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.