Table of Contents

State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 24-0007

This file contains the following documents in the order listed:

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

December 18, 2024

Dana Flannery
Director Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

RE: TN 24-0007

Dear Dana Flannery:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed New Mexico state plan amendment (SPA) to Attachment 4.19-A, B, and D NM 24-0007, which was submitted to CMS on September 24, 2024. This plan amendment increases reimbursement rates for inpatient and outpatient hospitals, and nursing facilities.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2)of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of August 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Diana Dinh at 667-290-8857 or diana.dinh@cms.hhs.gov or Monica Neiman at 945-356-1231 or at monica.neiman@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 24 — 0007

2. STATE: NM

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
08/01/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C
42 CFR 419

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 959,309
b. FFY 25 $ 5,755,856

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 A (Page 4)
Attachment 4.19 B (Page 6aa)
Attachment 4.19 D (Page 11)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19 A (Page 4) Supersedes (92-09)
Attachment 4.19 B (Page 6aa) Supersedes 15-11
Attachment 4.19 D (Page 11) Supersedes 15-13

9. SUBJECT OF AMENDMENT
New Mexico Health Care Authority (HCA) Medical Assistance Division (MAD) is requesting to raise Medicaid reimbursement rates for Inpatient/Outpatient Hospitals and Nursing Facilities.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Dana Flannery

13. TITLE
Director, Medical Assistance Division

14. DATE SUBMITTED
09/24/2024

15. RETURN TO
Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348

FOR CMS USE ONLY

16. DATE RECEIVED
September 24, 2024

17. DATE APPROVED
December 18, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

within the control of the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

3. The Department shall review the supporting documentation and, if appropriate, grant an exemption from or modification of the target rate. The Department's determination on the merits of the appeal will be made within 180 days of receipt of the appeal request, although the State may make a determination to extend such period to a specified date as necessary.

III. PROSPECTIVE PAYMENT METHOLOGY FOR HOSPITALS

Payment for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section I, subsections C through E) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. The prospective rates for each hospital's Medicaid discharges will be determined by the Department in the manner described in the following subsections.

A. Services Included In or Excluded From the Prospective Payment Rate
   1. Prospective payment rates shall constitute payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or upon completion of the transfer of the patient to another acute care hospital.
   2. The prospective payment rate shall include all services provided to hospital inpatient, including:
      a. All items and non-physician services furnished directly or indirectly to hospital inpatient, including but not limited to 1) laboratory services; 2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees and hips; 3) radiology services including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to patients by a physician's office, other hospital or radiology clinic; 4) another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.
   3. Services which may be billed separately include:
      a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient to the second hospital.
      b. Physician services furnished to individual patients.

B. Computation of DRG Relative Weights
   1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from New Mexico Medicaid hospital claim data. All such claims are included in the relative weight computation, except as described below.

2. Hospital claims data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:
    a. Claims are edited to merge interim bills from the same discharge.
    b. All Medicaid inpatient discharges will be classified using the Diagnostics Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources. Claims are assigned to appropriate DRGs using Version 6.0 of the Health Systems International DRG grouper software.
    c. Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.
3. Charges for varying years are adjusted to represent a common year through application of inflation indices as described in Section IIT.C.8 of this plan.

C. Effective August 1, 2024, inpatient hospital DRG base rates will be increased for eligible hospitals. To be deemed eligible, a provider must be licensed in the state of New Mexico and receiving Medicaid reimbursement less than the Medicare equivalent rate.

Eligible providers are grouped into 4 classes defined below. Each class of eligible providers will receive an increase to their inpatient hospital base rate applicable to the class of providers.

1. Underserved 20% Rate Increase effective August 1, 2024 - Health Resources & Services Administration (HRSA) Underserved definition: Medically Underserved Areas/Populations (MUA) are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. The lowest score (highest need) is 0; the highest score (lowest need) is 100. To qualify for underserved designation, the Index of Medical Underservice (IMU) score must be less than or equal to 62.0.
2. Rural 12% Rate Increase effective August 1, 2024 - Are those that are not urban or underserved.
3. Urban 6% Rate Increase effective August 1, 2024 - Based on Rural Health Information Hub (RHI) supported by HRSA; NM Urban counties are Bernalillo, Los Alamos, Sandoval, Santa Fe and Dona Ana.
4. University of New Mexico (and affiliates) 4% Rate Increase

D. Effective August 1, 2024, PPS Exempt facilities deemed eligible for rate increases will receive the applicable rate increase for their category. The percentage increase will be applied to their effective TEFRA per discharge rate for FFS settlement.

Hospital based rural health clinic services are paid at the provider's encounter rate established by Medicare that is in effect for the date of service. When a hospital based rural health clinic receives the annual rate notification from CMS, the provider forwards a copy of that notice to the state agency which then implements that rate for the provider for Medicaid payments. There is no retroactive cost settlement. The effective date of this change is July 1, 2015.

Effective August 1, 2024, the OPPS rates will be increased for eligible hospitals. To be deemed eligible a provider must be licensed in the state of New Mexico and receiving Medicaid reimbursement less than the Medicare equivalent rate.

Eligible providers are grouped into 4 classes defined below. Each class of eligible providers will receive an increase to their OPPS rate applicable to the class of providers:

i. Underserved 20% Rate Increase effective August 1, 2024 - Health Resources & Services Administration (HRSA) Underserved definition: Medically Underserved Areas/Populations (MUA) are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. The lowest score (highest need) is 0; the highest score (lowest need) is 100. To qualify for underserved designation, the Index of Medical Underservice (IMU) score must be less than or equal to 62.0.

ii. Rural 12% Rate Increase effective August 1, 2024 - Are those that are not urban or underserved.

iii. Urban 6% Rate Increase effective August 1, 2024 - Based on Rural Health Information Hub (RHI) supported by HRSA; NM Urban counties are Bernalillo, Los Alamos, Sandoval, Santa Fe and Dona Ana.

iv. University of New Mexico (and affiliates) 4% Rate Increase effective August 1, 2024.

A. Base Year

Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, Year 3. Because rebasing is done every three years, operating year will again become Year 1, etc.

Cost incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing of costs in excess of 110% of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

For implementation Year 1 (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984.

Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost report. The rate period January 1, 1996, through June 30, 1996, will be considered Year 1. The rate period July 1, 1996, through June 30, 1997, will be considered year 2, and the rate period July 1, 1997, through June 30, 1998, will be considered year 3. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section.

Effective for dates of service on or after July 1, 2015, each private nursing facility's existing "Low Level of Care" rate is increased 4%.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (NHI).

Each provider's operating cost will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating Year 1. For the out of cycle rebasing occurring for rates effective January 1, 1996.

V. Effective August 1, 2024, nursing facility Medicaid per diem rates will be increased for nursing facilities in New Mexico. To be deemed eligible a provider must be licensed in the state of New Mexico and have an active fee-for-service (FFS) rate. Each eligible nursing facilities per diem FFS rate for high and low Medicaid will be increased by the amounts listed below:

i. High Medicaid Rate Increase $14.19/day
ii. Low Medicaid Rate Increase $9.69/day