmarks, the following types of rates have not been included in the benchmarking analysis, when identified:

- Services with a different underlying base unit of service than the New Mexico standard unit of service.
- Services that are manually priced and do not have a specific fee schedule rate.
- Rates that are paid to a specific provider or provider group.

Service Area and Service Subgroups

Mercer collaborated with HSD to develop seven service areas as part of the Phase 1 benchmarking analysis. Mercer selected the specific service areas based on the applicable fee schedule(s), 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 procedure code level comparisons in the supplemental Excel™ file titled "Provider Rate Benchmarking Study P1 - Proc Code Detail" dated March 9, 2022 for the top 20 procedure codes in each service subgroup.

Table 3: Criteria for each Service Area and Subgroup in Phase 1

Service Area	Service Subgroup	Identification Criteria
HCBS	1115 Waiver Community Benefit	Community Benefit Services outlined in 1115 waiver
	State Plan Case Management	Telephonic and in person care and case management and TCM/CCM procedure codes
	1915(c) Waiver Services	Medically Fragile Waiver: Category of eligibility (COE) 095
		Developmental Disabilities and Mi Via Waiver: Category of eligibility (COE) 096
		Supports Waiver: Category of eligibility (COE) 096 with SWA or SWD Setting of Care
Physician & Other Practitioner	E&M Surgery Radiology/Lab/Path Medicine Anesthesia	CPT® Codes: 00100 – 01999, 99100 – 99150 CPT® Codes: 10021 – 69990 CPT® Codes: 70010 – 79999, 80047 – 89398 CPT® Codes: 90281 – 99607 CPT® Codes: 99202 – 99499

Service Area	Service Subgroup	Identification Criteria
(CPT®[7] Codes)		
HCPCS Level II Codes	DME Transportation Physician Administered Drugs Other	DME procedure codes included in the DME Fee Schedule Transportation procedure codes included in the Medicaid Transportation HCPCS Codes Fee schedule "J" HCPCS Codes Other non-mapped HCPCS codes
Maternal and Child Health	Child Health and EPSDT	Claims for up to age 21 with corresponding health examination ICD-10 diagnosis codes (Z codes) or procedure codes defined by the American Academy of Pediatrics
	Maternity-Related Care	Claims with corresponding ICD-10 gestational, prenatal, or postpartum diagnosis codes (Z and O codes). Does not include claims with a procedure code already included on the EPSDT subgroup
	Newborn-Related Care	Claims with corresponding ICD-10 perinatal diagnosis code (P codes) or newborn procedure codes. Does not include claims with a procedure code already included on the EPSDT subgroup
	Family Planning	Category of Service Code = 60
Behavioral Health	General Behavioral Health Opioid Treatment Program Applied Behavioral Analysis	Procedure codes unique to the BH or ABA Fee Schedules
Dental	Orthodontics	HCPCS Codes: D8000 – D8999
	Diagnostic/Preventive/Other	Other "D" HCPCS Codes
FQHC/RHC	FQHC	Billing Provider Type = FQHC
	RHC	Billing Provider Type = RHC

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

[7] CPT® is a registered trademark of the American Medical Association

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 by procedure code for the MF and DD waiver populations that are authorized only under the 1915(c) HCBS waivers, and encounter data for all other service areas. FFS claims data was not yet available for the Supports waiver, which went into effect in 2020.

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. During CY2019, the MCOs subcontracted a majority of NEMT services and a portion of dental services and have global capitation arrangements with related provider entities. In addition, the majority of dental services in managed care are subject to an administrative services agreement.

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 4%.

- Zero paid encounters – Identified as denied encounter lines on a claim.
- Zero FFSE – Identified as encounter lines on a claim without a calculated FFSE paid amount.
- 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.
- Medicare crossover claims – Identified as claims with Claim Types A, B, or C.
- 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 analysis. 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. These increases are not made to

the FFS rates. Below is the list of the state directed payments impacting services include in the Phase 1 benchmarking analysis.

University of New Mexico Medical Group (UNMMG) Uniform Percent Increase

Initial Implementation Date
January 1, 2019

Impacted Benchmark Service Areas
CPT® and HCPCS

Impacted Provider Class
The University of New Mexico Health Sciences Center clinical delivery system including: UNM Medical Group, UNM Sandoval Regional Medical Center, UNM Hospitals, and associated clinics and programs.

Type of Directed Payment
Uniform percentage increase of approximately 96% of contracted rates between the practice plans and the MCOs.

Supplemental Payments

Authorized through the New Mexico Medicaid State Plan,[8] 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 include in the Phase 1 benchmarking analysis.

Physician Supplemental Payment

This supplemental payment for eligible physician services increases New Mexico FFS fee schedule reimbursement to the CMS Medicare fee schedule in effect for the date the service was rendered. Payments are made to providers quarterly.

FQHC/RHC Wrap-Around Payments

This supplemental payment reconciles the difference between MCO encounter paid amounts and the prospective payment system (PPS) rates for FQHC/RHC facilities. The wrap-around payments are made directly to providers and not through managed care. These payments are made to FQHC/RHC providers on an interim and final settlement basis annually. Per the Centennial Care MCO contracts, the MCOs are to reimburse FQHC/RHC clinics at the PPS rates thus negating the need for any supplemental payments.

[8] 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]

Section 4
Selected Benchmarks

New Mexico Medicare FFS

CMS is the largest payer of health care services in the country.[9] 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 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.

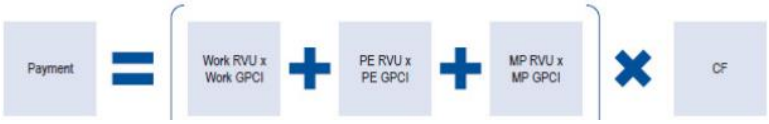
Medicare primarily covers hospital inpatient and outpatient, preventive and medically necessary services, skilled nursing facility, home health, hospice, and pharmacy care for people over age 65 or with certain disabilities. Importantly, Medicare does not cover long-term custodial care in a nursing home,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

For Phase 1, Mercer used Medicare payment rates as a benchmark for the following services:

- Maternal and Child Health (where applicable)
- Physician Services
- Durable Medical Equipment (DME)
- Emergency Medical Transportation
- Physician Administered Drugs
- FQHC/RHC

Medicare is a primary benchmark for the Physician Service Area as this is a commonly adopted approach for Medicaid programs. The Medicare rates for Physician Services are calculated based on the Physician Fee Schedule (PFS) formula shown below using the non-facility components.

Figure 5: Medicare PFS Payment Rates Formula[10]



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

[10] How to Use the MPFS Look-Up Tool Booklet (MLN901344) (cms.gov)

Mercer used the July 2021 release of the Conversion Factor (CF), Relative Value Unit (RVU), and New Mexico specific Geographic Pricing Cost Index (GPCI) in the benchmarking analysis for Physician services.

The following services do not use the PFS payment formula and have their own Medicare fee schedules.

- Anesthesiology, which uses a combination of Base Units and a New Mexico specific Conversion Factor. The CY2021 Base Units and Conversion Factor were used in the analysis.
- Ambulance, which has a separate rate for rural and non-rural zip codes. The CY2021 Ambulance rates were used in this analysis.
- Physician administered drug, which uses the October 2021 Medicare Part B drug average sales price.
- Clinical diagnostic laboratory services HCPCS which have separate published fee schedules. The 2021Q3 rates were used in this analysis.

The Medicare rates, CF, RVU, and GPCI factors are publicly available on the CMS website.[11]

Medicaid – Other States

In addition to Medicare, other state Medicaid reimbursement rates were also used for benchmark comparisons. Mercer used the published FFS fee schedule rates for each state. These fee schedules may not include other sources of provider reimbursement, such as 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 the Phase 1 service areas. The figures below represent the state profiles from CY2019 as reported by the Kaiser Family Foundation. See Appendix A for additional demographic information on NM and the other selected benchmark states and the data sources used.

[11] https://www.cms.gov/Medicare/Medicare

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.[12] 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.

For purposes of comparing the FFS rates as a benchmark, the following services are excluded:

- DME services generally have a separate rate (identified by the "RR" modifier) for equipment that is rented instead of purchased. The Arizona DME fee schedule contains daily rental rates for certain equipment, which is not consistent with the New Mexico rental DME rate structure. Services with daily rental rates have not been included in the benchmark analysis.
- Applied Behavior Analysis (ABA) services are a covered benefit in Arizona but specific ABA rates are not published as they are manually priced for each provider.

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. See Appendix B for additional details. Rates were effective as of July 1, 2021 for transportation services,

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

October 1, 2021 for dental services and physician administered drugs, and January 1, 2021 for all other services.

For purposes of comparing the FFS rates as a benchmark, the following services are adjusted:

- Colorado has separate DME rates for rural and non-rural counties. The New Mexico Medicaid provider's geographic location for each claim was used to determine which Colorado fee schedule should be used in the benchmarking analysis. This approach produces an average Colorado rate for DME services weighted on the rural/non-rural claims mix for New Mexico managed care providers.

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 FFS rates. Rates were effective in 2021 or earlier. This varies for specific service areas between August 1, 2012 for ambulance services and October 16, 2021 for BH services. The rates used in this analysis are publicly available on the Louisiana State Medicaid website. See Appendix B for additional details.

For purposes of comparing the FFS rates as a benchmark, the following services are adjusted/excluded:

- Louisiana has a separate anesthesia conversion factor for children 15 years and younger. The New Mexico Medicaid member's age at the time of each claim was used to determine which Louisiana conversion factor should be used in the benchmarking analysis. This approach produces an average Louisiana conversion factor for anesthesia services weighted on the claims mix for New Mexico managed care member ages.
- Louisiana has separate ambulance rates for each of the nine regions. To simplify the comparison to the New Mexico rate, the minimum Louisiana rate was used to compare to the non-rural New Mexico rate and the maximum Louisiana rate was used to compare to the rural New Mexico rate. The New Mexico Medicaid provider's geographic location for each claim was used to determine which Louisiana fee schedule should be used in the benchmarking analysis. This approach produces an average Louisiana rate for ambulance services weighted on the CY2019 rural/non-rural claims mix for New Mexico managed care providers.
- Louisiana has an enhanced fee schedule for Louisiana State University professional service providers. These enhanced rates have not been used in this analysis.

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. Rates were effective as of July 1, 2021 for ambulance and ABA services, and October 1, 2021 for all other services. The rates used in this analysis are publicly available on the Washington State Medicaid website. See Appendix B for additional details.

For purposes of comparing the FFS rates as a benchmark, the following services are adjusted/excluded:

- Washington has an enhanced pediatric fee schedule for children 17 years and younger and an enhanced fee schedule for schedule for members 18 to 20 years old. The New Mexico Medicaid member's age at the time of each claim was used to determine which Washington fee schedule should be used in the benchmarking analysis. This approach produces an average Washington rate for services across the enhanced and regular fee schedules.
- Washington has separate DME rates for rural counties, non-rural counties, Seattle, and Vancouver. Mercer used only the rural and non-rural rates in the benchmarking analysis. For each claim in the weighting, the New Mexico Medicaid provider's geographic location for each claim was used to determine whether to use the rural or non-rural fee schedule. This approach produces an average Washington rate for DME services weighted on the rural/non-rural claims mix for New Mexico managed care providers.
- Group ABA rates in Washington vary based on whether the group has two, three, or four members. The New Mexico group ABA rate does not vary based on the size of the group. For this analysis, the three-member Washington group ABA rate is being compared to New Mexico ABA group rate.

Section 5

Results

Mercer presents the results of the Phase 1 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 benchmarks. Based on the analysis, Mercer observed that the average managed care reimbursement is generally on track with the FFSE amounts. However, Mercer observed differences for anesthesia, behavioral health, and physician services due to:

- Variation in the reported units of service (e.g., per visit versus per 15 minutes)
- Involvement of Core Services Agencies
- Reimbursement differences by provider type (e.g., physicians, BH agencies, and dentists) which may be attributed to different treatment of items such as the state's GRT

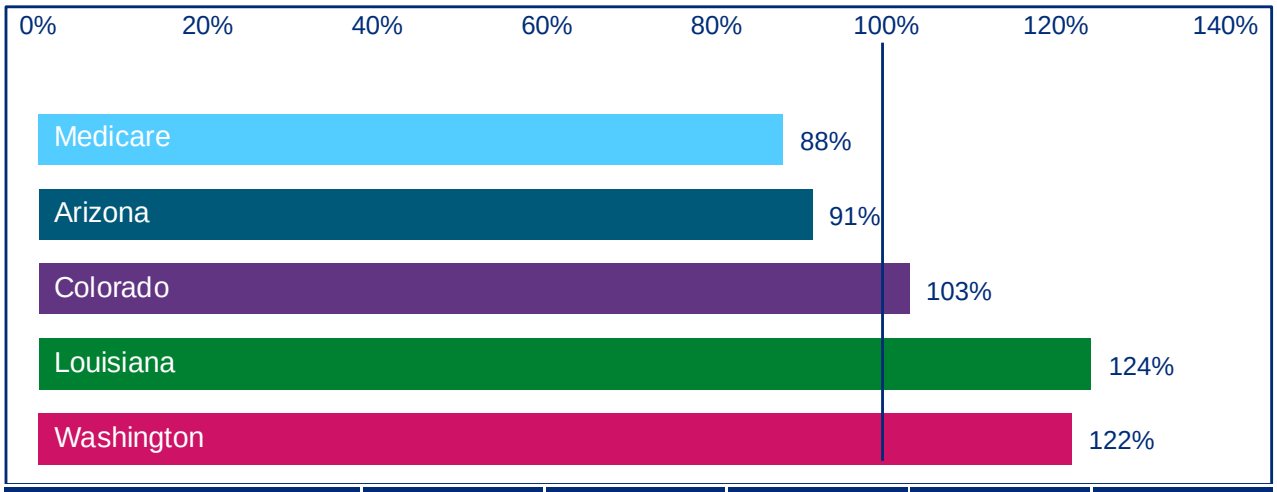
Mercer will seek feedback from MCOs and providers during the stakeholder engagement activities to better understand drivers of these patterns.

While New Mexico FFS reimbursement levels are consistently lower than Medicare, they tend to be slightly above Colorado in aggregate and in the middle of the other three benchmark state Medicaid programs. Each of the sections below will discuss these findings in more detail for each service group.

For the HCBS and FQHC/RHC 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 below, we illustrate the overall results for the CY2021 New Mexico FFS fee schedules compared to the presented benchmarks for all non-HCBS and non-FQHC/RHC service areas.

Figure 7: Overall CY2021 New Mexico Medicaid FFS Relativity to Each Benchmark



Service Area	Medicare	AZ	CO	LA	WA
Total	**88%**	**91%**	**103%**	**124%**	**122%**
HCBS *(43% of total expenditures)*	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]
Physician & Other Practitioner *(21% of total expenditures)*	86%	87%	104%	131%	123%
HCPCS Level II *(10% of total expenditures)*	85%	86%	112%	99%	107%
Maternal & Child Health *(5% of total expenditures)*	96%	94%	106%	142%	119%
Behavioral Health *(9% of total expenditures)*	97%	116%	109%	144%	138%
Dental *(6% of total expenditures)*	N/A[2]	83%	83%	88%	113%
FQHC/RHC *(6% of total expenditures)*	N/A[1]	N/A[1]	N/A[1]	N/A[1]	N/A[1]

1. Due to the types of services and reimbursement approaches in the 1915(c) Waivers and FQHC/RHC Service Areas, the relativities to the selected benchmarks are not displayed. See the Summary of Results section for additional detail.

2. Professional Dental services are not covered by Medicare therefore; Medicare was excluded as a benchmark.

The supporting Excel™ file titled “Provider Rate Benchmarking Study P1 - Proc Code Detail” dated March 9, 2022 includes detail at the procedure code level to support the summary of results. Where applicable, the data for the top 20 procedure codes for each service subgroup is provided. The procedure code detail presented in the supporting Excel™ file reflects 82% of the CY2019 expenditures analyzed for this study.

HCBS

Medicare	AZ	CO	LA	WA
✓	✓	✓	✓	✓

HCBS are offered to Medicaid members through several HSD programs. In this service area, Mercer reviewed and evaluated the services in the 1115 Waiver Community Benefit, State Plan case management services and the 1915(c) waiver services included in the DD, MF, and Supports waivers. The Mi Via waiver is New Mexico's self-direction waiver where members can manage their own services and supports within an approved budget. Rates are negotiated for this waiver and therefore excluded from this report.

Most of the expenditures in this service area are for the services in the 1115 Waiver Community Benefit and the 1915(c) waivers (98%) where HSD reimburses all of the 1115 Waiver services through managed care, and all of the 1915(c) waiver services under the FFS delivery system. Medicare does not cover most of the services in the HCBS service area; however, it is an available benchmark for the skilled maintenance therapies (SMT) presented in the 1115 Waiver Community Benefit.

1115 Waiver Community Benefit

The 1115 Waiver Community Benefit services account for 51% of all HCBS services presented in this report, and personal care services (99509 and T1019) make up a majority (81%) of the expenditures for the 1115 Waiver Community Benefit. The managed care reimbursement for these services correspond to 124% of the FFSE reimbursement levels. This category primarily includes services authorized through the 1115 managed care program, such as personal care services and the SMT – occupational therapy, speech therapy, and physical therapy.

Since the majority of codes in this service group are specific to the 1115 waiver and do not have a corresponding New Mexico FFS rate, benchmarking SMT codes to Medicare and the other states provides the most relevant information for this study.

Overall, New Mexico SMT rates are lower than Medicare, Arizona, and Colorado but higher than Louisiana and Washington when comparing across all SMT.

Table 4: Relativities for the Selected Benchmarks by SMT Type

	CY2021: NM Medicaid FFS Percent of Benchmark				
Skilled Maintenance Therapies	**Medicare**	**AZ**	**CO**	**LA**	**WA**
All SMT	**88%**	**90%**	**98%**	**142%**	**145%**
Physical Therapy	90%	85%	97%	147%	149%
Occupational Therapy	81%	77%	141%	98%	134%
Speech Therapy	79%	133%	97%	123%	132%

State Plan Case Management

State Plan case management services represent 2% of HCBS services, and managed care pays 170% of the FFSE reimbursement for these services. This category primarily includes the procedure codes for the Health Home monthly benefit (G9001 and G9003) and Targeted Case Management services (T1017 and T2023). The Health Home services represent 73% of the managed care expenditures for this service group, and HSD develops the provider-specific rates, which are approved by CMS. The managed care expenditures for T1017 are significantly higher than the FFSE using the units as reported on the managed care encounters. This appears to be driven by differences between the units reported in managed care, which align with a monthly case rate, instead of the FFSE rate which is per 15 minutes. Therefore, this this direct comparison may be unreliable. Mercer will follow up with the MCOs regarding this comparison during the stakeholder engagement process of this study. This service group captures only the State Plan services; we provide the information for the waiver case management service in the 1915(c) section below.

1915(c) Waiver Services

In New Mexico, the Department of Health (DOH) Developmental Disabilities Supports Division operates three waivers for individuals with intellectual and developmental disabilities – the DD Waiver, the MF Waiver, and Mi Via waiver. As per CMS waiver requirements, DOH conducts a comprehensive rate study every five years from which waiver rates are developed.

Given that these services are not Medicare covered benefits, and each state designs its waiver programs differently, Mercer has compared the rate levels using the general categories of service (e.g., residential, personal support) rather than by specific procedure code. The selected benchmarking states each have a DD waiver, which is the primary source used for comparison to New Mexico's DD waiver. We present the rate ranges for each category of service in Table 5 below. The supporting Excel™ file titled "Provider Rate Benchmarking Study P1 - Proc Code Detail" dated March 9, 2022 provides details of the New Mexico services as well as those of the benchmarking states to assist in the comparison of rate across states. However, for purposes of this table, we have only listed the range of rates for each category.

Overall, New Mexico's rate levels for the DD waiver align with the benchmarking states; however, for many services, the other states have additional tiers or levels to differentiate rates by geographic location, staffing ratio, or level of intensity.

Table 5: Rate Ranges for Developmental Disabilities Waiver by Service Category (with Expenditures of $1M or more)

NM Service	2019 NM FFS Expenditures	NM Rate Range	AZ Rate Range	CO Rate Range	LA Rate Range	WA Rate Range
Residential Habilitation (Daily rates)						
Supported Living	*$124,206,433*	*$210.35-$435.81*	*$96.17-$1,000.20*	*$70.77-$245.69*	*$82.33-$123.09*	*$66.17-$737.07*
Family Living	*$110,407,940*	*$119.48-$129.47*	*$137.56*	*$65.64-$227.87*	*$52.67-$69.32*	*$73.95-$281.01*
Intensive Medical Living Services	*$2,843,067*	*$468.00*	*$439.18-$579.06*	*Approved on individual basis*	*N/A*	*$66.17-$737.07*
Customized Community Support (15 minutes)						
Individual	*$63,768,844*	*$7.18-$8.20*	*$3.96-$7.21*	*$3.13-$10.38*	*$4.13*	*Contracted rates*
Group	*$18,608,067*	*$2.68-$5.97*	*$1.87-$3.45*	*$3.13-$10.38*	*$2.35-$3.25*	*Contracted rates*
Community Integrated Employment						
Aide	$23,462,381	$18.03-$34.44 (hour)	$33.62-$39.32 (hour)	N/A	$16.00 (hour)	N/A
Supported Employment	$2,100,686	$2.22-$15.30 (15 minutes) $56.42 (hour, Intensive)	$2.38-$6.12 (15 minutes) $44.10-$52.08 (hour, Intensive)	$3.44-$7.57 (15 minutes) $56.80 (hour, Individual)	Daily rates only	*Contracted rates*
Waiver Case Management	$9,789,690	$314.35 (monthly)	N/A	$141.74 (monthly)	$135.99-$155.00 (monthly)	N/A
In-Home Supports	$9,029,858	$6.87 (15 minutes)	$3.06-$7.10 (15 minutes)	$5.78 (15 minutes)	$1.65-$4.00 (15 minutes)	$8.18 (15 minutes)
Speech Pathology	$7,565,357	$22.90-$29.20 (15 minutes)	$21.35-$42.47 (15 minutes)	N/A	$21.00 (15 minutes)	$180 per session
Behavior Support	$6,931,400	$18.34-$23.66 (15 minutes)	$20.36-$40.67 (15 minutes)	$25.54 (15 minutes)	$18.00-$31.25 (15 minutes)	*Contracted rates*
Physical Therapy	$5,843,793	$18.84-$29.20 (15 minutes)	$21.35-$42.47	N/A	$22.20-$23.00	*Contracted rates*
Occupational Therapy	$5,082,929	$18.84-$29.20 (15 minutes)	$18.25-$42.47 (15 minutes)	N/A	$22.20-$23.00 (15 minutes)	*Contracted rates*
Respite *(Individual and Group)*	$3,362,044	$3.28-$4.67 (15 minutes)	$2.51-$5.91 (15 minutes)	$5.64 (15 minutes, Individual)	$4.00 (15 minutes)	$2.61-$4.58 (15 minutes)
Adult Nursing Services *(RN/LPN)*	$2,167,578	$13.92-$19.23 (15 minutes)	$9.77-$16.25 (15 minutes)	N/A	$16.00-$34.00 (15 minutes)	$7.08-$9.19 (15 minutes)

In addition to comparing the service rates in the published DD waiver fee schedule to the selected benchmark states, Mercer also compared the New Mexico DD waiver service rates to the other published fee schedules for the 1915(c) waivers in place in New Mexico (for services that overlap). This comparison is helpful to evaluate whether services are being paid consistently across waivers; however, there may be cases where services are defined differently in each waiver, supporting a differentiation in the payment rate.

Some general observations are as follows:

- The published fee schedule rates for the MF waiver are generally higher than those paid for comparable services in the DD waiver. This may be expected given the higher level of need of individuals enrolled in the MF waiver.
- There are several services offered in the Supports waiver that show a higher payment rate in the published fee schedule as compared to the DD waiver rates, including:
  - Employment Supports
  - Behavioral Support Consultation
  - Respite (i.e., $3.38 compared to $3.28 in the DD waiver)
  - Environmental modifications has a limit of $5,000 for every 5 years; the published DD waiver fee schedule indicates a rate of $9.50 each

Physician & Other Practitioners

Medicare	AZ	CO	LA	WA
✓	✓	✓	✓	✓

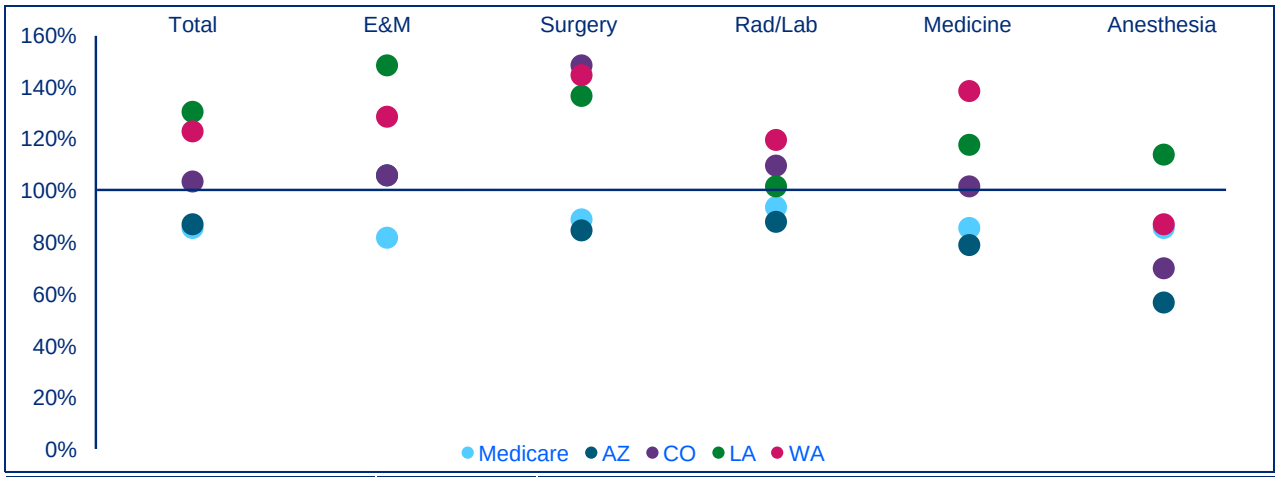
The physician and other practitioner service area includes subgroups defined based on the American Medical Association guidelines for CPT® codes, with Evaluation & Management (E&M) representing half of the total expenditures. New Mexico pays for these services under FFS using the posted fee schedules. For Anesthesia, the fee schedule defines the base units and conversion factors to calculate the applicable payment amount based on the time units billed for the service. HSD updates the fee schedules on an ad hoc basis to add new procedure codes.

Physicians bill nearly all submitted encounters in this overall service area; however, certain subgroups do have other provider types. For example, other practitioners such as optometrists and physical therapists bill for services included in the Medicine category.

In New Mexico, the majority of physician and other practitioner services are provided under managed care (91%) and on average, MCOs pay for physician and other practitioner services at 95% of the average FFSE payment levels. The procedure code detail for Physician & Other Practitioners services shown in the supporting Excel™ file reflects 66% of the CY2019 expenditures analyzed for benchmarking this service area.

Compared to other selected benchmarks, New Mexico's FFS physician and other practitioner payment rates are lower than Medicare and Arizona, but higher than Colorado, Louisiana, and Washington. Figure 8 below shows the benchmarking results for each state, separated by the individual services subgroups.

Figure 8: Physician and Other Practitioner – NM Medicaid FFS Benchmarking Results



Service Subgroup	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC/FFSE	Medicare	AZ	CO	LA	WA
Total	**95%**	**86%**	**87%**	**104%**	**131%**	**123%**
Evaluation & Management *(50% of total expenditures)*	101%	82%	106%	106%	149%	129%
Surgery *(19% of total expenditures)*	107%	89%	85%	149%	137%	145%
Radiology/Laboratory *(17% of total expenditures)*	100%	94%	88%	110%	102%	120%
Medicine *(11% of total expenditures)*	100%	86%	79%	102%	118%	139%
Anesthesia *(3% of total expenditures)*	30%[1]	86%	57%	70%	114%	87%

1. This calculation is influenced by discrepancies between the units reported in managed care and the FFS payment formula. See the Anesthesia section for additional detail.

Evaluation & Management

Half of the overall physician expenditures in the managed care program (50%) are for E&M codes, and the managed care expenditures are 101% of the FFSE reimbursement. Office/outpatient visits are 60% of the expenditures in this category, emergency department visits are approximately 19%, and the remaining 21% are a mix of other physician services, including facility care in hospitals and nursing facilities, discharge, critical care, adult preventive visits, and home visits. The posted fee schedule was updated in 2019 when HSD increased rates across many codes including raising any that were below 90% of the Medicare rate.

It is common for professional services provided in a facility setting to be paid lower than those provided in an office setting, as the facility is responsible for and reimbursed for the overhead, equipment, and services it provides. In FFS, New Mexico limits payments for office-based services to 60% of the office rate when the service is performed in a hospital-based setting.

Similarly, the encounter data shows lower average payments for office visit codes where the provider type is identified as a physician component of a facility provider. However, the managed care payments do not show the level of differentiation between facility and office-based services, where the average managed care rate is 109% of the FFSE rate for this provider type. Physician component of a facility provider type represented 9% of the total expenditures in this category.

It is also common for nurse practitioners to be paid a percentage of the physician rate. In FFS, New Mexico establishes payments for some providers, such as nurse practitioners billing independently, to 90% of the physician rate. The managed care payments do not appear to differ significantly between physician and nurse practitioner provider types for office visit codes; but the FFS policy produces lower FFSE reimbursement for nurse practitioners, who provide many of the primary care services to New Mexico Medicaid members. For emergency room visits, the managed care rates for nurse practitioners greatly exceed the FFSE as well as the managed care rate for physicians. This may suggest an underlying discrepancy in the encounter submitted units. The Certified Nurse Practitioner (CNP) billing provider type represented 4% of the encounter expenditures in this category.

Medicare also reimburses many of the E&M codes used in New Mexico, with the exception of codes for consultations and preventive visits. In 2019, HSD increased fees for E&M codes to a minimum of 90% of the 2019 Medicare rate, but has not updated them as Medicare rates have continued to change. The New Mexico rates for these codes represent 82% of the current Medicare rate overall, with individual codes ranging from 73% to 114% of the Medicare rate.

Most of the E&M codes in this category are consistent across states, with 97%-100% of the New Mexico procedure code expenditures appearing on other fee schedules. Arizona appears to frequently align rates for these codes at a percentage of the Medicare fee schedule, while the other benchmark states show more variation between codes relative to Medicare. Overall, New Mexico rates are higher than all selected benchmark states.

Surgery

In New Mexico, the surgery FFS payments are based on a published fee schedule with different rates based on modifiers to indicate if the billed service is professional only, technical only or combined (i.e., global).

Surgery codes comprise 19% of the managed care physician expenditures across several thousand code/modifier combinations billed in 2019. On average, the managed care payments are 107% of the FFSE reimbursement. Different payments apply for specific circumstances, such as procedures performed by assistant surgeons, multiple procedures on the same day, and bilateral and incidental procedures. Physicians bill most of the expenditures with managed care payments at 102% of the FFSE rate, while rates paid to ambulatory surgical centers are frequently higher and show managed care payments at 125% of the FFSE rate.

Most of the codes in this category are consistent across the selected benchmarks, with 97%-98% of the New Mexico procedure codes appearing on other fee schedules. New Mexico rates are lower than rates paid by Medicare and Arizona, and higher than rates paid by Colorado, Louisiana, and Washington.

Laboratory/Radiology

New Mexico laboratory/radiology FFS payments are based on a published fee schedule with rates that vary based on modifiers that signify whether the billed service is professional only, technical only or combined (i.e., global).

Laboratory/Radiology codes represent 17% of the managed care physician expenditures across more than one thousand code/modifier combinations billed in 2019. The managed care payments are 100% of the FFSE reimbursement. Physicians and Freestanding Clinics bill most of the expenditures in this category; and MCOs pay them at 99% and 102% of the FFSE rate, respectively.

Most of the codes in this category are consistent across the selected benchmarks, with 95%-99% of the New Mexico procedure codes appearing on other fee schedules. New Mexico rates are lower than rates paid by Medicare and Arizona, and higher than rates paid by Colorado, Louisiana, and Washington.

Medicine

Medicine codes reflect 11% of the managed care physician expenditures across more than 700 billed code/modifier combinations. These codes are billed primarily by physicians, but also include Optometrist, Physical Therapist, and Psychologist provider types. Overall, the managed care expenditures are 100% of the FFSE.

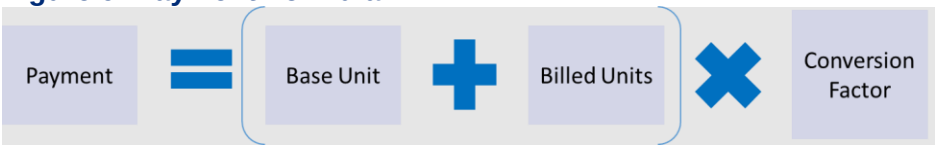
Overlapping codes across the selected benchmarks capture between 86% (Louisiana) to 97% (Arizona and Colorado) of the 2019 expenditures. Medicare does not cover routine eye exams for vision correction, which is an optional benefit for adults in Medicaid and covered in Centennial Care. Medicaid also frequently covers many CPT® codes for administering certain vaccinations that are not covered by Medicare. The New Mexico rates for the overlapping medicine codes are 86% of the Medicare rate overall.

For the other states selected as benchmarks, Arizona and Colorado share many of the same medicine codes as New Mexico. Louisiana does not cover optional routine eye exams for vision correction for adults and does not publish a rate for many other medicine codes used in New Mexico and other states. For the shared codes, New Mexico rates are higher than three out of the four selected benchmark states (lower only than Arizona).

Anesthesia

Anesthesia codes reflect 3% of the managed care physician expenditures and are paid differently than the other physician services. The fee schedule defines the base units and conversion factor that are used to calculate the payment amount on each claim with the following formula.

Figure 9: Payment Formula



The payment formula depends directly on the billed units, which are defined as 15 minute time increments and do not include the base units defined in the fee schedule. For purposes of calculating average rates in this report, Mercer used the billed units in the formula. The managed

care expenditures for anesthesia are significantly lower than the FFSE using the units as-reported on the managed care encounters, at only 30% of the FFSE reimbursement. This difference appears to be driven by discrepancies between the units reported in managed care and the FFS payment formula, making this direct comparison unreliable. Mercer will follow up with MCOs regarding this comparison during the stakeholder engagement process of this study.

Nearly all of the codes in this category are consistent across Medicare and the selected states, with 99%-100% of the New Mexico procedure codes matching codes from the benchmark fee schedules. As the FFS payment formula above is applicable to the other selected benchmarks, the payment rates can be directly compared using the units as-reported for all calculations. New Mexico rates are lower than rates paid by all other benchmarks (ranging from 57%-87%), except Louisiana (at 114%). The base units were very similar between the selected benchmarks, with Louisiana varying the most. The main driver of variation between reimbursement levels is the conversion factor as displayed below.

Table 6: Summary of CY2021 Anesthesia Conversion Factors

State/Payer	CY2021 Conversion Factor	NM Percent of
New Mexico	$18.43	
Medicare	$21.43	86%
Arizona	$32.12	57%
Colorado	$26.59	69%
Louisiana*	$15.38 and $18.46	120%-100%
Washington	$21.20	87%

** Louisiana has a separate anesthesia conversion factor for members 15 years and younger ($18.46) and 16 years and older ($15.38).*

HCPCS Level II Codes

Medicare	AZ	CO	LA	WA
✓	✓	✓	✓	✓

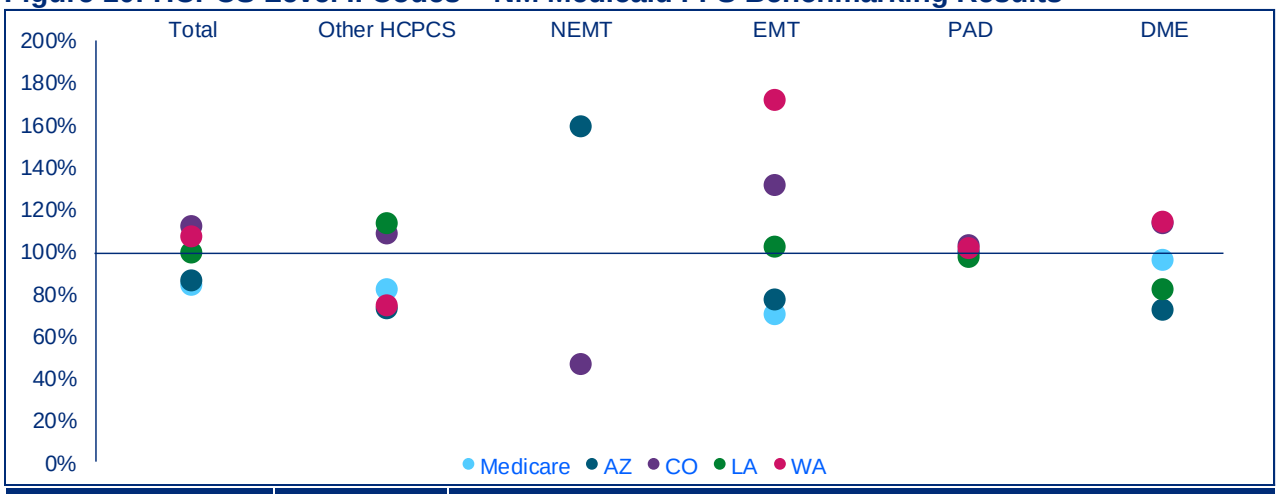
The HCPCS Level II service area includes transportation (EMT and NEMT), physician administered drugs (PAD), DME, and all other HCPCS services. New Mexico pays for transportation and DME services under FFS using the posted transportation and DME fee schedules. New Mexico pays for PAD and other HCPCS services under FFS using the posted HCPCS codes fee schedule. HSD generally updates the fee schedules on an ad hoc basis to add new procedure codes, but updates the PAD codes quarterly to align with Medicare's rate update schedule.

New Mexico delivers the majority of HCPCS services under managed care (75%) and on average, MCOs pay 117% of the FFSE for HCPCS services. The procedure code detail for HCPCS Level II Codes shown in the supporting Excel™ file reflects 78% of the CY2019 expenditures analyzed for benchmarking this service area.

Compared to other selected benchmarks, New Mexico's FFS HCPCS payment rates are lower than Medicare, Arizona and Louisiana, but higher than Colorado and Washington. Figure 10

below shows the benchmarking results for each state, separated by the individual services subgroups.

Figure 10: HCPCS Level II Codes – NM Medicaid FFS Benchmarking Results



Service Subgroup	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC/FFSE	Medicare	AZ	CO	LA	WA
Total	**117%**	**84%**	**86%**	**112%**	**99%**	**107%**
Other HCPCS *(27% of total expenditures)*	97%	82%	73%	108%	113%	74%
NEMT *(23% of total expenditures)*	226%	N/A[1]	159%	46%	N/A[2]	N/A[2]
EMT *(19% of total expenditures)*	106%	70%	77%	131%	102%	172%
PAD *(20% of total expenditures)*	101%	100%	99%	103%	97%	101%
DME *(11% of total expenditures)*	117%	96%	72%	113%	82%	114%

1. Medicare does not cover non-emergent transportation; therefore, Medicare was excluded as a benchmark for this subgroup.
2. Louisiana and Washington cover non-emergent transportation but fee schedule rates are not posted online; therefore, Louisiana and Washington were excluded as a benchmark for this subgroup.

Other HCPCS Level II

Other HCPCS services represent 27% of the managed care HCPCS code expenditures, and the average managed care reimbursement for these codes is 97% of the FFSE reimbursement. The other HCPCS codes include approximately 1,000 procedure codes for a range of different types of services and provider types. Below are the different services included in the other HCPCS service subgroup:

- Select HCBS services provided through the EPSDT benefit (S5125, T1000)
- Medical/surgical supplies ("A" codes that are not transportation)
- Enteral and Parenteral Therapy ("B" codes)
- Other DME not in the New Mexico DME fee schedule ("E" codes)
- Procedures / Professional Services – Temporary ("G" codes)
- DME for Medicare Administrative Contractors ("K" codes)
- Orthotic and Prosthetic Procedures, Devices ("L" codes)
- Pathology and Laboratory Services ("P" codes)
- Miscellaneous Services (Temporary Codes) ("Q" codes)
- Diagnostic Radiology Services ("R" codes)
- Commercial Payers (Temporary Codes) ("S" codes)
- Established for State Medical Agencies ("T" codes)
- Vision, Hearing and Speech-Language Pathology Services' ("V" codes)

Given the array of different services included in the other HCPCS codes subgroup, we have presented the comparisons to Medicare and the other state benchmarks (if available) by the type of service in the following table. Generally, New Mexico is paying significantly lower for "V" codes (Vision, Hearing, and Speech-Language Pathology Services) than Medicare and the benchmark states with the exception of Washington. For the other services, New Mexico is reimbursing slightly below Medicare and Arizona (on average), but higher than Colorado, Louisiana, and Washington.

For the HCBS – EPSDT services, the attendant care service (procedure code S5125) accounts for a majority of the expenditures. Medicare does not cover these services and those offered in the other benchmark states vary. This is a temporary intervention provided to a functionally impaired individual in their own home where the service would be discontinued when long-term services become available. The published New Mexico FFS rate for this service is $3.43 per 15 minutes. This service is also available through New Mexico's 1915(c) DD waiver (Customized In-home Supports) and is paid a FFS rate of $6.87 per 15 minutes.

Table 7: Summary of Other HCPCS Codes Benchmarking Results

Other HCPCS Service Type	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC Dollar Distribution	Medicare	AZ	CO	LA	WA
Total	**100%**	**82%**	**73%**	**108%**	**113%**	**74%**
HCBS - EPSDT	21%	N/A – not covered under Medicare; HCBS services vary by state and are not comparable				
"A" Codes	12%	103%	77%	129%	173%	64%
"B" Codes	0%	100%	66%	198%	5%	N/A

Other HCPCS Service Type	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC Dollar Distribution	Medicare	AZ	CO	LA	WA
"E" Codes	11%	103%	84%	105%	149%	101%
"G" Codes	19%	93%	93%	184%	124%	119%
"K" Codes	3%	100%	78%	150%	142%	101%
"L" Codes	23%	100%	93%	137%	144%	104%
"P" Codes	0%	144%	135%	406%	N/A	234%
"Q" Codes	1%	99%	88%	123%	100%	100%
"R" Codes	0%	N/A	50%	594%	N/A	196%
"S" Codes	0%	N/A	12%	124%	180%	118%
"T" Codes	4%	N/A	N/A	97%	109%	17%
"V" Codes	5%	22%	22%	40%	35%	136%

Non-Emergent Medical Transportation

NEMT services reflect 23% of the managed care HCPCS code expenditures, with 'Non-emergency transport taxi' (A0100) and 'Interest Escort in Non ER' (A0090) accounting for a majority of the NEMT expenditures (i.e., 64% and 21%, respectively). The average managed care reimbursement Mercer calculated is 226% of the FFSE reimbursement. However, MCOs pay these providers using subcapitation for many of the NEMT services, which may be influencing the comparability of the MCO payment amount in the encounter data and the FFSE. In addition, the MCOs appear to reimburse procedure code A0090 (Interest Escort in Non ER) on a per trip basis while the FFS rate is on a per mile basis, which may cause the relativity calculation to be overstated. Mercer will follow up with MCOs to obtain additional insight into these patterns during the stakeholder engagement activities.

NEMT does not have significant overlap with Medicare and the other states, given that NEMT is not a covered Medicare benefit and NEMT rates are not published for Louisiana and Washington. However, we were able to draw some comparisons to the NEMT rates for Arizona and Colorado. New Mexico rates on average are higher than Arizona but lower than Colorado.

Emergent Medical Transportation

EMT services reflect 19% of the managed care HCPCS code expenditures, and the average managed care payments are 106% of the FFSE reimbursement for all EMT services. Ground ambulance providers represent most of the EMT expenditures (68%) and air ambulance providers account for 32% of EMT expenditures. Mercer's analysis shows higher managed care reimbursement for the air ambulance services, for which average managed care payments are 121% of the FFSE reimbursement.

Most of the EMT service codes in this category are consistent across states, where New Mexico rates are lower on average than Arizona and Medicare but higher than Colorado, Louisiana, and Washington.

Physician Administered Drugs

PAD services represent 20% of the managed care HCPCS code expenditures, and the average managed care payments are 101% of the FFSE reimbursement. For the majority of codes (74%), MCO reimbursement is below the FFSE, however the remaining codes are paid well above the FFSE resulting in the aggregate relativity of 101%.

Most of the PAD service codes in this category are consistent across states, and it appears that Colorado and Washington have aligned their PAD fee schedules with Medicare.

New Mexico FFS rates on average are equal to the Medicare rates, with a few exceptions in procedure codes with low utilization. On average, New Mexico rates are similar to Arizona and above the rates in Colorado and Washington.

There is a notable difference in relativities for Arizona and Louisiana for the procedure code 'Injection, Pegfilgrastim 6Mg' (J2505). J2505 is a drug that faced market competition with the launch of biosimilar products starting in 2018. As such, the Medicare Average Sales Price (ASP) rate listed for J2505 has declined significantly since 2018. It does not appear that Arizona or Louisiana have recently adjusted their J2505 rates to reflect the most current declining Medicare ASP rates.

Durable Medical Equipment

DME services represent 11% of the managed care HCPCS code expenditures, and the average managed care payments are 117% of the FFSE reimbursement. Typically, DME rates vary if the equipment is purchased or rented, and Mercer's analysis shows that 54% of managed care expenditures are for rented DME while 46% of managed care expenditures are for purchased DME.

New Mexico has separate DME fee schedules for rural zip codes (identified by a U1 modifier) and zip codes in the Competitive Bidding Area (CBA) (identified by a U2 modifier). Non-rural non-CBA rates are listed in the general HCPCS codes fee schedule. For the purpose of this benchmarking study, only the procedure codes that appear on the separate DME fee schedules are classified as DME. On average, the MCOs pay significantly higher than the FFSE, with the exception of the MCO reimbursement rate for rented Negative Pressure Wound Therapy Pump (E2402-RR) for which the average MCO payment is 48% of the FFSE.

A large number of DME service codes in this category are consistent across states; however, there are some nuances to the other benchmark states worth noting:

- For a number of rental DME procedure codes, Arizona's fee schedule indicates the rate is a daily rate that is not consistent with how New Mexico reimburses the DME rentals. The daily rental DME services from the Arizona fee schedule have been excluded from the DME analysis as to not influence the overall comparison to Arizona reimbursement.
- DME is a Medicaid covered benefit in Washington but the complete fee schedule is not posted on the Washington Medicaid website. Based on the publicly available information, we were able to match 15% of codes with New Mexico.

The New Mexico rates are relatively consistent but slightly below the Medicare rates for nearly all codes. On average, New Mexico is paying lower than Arizona and Louisiana for DME services while New Mexico is paying higher than Colorado for most DME services. Given that the

Washington DME fee schedule was not available on the Washington Medicaid website, the results for the few matching codes are not reliable and should not be used for evaluation.

Maternal and Child Health

Medicare	AZ	CO	LA	WA
✓	✓	✓	✓	✓

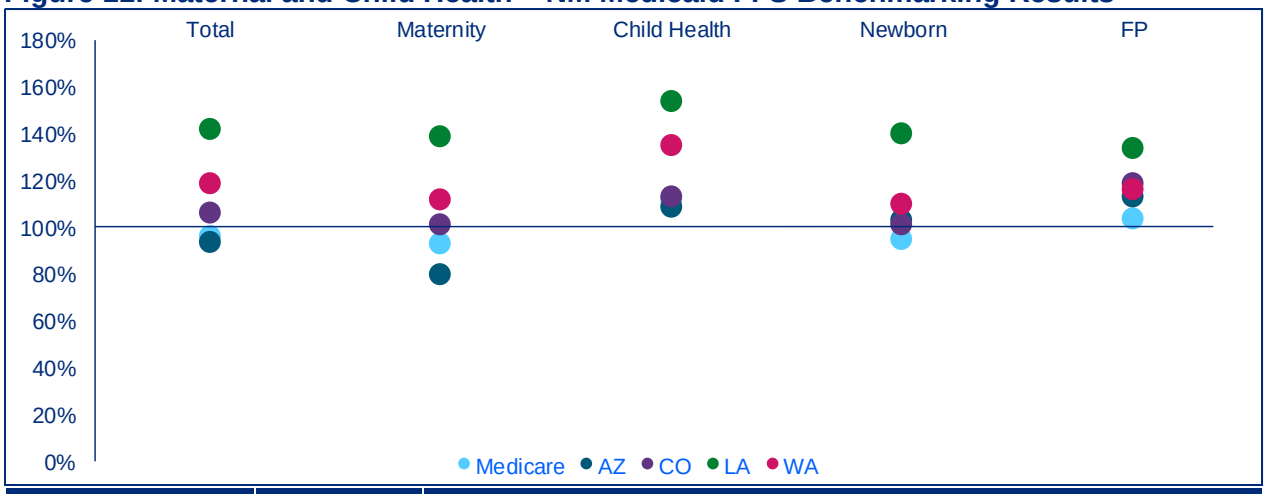
The maternal and child health service area includes maternity-related care, child health, newborn-related care, and family planning subgroups. While Medicare covers some of the codes identified in this category, maternal and child health services are not widely used in Medicare due to the demographics of the covered populations. Therefore, the selected state benchmarks provide a more robust benchmark for these services. New Mexico pays for these services under FFS using the posted fee schedules for the applicable procedure codes. HSD updates the fee schedule on an ad hoc basis to add new procedure codes.

Physicians bill nearly all submitted encounters in this service area as opposed to other provider types; other less frequent provider types include certified nurse practitioners, the physician component for a facility provider, laboratory/radiology facilities, and medical equipment. Some maternal and child health services are provided in a facility setting. The professional claims for these services are included in this Phase 1 report, while any separate facility claims will be included in Phase 2.

The majority of maternal and child health services are provided under managed care (91%) and on average, MCOs pay for maternal and child health services at 94% of the FFSE payment levels. The procedure code detail for Maternal and Child Health services shown in the supporting Excel™ file reflects 82% of the CY2019 expenditures analyzed for benchmarking this service area.

Overall, New Mexico's FFS rates for child and maternal health are lower than Arizona and higher than rates paid by Colorado, Louisiana, and Washington. New Mexico's rates are also lower than Medicare; however, Medicare is not a robust benchmark for this category of service. Figure 11 below shows the benchmarking results for each state, separated by each service subgroup.

Figure 11: Maternal and Child Health – NM Medicaid FFS Benchmarking Results



Service Subgroup	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC/FFSE	Medicare	AZ	CO	LA	WA
Total	**94%**	**96%**	**94%**	**106%**	**142%**	**119%**
Maternity *(40% of total expenditures)*	87%	93%	80%	101%	139%	112%
Child Health *(35% of total expenditures)*	99%	112%	109%	113%	154%	135%
Newborn *(14% of total expenditures)*	104%	95%	103%	101%	140%	110%
FP *(11% of total expenditures)*	95%	104%	113%	119%	134%	116%

Maternity-Related Care

Maternity-related care represents 40% of maternal and child health service expenditures, and the average managed care payments are 87% of the FFSE reimbursement. This difference appears to be primarily driven by low units reported for anesthesia codes on the managed care encounter data (see additional discussion under Physician services). Excluding these anesthesia codes, the average managed care payments are 99% of the FFSE reimbursement.

This category primarily includes physician visits related to delivery, antepartum, and postpartum care, routine office visits, and obstetrical imaging. The top two codes in the 2019 managed care data are bundled codes for routine deliveries that include antepartum and postpartum care. These two codes reflect 28% of the expenditures for maternity-related care.

Most of the maternity-related codes in this category are consistent across selected benchmarks, with 93%-98% of the New Mexico procedure codes appearing on other state fee schedules. As noted earlier, although Medicare covers these codes, low maternity volume in Medicare makes the comparison less relevant. Overall, New Mexico rates are lower than Medicare and Arizona, and higher than Colorado, Louisiana, and Washington. New Mexico rates are higher for caesarian deliveries. Rates in Louisiana and Washington are equivalent for both caesarian and vaginal deliveries.

Child Health and EPSDT

Child-related care represents 35% of maternal and child health service expenditures, and the average managed care payments are 99% of the FFSE reimbursement.

This category primarily includes periodic preventive office visits, vaccine administration, and developmental screenings. While Medicare includes some of the codes identified in this category, specific child-related services are not widely used in Medicare due to the demographics of the covered populations. Medicare does not cover routine preventive visits for children, which are a key driver in this category. As a result, the overlap with Medicare codes is much lower than other categories, at 35%. For the codes that do overlap, the New Mexico rates are higher than the Medicare rates, particularly for immunization codes.

Most of the child-related codes in this category are consistent across states, with 83%-99% of the New Mexico procedure codes appearing on other states' fee schedules. Overall, New Mexico rates in this category are higher than all selected state benchmarks. New Mexico's rate for 99173 is a particular outlier compared to other selected benchmarks, but only represents 2% of the expenditures in this category. New Mexico rates are all preventive visits (99391-99396 and 99381-99385) are the same regardless of age, but vary by age in other states. Similarly, several immunization codes have the same rate in New Mexico (90460, 90461, 90471, 90472, 90473, and 90474). Mercer also observed this for several other states, but frequently the rates are lower for the codes related to additional administration (90461, 90472, and 90474).

Newborn-Related Care

Newborn-related care represents 14% of maternal and child health service expenditures, and the average managed care payments are 104% of the FFSE reimbursement.

This category primarily includes physician visits related to critical and intensive care for newborns. Most of the maternity-related codes in this category are consistent across selected benchmarks, with 85%-93% of the New Mexico procedure codes appearing on other states' fee schedules. While Medicare covers many of the codes identified in this category, newborn-related services are not widely used in Medicare due to the demographics of the covered populations. Overall, New Mexico rates are lower than Medicare and higher than all selected state benchmarks.

Family Planning

The remaining 11% of child and maternal health managed care expenditures are for family planning services, and the average managed care payments are 95% of the FFSE reimbursement.

This category primarily includes long-acting reversible contraception (LARC) drug/devices and insertion/removal, physician office visits, and surgical sterilization. While Medicare includes some of the codes identified in this category, family planning services are not widely used in Medicare

due to the demographics of the covered populations. Medicare does not cover LARCs, preventive visits or office consultation codes, which are key drivers in this category. As a result, the overlap with Medicare codes is much lower than other categories, at 38%.

Most of the family planning codes in this category are consistent across states, with 83%-99% of the New Mexico procedure codes appearing on other states' fee schedules. Overall, New Mexico rates are higher than all selected state benchmarks. Mercer observed rates in New Mexico for the insertion and removal of an implant or IUD are frequently three to five times higher than the other selected states. These codes received large rate increases in 2019 and 2020.

Behavioral Health

Medicare	AZ	CO	LA	WA
✓	✓	✓	✓	✓

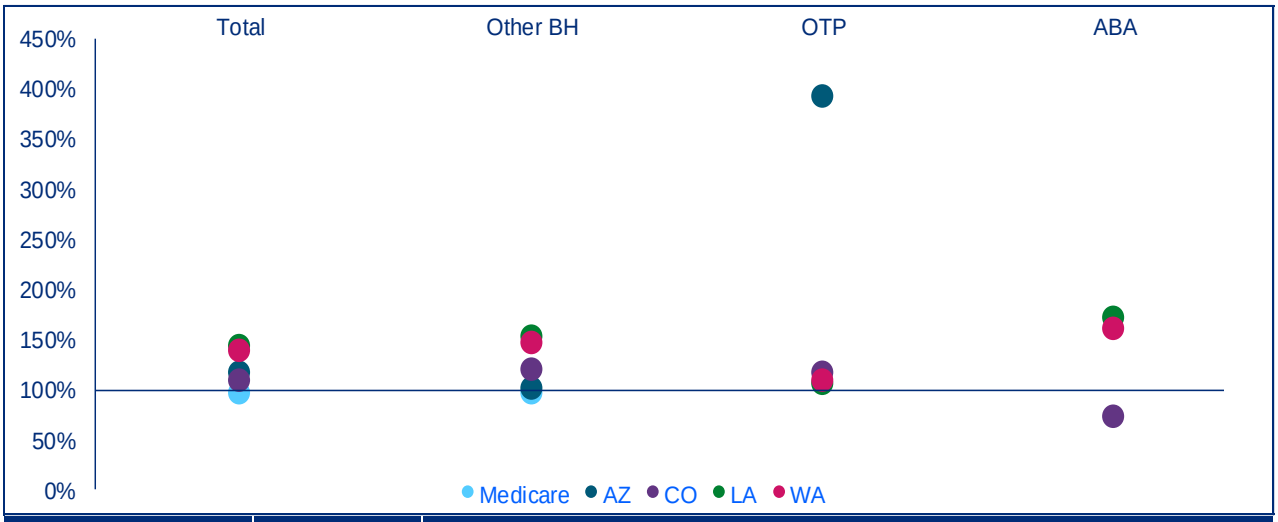
For the purposes of this analysis, the BH service area includes the procedure codes that are only included in the behavioral health fee schedule. Procedure codes that overlap among multiple fee schedules are analyzed in other sections of this report to avoid duplication. New Mexico pays for behavioral health services under FFS using the payment rates in the posted BH, Opioid Treatment Programs (OTP), and ABA fee schedules. The posted BH fee schedule was updated in 2019 when HSD increased rates across many codes including raising any that were below 90% of the Medicare rate.

The primary provider types billing for these services include BH Agencies, OTP, Core Service Agencies (CSA), Treatment Foster Care Agencies, Licensed Professional Clinical Counselors (LPCC), and Licensed Clinical Social Workers (LCSW). The BH service area includes CPT® codes as well as HCPCS codes. In many cases, HCPCS codes are not reimbursed by Medicare; therefore, the Medicare benchmark primarily reflects CPT® codes captured exclusively on the BH fee schedule.

The majority of BH services are provided under managed care (95%) and on average, MCOs pay for BH services at 100% of the FFSE payment levels. The procedure code detail for BH services shown in the supporting Excel™ file reflects 94% of the CY2019 expenditures analyzed for benchmarking this service area.

Compared to other selected benchmarks, New Mexico's FFS BH payment rates are lower than Medicare and higher than Arizona, Colorado, Louisiana, and Washington. Figure 12 below shows the benchmarking results for each state, separated by the individual services subgroups.

Figure 12: Behavioral Health – NM Medicaid FFS Benchmarking Results



Service Subgroup	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC/FFSE	Medicare	AZ	CO	LA	WA
Total	**100%**	**97%**	**116%**	**109%**	**144%**	**138%**
General BH *(74% of total expenditures)*	100%	97%	101%	120%	152%	146%
OTP *(15% of total expenditures)*	99%	N/A[1]	392%	116%	105%	109%
ABA *(11% of total expenditures)*	98%	N/A[2]	N/A[3]	73%	172%	161%

1. Medicare covers OTP services but reimburses providers on a bundled payment, which is not comparable to New Mexico FFS; therefore, Medicare was excluded as a benchmark for this subgroup.
2. ABA is not a Medicare covered service; therefore, Medicare was excluded as a benchmark for this subgroup.
3. Arizona uses a manual price instead of a published fee schedule for ABA; therefore, Arizona was excluded as a benchmark for this category; therefore, Medicare was excluded as a benchmark for this subgroup.

General Behavioral Health

The General BH category represents 74% of the managed care BH expenditures. Overall, the managed care average payments are 100% of the FFSE reimbursement. However, this relationship varies by provider type with reimbursement ranging from 95% (LPCC) to 111% (CSA). BH Agencies represent 39% of the expenditures in this category and are reimbursed at 98% of the FFSE in the encounter data.

The codes in this category vary across states due to the state-specific nature of some HCPCS codes. Overlapping codes across the selected benchmarks capture between 58% (Medicare) to 88.3% (Arizona) of the expenditures. For Medicare, most of the overlapping codes were psychiatric diagnostic and psychotherapy CPTs® that are not present on the separate CPT® fee schedule. While HSD previously raised overlapping codes to a minimum of 90% of the Medicare rate, the Medicare rates have continued to change since 2019. The New Mexico rates for these

overlapping codes are 97% of the current Medicare rate overall, with individual codes ranging from 71% to 150% of the Medicare rate.

For the other states selected as benchmarks, many of the codes overlap with each other and with Medicare. Arizona, Colorado, and Washington appear to frequently align rates at a percentage of the Medicare fee schedule. For the codes that do not overlap with Medicare, Arizona had the most alignment with the codes included on the BH fee schedule. The New Mexico rates for these codes is higher than the comparison rates from Arizona. Across all codes, the New Mexico rates are higher in aggregate than the four selected benchmark states. Unlike these other states, the New Mexico fee schedule includes modifiers to vary the reimbursement rate by provider education level. For example, the top code 90837 has ranges from a $141.95 rate for MD/DO to a $122.36 rate for all other education levels. For purposes of comparison, the MD/DO rate is used for benchmarking and reflects the highest provider education level and highest reimbursement rate. This may contribute to the higher comparisons to other benchmarks, where a single rate is used regardless of provider education level.

Opioid Treatment Program

The OTP category represents 15% of the managed care BH expenditures. New Mexico offers Methadone treatment for Substance Use Disorder treatment through Opioid Treatment Programs. The related fee schedule includes four codes, with 97% of the expenditures billed under H0020. Overall, the managed care expenditures are 99% of the FFSE reimbursement. There is a high level of overlap across the selected benchmark states, with all four publishing a fee schedule rate for H0020. New Mexico's fee schedule rate is higher than all four other states, and significantly higher than the fee schedule rate in Arizona. It is unclear if Arizona uses different criteria than the other states for this service.

Applied Behavioral Analysis

New Mexico covers treatment for members diagnosed with Autism through ABA. This category represents 11% of the overall BH expenditures, and the average managed care payments were 98% of the FFSE reimbursement. This category includes 27 code and modifier combinations, across nine unique procedure codes. Most of the expenditures are captured in only a few code/modifier combinations, with 62% captured in a single code/modifier and 94% captured in the top five codes/modifiers. Most of the expenditures are billed by BH Agencies. Across all providers, the managed care expenditures are 98% of the FFSE reimbursement.

Colorado and Louisiana had fee schedule rates for codes representing over 98% of the managed care expenditures. Washington had lower overlap, but still aligned with codes for 74% of the expenditures. Compared to these other states, New Mexico's rates for ABA are lower than Colorado, but higher than Louisiana and Washington. While New Mexico's rates are lower in aggregate than Colorado, there was significant variation by code with many paid higher in New Mexico. However, T1026 rates are significantly lower in New Mexico's fee schedule compared to Colorado.

Dental

Medicare	AZ	CO	LA	WA
X	✓	✓	✓	✓

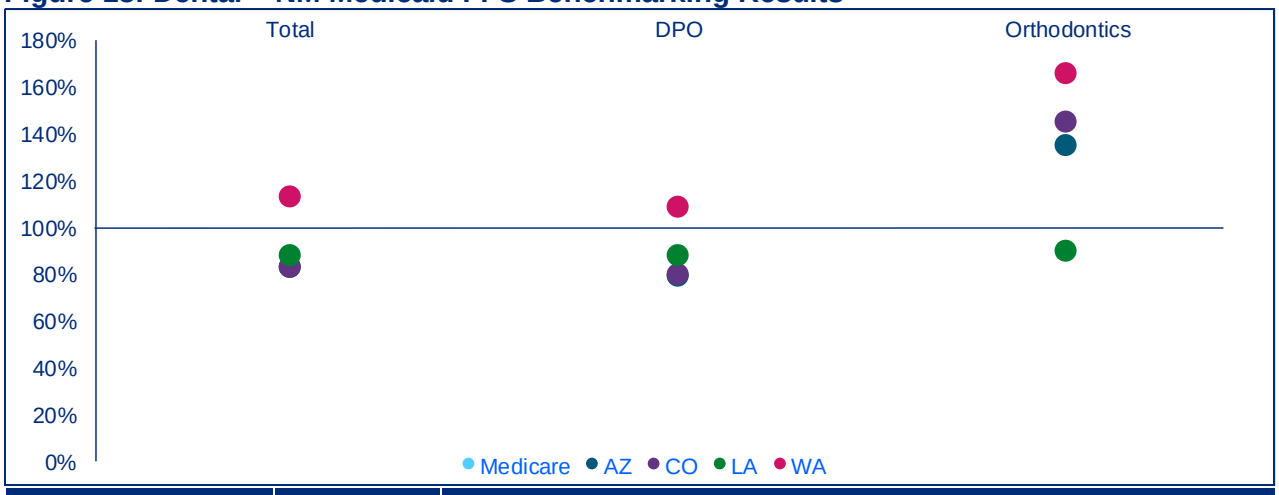
The dental service area includes diagnostic/preventive/other (D/P/O) and orthodontics services subgroups, with D/P/O representing the majority of dental expenditures. Medicare does not cover professional dental services and is not included as a benchmark for the dental service area. New Mexico pays for these services under FFS using the posted dental fee schedule. HSD updates the fee schedule on an ad hoc basis to add new procedure codes.

Dentists bill nearly all submitted encounters in this service area as opposed to other provider types; however, there are some dental services that are provided by FQHCs. These are included in the FQHC/RHC service area, presented later in this report. In addition, a subset of other dental services must be delivered in combination with anesthesia (dental surgeries), and these are provided in an Outpatient Hospital setting. Therefore, they are excluded from the information presented in this Phase 1 report and will be included in Phase 2.

The majority of dental services are provided under managed care (91%) and on average, MCOs pay for dental services at 95% of the FFSE payment levels. The procedure code detail for dental services shown in the supporting Excel™ file reflects 70% of the CY2019 expenditures analyzed for benchmarking this service area.

New Mexico's FFS dental payment rates are lower than most of the benchmarking comparison states, but paying more than Washington. Figure 13 below shows the benchmarking results for each state, separated by the 'Diagnostic/Preventive/Other Dental' and 'Orthodontics' groups.

Figure 13: Dental – NM Medicaid FFS Benchmarking Results



Service Subgroup	CY2019	Selected CY2021 Medicaid FFS Benchmarks				
	MC/FFSE	Medicare	AZ	CO	LA	WA
Total	**95%**	**N/A[1]**	**83%**	**83%**	**88%**	**113%**
D/P/O *(91% of total expenditures)*	96%	N/A[1]	79%	80%	88%	109%
Orthodontics *(9% of total expenditures)*	94%	N/A[1]	135%	145%	90%	166%

1. Professional Dental services are not covered by Medicare therefore; Medicare was excluded as a benchmark for this category.

Diagnostic/Preventive/Other Dental

A majority of the overall dental expenditures in the managed care program (91%) are for the D/P/O category of dental services, and the average managed care reimbursement for this subcategory is 96% of the FFSE reimbursement. Most of the dental service codes in this category are consistent across states, with 90%-98% of the New Mexico procedure codes appearing on other states' fee schedules. New Mexico rates are lower than three out of the four selected benchmark states (higher only than Washington).

Orthodontics

Orthodontics services reflect the remaining 9% of the managed care dental expenditures. Comprehensive orthodontic treatment of adolescents (D8080) makes up 85% of orthodontic expenditures. The New Mexico rate for this code is higher than three out of the four selected benchmark states (paid lower than Louisiana).

FQHC/RHC

Medicare	AZ	CO	LA	WA
✓	✓	X	✓	✓

Medicaid programs primarily pay for FQHC and RHC services on a 'per encounter' basis meaning that each visit is paid a rate and the individual services provided (by procedure code) are not paid separately. The New Mexico encounter rates for FQHCs and RHCs are facility-specific and New Mexico pays for these services under FFS using the FQHC/RHC fee schedules. The facility-specific rates are typically based on facility costs so can vary widely by clinic. There are services exempt from the 'per encounter' reimbursement and New Mexico reimburses these services according to the professional fee schedule. The majority of the non-encounter services are related to dentures.

The FQHC/RHC service area includes dental FQHC, non-dental FQHC, and RHC visits paid on an encounter basis. Since the selected benchmark states also reimburse FQHCs and RHCs using facility-specific rates for the facilities in their respective state, the direct comparison to New Mexico is not possible. As such, Mercer reviewed the minimum rate, median rate, and maximum rate paid to FQHC and RHC facilities in each selected benchmark state for the comparison to New Mexico.

FQHC Non-Dental

A majority of the overall FQHC/RHC expenditures in the managed care program are for the FQHC non-dental category (79%), and the average managed care payments are 99% of the FFSE reimbursement. While there is some variability between providers, in total MCO reimbursement is slightly below the FFSE reimbursement.

Since the FQHC rates are facility-specific, there is significant variability between New Mexico payments and the selected benchmarks. The New Mexico rates are higher than Medicare and Louisiana at the minimum, median and maximum encounter rates, but lower than Washington. In comparison to Arizona, the maximum encounter rate is well above New Mexico's highest facility encounter rate, resulting in a lower relativity for Arizona's median and maximum rates. Table 8

below shows the FQHC non-dental benchmarking results for Medicare and each state, separated by the minimum, median, and maximum rate.

Table 8: Summary of FQHC Non-Dental Benchmarking Results

	CY2021: NM FFS Percent of Benchmark FFS Rates				
Rate Statistic	**Medicare**	**AZ**	**CO[1]**	**LA**	**WA**
Minimum Rate	103%	104%	N/A	156%	96%
Median Rate	103%	64%	N/A	117%	65%
Maximum Rate	133%	50%	N/A	107%	50%

1. FQHCs are a covered benefit in the Colorado Medicaid program, however the provider-specific rates are not publicly available on the Colorado Medicaid website; therefore, Colorado was excluded as a benchmark for this category.

FQHC Dental

FQHC dental services represent 10% of the FQHC/RHC managed care expenditures, and the average managed care payments are 102% of the FFSE reimbursement. While there is some variability between providers, in total MCO reimbursement is slightly above the FFSE reimbursement.

Since the FQHC rates are facility-specific, there is significant variability between New Mexico and the selected benchmarks. New Mexico, Louisiana, and Washington have separate rates for dental and non-dental FQHC claims while Medicare and Arizona does not appear to vary FQHC rates when dental services are delivered. The New Mexico rates are higher than Medicare and Louisiana at the minimum, median and maximum encounter rates and above Arizona and Washington for the minimum rate but lower for the median and maximum rates. Table 9 below shows the FQHC dental benchmarking results for Medicare and each state, separated by the minimum, median, and maximum rate.

Table 9: Summary of FQHC Dental Benchmarking Results

	CY2021: NM FFS Percent of Benchmark FFS Rates				
Rate Statistic	**Medicare**	**AZ**	**CO[1]**	**LA**	**WA**
Minimum Rate	118%	120%	N/A	180%	118%
Median Rate	118%	74%	N/A	134%	78%
Maximum Rate	133%	50%	N/A	107%	50%

1. FQHCs are a covered benefit in the Colorado Medicaid program, however the provider-specific rates are not publicly available on the Colorado Medicaid website; therefore, Colorado was excluded as a benchmark for this category.

Rural Health Center

RHC services reflect 9% of the managed care expenditures, and the average managed care payments correspond to 107% of the FFSE reimbursement. This difference is primarily driven by higher MCO reimbursement to Lovington Medical Clinic in the Nor-Lea Hospital District.

Since the RHC rates are facility-specific, there is significant variability between New Mexico and the selected benchmarks. The New Mexico rates are higher than Medicare at the minimum, median, and maximum encounter rates, below Arizona for all three rate statistics, and above Louisiana and Washington for the minimum and median rates but below for the maximum rates. Table 10 below shows the RHC benchmarking results for Medicare and each state, separated by the minimum, median, and maximum rate.

Table 10: Summary of RHC Benchmarking Results

	CY2021: NM FFS Percent of Benchmark FFS Rates				
Rate Statistic	**Medicare**	**AZ**	**CO[1]**	**LA**	**WA**
Minimum Rate	115%	54%	N/A	138%	118%
Median Rate	180%	64%	N/A	165%	106%
Maximum Rate	259%	79%	N/A	62%	48%

1. RHCs are a covered benefit in the Colorado Medicaid program, however the provider-specific rates are not publicly available on the Colorado Medicaid website; therefore, Colorado was excluded as a benchmark for this category.

Professional FQHC Services

Professional FQHC services reflect the remaining 2% of the managed care FQHC/RHC expenditures. Under FFS, services that are not billed as part of the encounter rate are paid according to the New Mexico professional fee schedule based on the service procedure code. Given this, the benchmark results for these services will follow the results in the service area and service subgroups in the other sections of this report.

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 1 of the study. In addition to the development of a similar benchmarking report for Phase 2 services, HSD and Mercer will conduct stakeholder outreach efforts to collect input on New Mexico provider reimbursement methodologies for each of the service areas. HSD plans to hold meetings separately 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 Phase 2 benchmarking report and 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

Selected Benchmark State Profiles

Health Insurance Coverage — New Mexico

U.S. Census Bureau Region — West

Total Population: 2,053,200

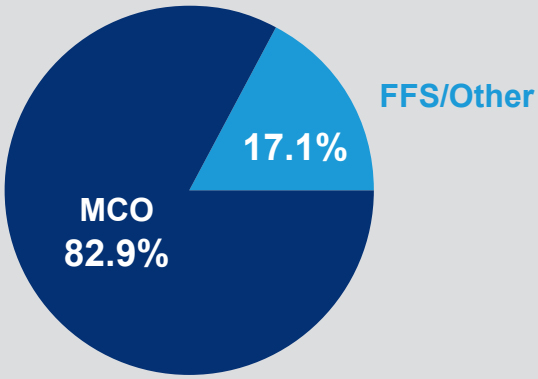
NM

	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)

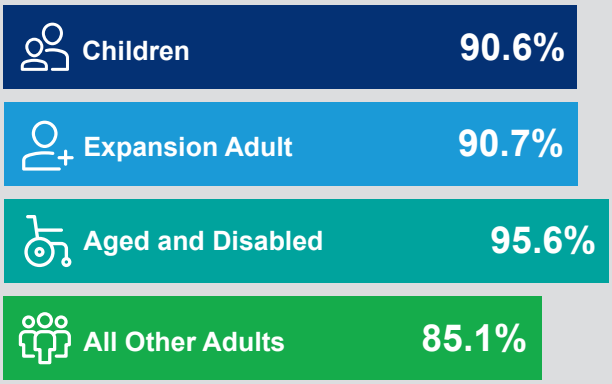
Medicaid program Delivery Systems

Enrollment by Delivery System



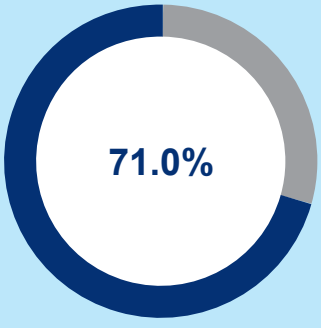
Source: KFF - State Health Facts (2019)

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

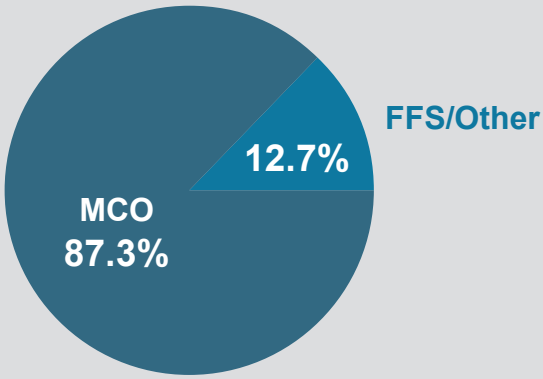
Total Population: 7,467,800

	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)

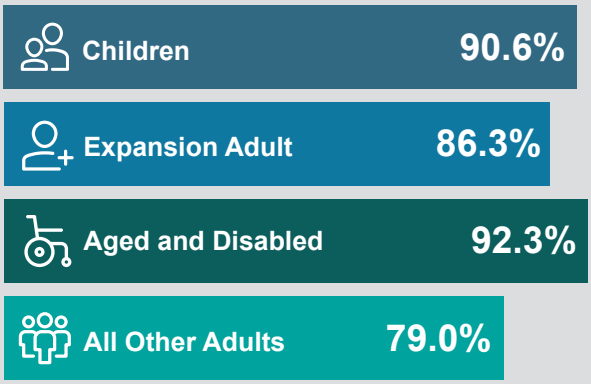
Medicaid program Delivery Systems

Enrollment by Delivery System



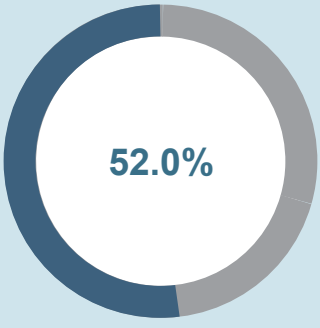
Source: KFF - State Health Facts (2019)

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

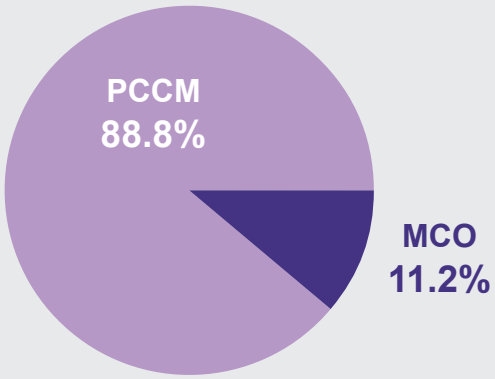
CO

	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)

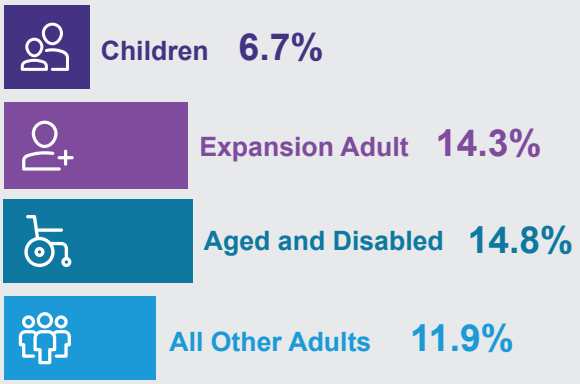
Medicaid program Delivery Systems

Enrollment by Delivery System



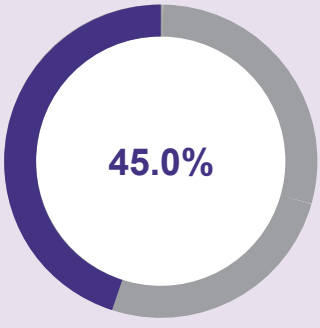
Source: KFF - State Health Facts (2019)

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

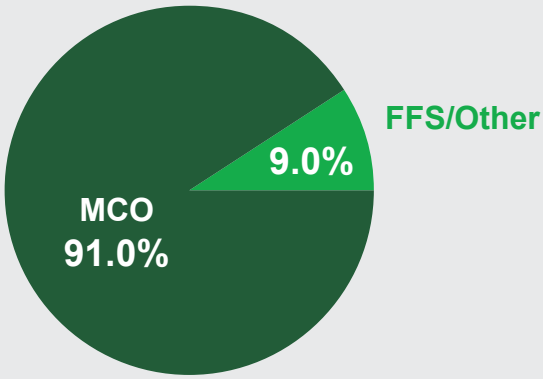
Total Population: 4,547,900

	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)

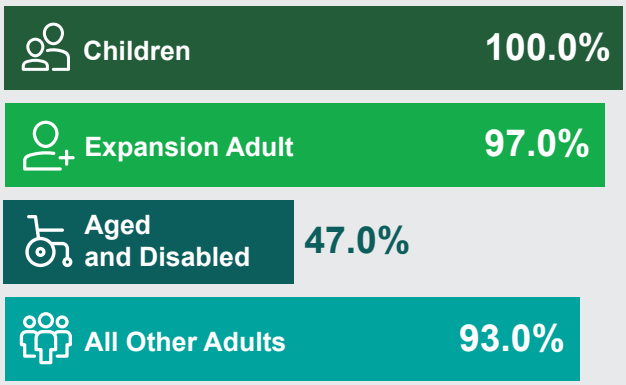
Medicaid program Delivery Systems

Enrollment by Delivery System



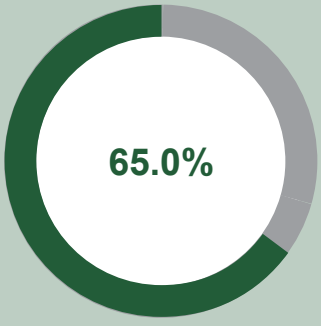
Source: KFF - State Health Facts (2019)

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

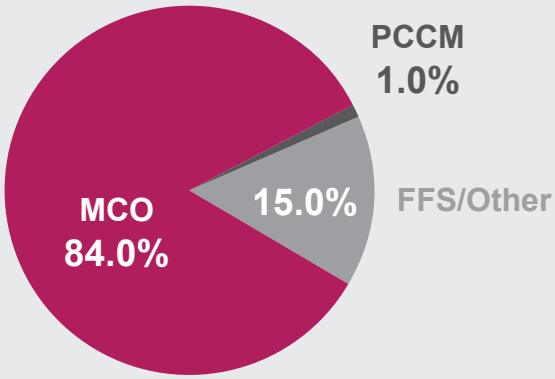
Total Population: 7,596,300

	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)

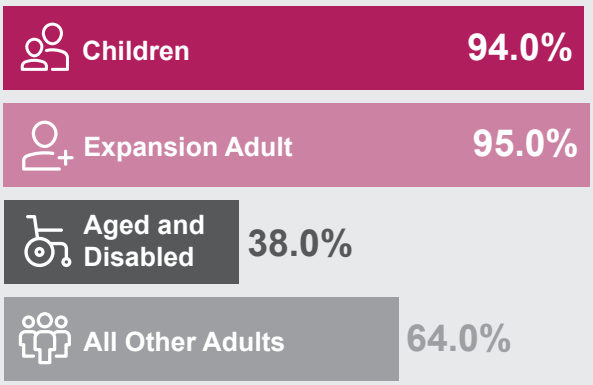
Medicaid program Delivery Systems

Enrollment by Delivery System



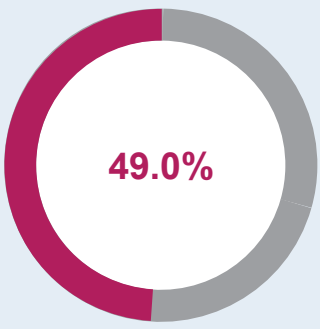
Source: KFF - State Health Facts (2019)

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 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]

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New Mexico Fee Schedule Mapping

Service Area	Service Subgroup	Fee Schedule
HCBS	1115 Waiver Community Benefit	N/A
	Case Management	TCM/CCM Fee Schedule
	1915(c) Waiver Services	Medically Fragile Waiver Rates Fee Schedule
		Developmental Disabilities Waiver Fee Schedule
		Supports Waiver Fee Schedule
Physician & Other Practitioners	Anesthesia	Anesthesia Codes Fee Schedule
	Surgery	CPT® Codes Fee Schedule
	Radiology/Lab/Path	
	Medicine	
	E&M	
HCPCS Codes	DME	DME Fee Schedule - Competitive Bidding Area & Rural
	Transportation	Medicaid Transportation HCPCS Codes Fee Schedule
	Physician Administered Drugs	HCPCS Codes Fee Schedule
	Other	
Maternal and Child Health	Child Health and EPSDT	CPT® or HCPCS Codes Fee Schedule (Depending on Specific Service)
	Maternity-Related Care	
	Newborn-Related Care	
	Family Planning	
Behavioral Health	Applied Behavioral Analysis (ABA)	Applied Behavioral Analysis (ABA) Fee Schedule
	Opioid Treatment Program	Behavioral Health Fee Schedule
	Other Behavioral Health	
Dental	Orthodontics	Dental Codes Fee Schedule
	Diagnostic/Preventive/Other	
FQHC/RHC	FQHC	FQHC Fee Schedule
	RHC	RHC Fee Schedule (Not Posted Publicly)

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]

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Appendix C

Glossary of Acronyms

Acronym	Meaning
ABA	Applied Behavior Analysis
ASP	Average Sales Price
BH	Behavioral Health
CBA	Competitive Bidding Area
CCM	Chronic Care Management
CF	Conversion Factor
CMS	Centers for Medicare & Medicaid Services
CNP	Certified Nurse Practitioner
COE	Category of Eligibility
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CSA	Core Service Agencies
CY	Calendar Year
D/P/O	Diagnostic/Preventive/Other
DD	Developmental Disabilities
DME	Durable Medical Equipment
DOH	Department of Health
E&M	Evaluation & Management
EMT	Emergent Medical Transportation
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee-For-Service
FFSE	Fee-For-Service Equivalent
FQHC	Federally Qualified Health Center
GPCI	Geographic Pricing Cost Index
GRT	Gross Receipts Tax
HCBS	Home- And Community-Based Services
HCPCS	Healthcare Common Procedure Coding System

Acronym	Meaning
HSD	State of New Mexico Human Services Department
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LPCC	Licensed Professional Clinical Counselors
LTSS	Long-Term Services And Supports
MCO	Managed Care Organization
MF	Medically Fragile
MMIS	Medicaid Management Information Systems
NEMT	Non-Emergent Medical Transportation
OTP	Opioid Treatment Programs
PAD	Physician Administered Drugs
PFS	Physician Fee Schedule
PPS	Prospective Payment System
RHC	Rural Health Clinic
RVU	Relative Value Unit
SMT	Skilled Maintenance Therapies
TCM	Transitional Care Management

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