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

FEB 14 2017

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

RE: TN 16-006

Dear Ms. Smith-Leslie:

Enclosed is a copy of approved New Mexico State Plan Amendment (SPA) No. 16-006 with an effective date of July 1, 2016. This amendment was submitted to implement a five percent reduction for inpatient hospital rates base rates and capital pass through amounts.

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

Because the proposed SPA would reduce or restructure provider payment rates, New Mexico is required to provide documentation in support of its determination that the payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as established in Section 1902(a)(30)(A) of the Act and codified in 42 CFR 447.203(b)(6) and 42 CFR 447.204. To demonstrate compliance with these requirements, the state submitted the following to the Centers for Medicare & Medicaid Services (CMS) with the proposed SPA:

1. With respect to the public process requirements at 42 CFR 447.204(a)(2), New Mexico provided documentation to show that the state considered input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services, and the impact of the proposed rate change.

The notice of rate reductions and request for public comments was published in both the Albuquerque Journal and the Las Cruces Sun News on April 30, 2016. The state notified Medicaid providers of the proposed payment reductions and requested public comment, in a Medical Assistance Program Manual Supplement sent on April 29, 2016. The state created a dedicated website and email address for accepting comments on the proposed rate reductions. In addition, New Mexico mailed a letter on April 28, 2016, to tribal leadership, Indian Health Service (IHS), and tribal health providers notifying them about the proposed reductions and requesting their comments. The New Mexico Human Services Department (HSD) also held an open forum and comment period concerning the proposed reductions during the May 9, 2016, Medical Advisory Committee (MAC) meeting; and conducted an in-person tribal consultation on June 6, 2016, in response to requests from tribal leadership. To allow for additional time to comment after the tribal consultation, HSD extended the tribal comment timeframe to June 15, 2016. The State received numerous comments from providers, tribal representatives, and the public. All comments were given consideration and HSD made revisions to the originally proposed reductions in response to concerns that were expressed during the comment period.

2. With respect to requirements at 42 CFR 447.204(b), New Mexico submitted an analysis of the effect of the change in payment rates on access, and an analysis of the information and concerns expressed through stakeholder input. The state concluded that the rate changes under the state plan would not negatively impact provider participation and access to care based on its analysis that (1) extensive work was done by HSD to engage providers through the MAC subcommittee and the hospital representatives on the subcommittee supported the payment reductions; (2) in accordance with their Medicaid provider participation agreements, hospitals must provide notice if they intend to terminate their participation in the Medicaid program. No notices of this kind have ever been received, except to account for hospital initiated reorganizations or changes of ownership; and (3) the number of general acute care hospitals participating in the New Mexico program is the same as those participating in the Medicare program which indicates a level of provider availability for Medicaid recipients that is comparable to that of the general population.

3. The state established procedures to monitor continued access to care after implementation of these rate reductions, consistent with 42 CFR 447.203(b)(6). The state will monitor utilization in relation to overall trends to determine whether there are changes that warrant further study relative to access. Additionally, HSD is including access as a standing agenda topic in its bi-weekly discussions with IHS and tribal health care facilities. Access is also a regular agenda item for the state's Native American Technical Advisory Committee.

   The impact of this reimbursement change applies only to Medicaid fee-for-service (FFS) payments for inpatient hospital stays provided by general acute care hospitals. In New Mexico, most Medicaid recipients (approximately 90 percent) are enrolled in the Centennial Care managed care program and 99 percent of FFS recipients in New Mexico are Native American. Rates paid to IHS and tribal facilities are not being reduced; therefore, the impact on beneficiary utilization is projected to be minimal.

4. The state also demonstrated that it has ongoing mechanisms for beneficiary and provider input on access to care. The HSD maintains a Medicaid call center and website that recipients and providers can use to express concerns about access and a complaint and grievance tracking system is maintained to insure that concerns are addressed. Such concerns can also be raised by IHS or tribal facilities during regularly scheduled bi-weekly calls with HSD.

CMS is approving this SPA as the state has reasonably substantiated its conclusion that access for these services is sufficient through a process consistent with the requirements of 42 CFR 447.203 and conducted the public process and notice described in 42 CFR 447.204 and 42 CFR 447.205. Consistent with the aforementioned regulations, the state has committed to monitoring access and CMS will be periodically contacting the state to understand how the state's monitoring activities are progressing. If access deficiencies are identified, the state will submit a corrective action plan within 90 days of identification.

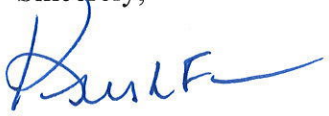
This letter affirms that the New Mexico Medicaid State plan amendment 16-006 is approved effective July 1, 2016 as requested by the State.

We are enclosing the CMS-179 and the amended plan pages.

- Attachment 4.19-A, Page 6a
- Attachment 4.19-A, Page 16

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,



Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	16-006	2. STATE New Mexico
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2016	

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X 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 C – Payment for Inpatient Hospital and Long-Term Care Facility Services.	7. FEDERAL BUDGET IMPACT: for FFY **2016: (- $752,600) - reduction** for FFY **2017: (-$3,011,000) - reduction**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A page 6a and page 16	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19A page 6a and page 16

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Payment – setting a new effective date for reimbursement rates reflecting 5% reduction in payment as described in public notice (included in SPA packet) to be effective July 1, 2016.

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
X OTHER, AS SPECIFIED: Authority Delegated to the Medicaid Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL: KMF for NSL	16. RETURN TO: Nancy Smith-Leslie, Director Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504 – 2348
13. TYPED NAME: Nancy Smith-Leslie	
14. TITLE: Director, Medical Assistance Division	
15. DATE SUBMITTED: June 30, 2016 rev 11/17/2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 30, 2016	18. DATE APPROVED: FEB 14 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin FAN	22. TITLE: Director, FMCG

23. REMARKS:

- 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. Any subsequent change to rates after July 1, 2016 will be made with notice of changes to rates as required by 42 CFR 447.205. Hospital base rates are published on the agency's website (http://www.hsd.state.nm.us/providers/fee-schedules.aspx). Except as otherwise noted in this plan, state developed fee schedule rates are the same for both governmental and private providers of hospital inpatient services.

- 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 I993 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.

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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. These cases will be removed from the DRG payment system and paid at an amount equal to 85% 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 transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are

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