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**State/Territory Name: New Mexico**

**State Plan Amendment (SPA) #: 19-0014**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

**Financial Management Group**

February 26, 2020

Ms. Nicole Comeaux
Director
Medical Assistance Division
New Mexico Human Services Department
2025 South Pacheco Drive
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Reference: NM 19-0014

Dear Ms. Comeaux:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0014. The New Mexico Human Services Department (HSD) implemented an increase in payment rates for hospital inpatient services effective July 1, 2019. Reimbursement rates for inpatient hospital services increased by 14 percent for Safety Net Care Pool (SNCP) hospitals; five percent for the State Teaching Hospital; and 12 percent for all other in-state hospitals. Additionally, hospital outlier claims will be increased from 85 percent to 90 percent of the hospital's standardized cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment 19-0014 is approved effective July 1, 2019. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Tamara Sampson at 214-767-6431 or Tamara.Sampson@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 1 9 0 1 4

2. STATE: New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY 19 $ 1,697,199
b. FFY 20 $ 6,788,795

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, page 6a
Attachment 4.19-A, page 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A page 6a (NM SPA 16-006)
Attachment 4.19-A page 16 (NM SPA 16-006)

10. SUBJECT OF AMENDMENT
Inpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
Authority delegated to the Medicaid Director

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Nicole Comeaux

14. TITLE
Director, Medical Assistance Division

15. DATE SUBMITTED
September 30, 2019

16. RETURN TO
Nicole Comeaux, J.D., M.P.H., Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED
September 30, 2019

18. DATE APPROVED
February 26, 2020

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

***Instructions on Back***

- Effective for services on or after October 1, 1997, the rates that were in effect as of October 1, 1996 will be updated.

- Effective April 1, 2014, base rates will be increased for all Safety Net Care Pool (SNCP) qualifying hospitals by 124 percent. Effective July 1, 2014, those rates will decrease to an amount equal to the pre-April 1, 2014 rate times 1.62 (increasing the historical rate by 62 percent). For the University of New Mexico Hospital the rates will be increased by 90 percent and 45 percent, respectively.

  In accordance with the above paragraph, hospital rates will be set as of April 1, 2014 and be effective for services performed on or after that date and until June 30, 2014. Revised rates will be set as of July 1, 2015 and be effective for services performed on or after that date until such time as the State makes future rate adjustments. Inpatient hospital rates base rates and capital pass through amounts are reduced 5% effective July 1, 2016. Inpatient hospital rates base rates and capital pass through amounts are increased by 14 percent for Safety Net Care Pool (SNCP) hospitals; 5 percent for the University of New Mexico Hospital; and 12 percent for all other in-state hospitals effective July 1, 2019. Except as otherwise noted in the state plan both governmental and private providers are paid the same. All rates are published on the Department's website at http://www.hsd.state.nm.us/providers/fee-schedules.aspx Notice of changes to rates will be made as required by 42 CFR 447.205.

- No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

- The rates will be updated annually for inflation, effective October 1 each year, using the methodology in paragraph C. I.

- Cost reporting periods ending in 1993 are used as the base year for the rates in effect as of October 1, 1996. The October 1, 1996 base year cost per discharge was determined from Title XIX discharges from audited or desk reviewed cost reports for reporting periods ending in calendar year 1993 and inflated forward to the midpoint of the federal fiscal year 1997 using the update factors specified in III.C.8- as described in paragraphs C.2.b. through C.13 below.
  The operating cost per discharge and the excludable cost per discharge as of October 1, 1996 will be combined into one base year cost per discharge. The combined base year cost per discharge will be updated for inflation using the update factor in paragraph C.1.

- The excludable cost per discharge will be handled in the same manner as described in III.E.

- The methodology described in paragraphs C.2.b. through C.13 below represent the methodology in effect prior to October 1, 1997 and is retained intact in the state plan solely to document how the rates in effect as of October 1, 1997 were determined.

3. In the event that the interim rate exceeds the final rate, the following procedure will be implemented:

   The facility will have 30 days from the date of notification of overpayment to submit the amount owed to the Department in full. If the amount is not submitted on a timely basis, the Department will begin withholding from future payments until the overpayment is satisfied in full.

4. Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. Special Prospective Payment Provisions

1. Outlier Cases
   Effective for discharges occurring on or after April 1, 1992, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 days or more, when such services are provided to children who have not attained the age of six years in disproportionate share hospitals, and to infants under age one in all hospitals. Effective July 1, 2019 these cases will be removed from the DRG payment system and paid at an amount equal to 90% of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost- to-charge ratio as calculated from the hospital's most recent cost report.

   Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

2. Payment for Transfer Cases

   a. All cases transferred from one acute care hospital to another will be monitored under the utilization review policy to ensure that the Department does not pay for inappropriate transfers.

   b. The following methodology will be used to reimburse the transferriug and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are