HUMAN SERVICES DEPARTMENT

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Letter of Direction #128

Date: **February 3, 2025**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**

Subject: **Pediatric Diagnosis-Related Group (DRG) & ICU Hospital Inpatient Payment Rates Effective January 1, 2023, through March 31, 2023**

Title: **Pediatric DRG & ICU Hospital Inpatient Payment Rate Increases**

The Human Services Department Medical Assistance Division (HSD/MAD) has received approval from Centers for Medicare and Medicaid Services (CMS) for a CY23 January 1, 2023-March 31, 2023, Pediatric Diagnosis-Related Group (DRG) & Intensive Care unit (ICU) Hospital Inpatient state directed payment. The purpose of this Letter of Direction (LOD) is to provide guidance to the Centennial Care 2.0 Managed Care Organizations (CC 2.0 MCOs) for implementation of the inpatient hospital rate increases for general acute care hospitals (Provider Type 201), which includes a 50% rate increase for any hospital admission that included an Intensive Care Unit (ICU) stay and a 12.4% increase for DRG provider-specific rates and pass-through rates for all other inpatient hospital stays (the 12.4% increase excludes the ICU 50% increase) and for the implementation of a 12.4% inpatient rate increase to Prospective Payment System exempt (PPS-exempt) rehabilitation hospitals (Provider Type 202), inpatient rehabilitation hospitals (Provider Type 203), PPS-exempt inpatient psychiatric hospitals (Provider Type 204), and inpatient psychiatric hospitals (Provider Type 205) for utilization incurred by Medicaid enrollees under age 21 beginning January 1, 2023, through March 31, 2023. This inpatient rate increase is applicable only to in-state providers. The Pediatric Diagnosis-Related Group (DRG) & Intensive Care unit (ICU) Hospital Inpatient state directed payment is a separate payment term directed payment; and was not included in CC 2.0 MCO capitation.

The Department acknowledges that inpatient hospital services may be paid using different methodologies from the Medicaid fee-for-service (FFS) program under Centennial Care 2.0. MAD is not directing the MCOs to revise their payment methodologies; however, all increases described in this LOD apply to hospital provider reimbursement at the rates and percentages set forth by the Department below.

Increase in Payment Rates for Inpatient Hospital Services for Utilization Incurred by Medicaid Enrollees under age 21

The MCOs are directed to increase Medicaid reimbursement rates for inpatient hospital services as follows for Utilization Incurred by Medicaid Enrollees under age 21 from January 1, 2023-March 31, 2023:

- Increase of 50 percent (50%) for hospital admission that includes ICU stays (provider type 201)
- Increase of 12.4 percent (12.4%) to the DRG provider-specific rates and pass-through rates for all other inpatient hospital stays for general acute care hospitals (provider type 201)
- Increase of 12.4 percent (12.4%) to specific inpatient hospital percentage for provider types 202-205.

Provider Type 201 DRG
For Provider Type 201 DRG, HSD applied the inpatient hospital increase (12.4%) to DRG rates paid to general acute care hospitals, including critical access hospitals, by raising both the provider-specific amount and the pass-through amount. Neither the DRG weight nor the cost-to-charge ratio was changed. See below:

DRG Formula = (**Provider-Specific Amount*** x DRG Weight) + **Pass-Through Amount***
**The rate increase percentages (12.4%) were applied to the Provider-Specific Amount and the Pass-Through Amount only*

Accordingly, the MCOs should apply a corresponding inpatient increase to each general acute care hospital, regardless of whether MCO reimbursement is paid based on the DRG methodology. The Provider-Specific Amounts, Pass-Through Amounts, and DRG Weights can be found on HSD's website at https://www.hca.nm.gov/providers/fee-for-service/

Provider Type 201 ICU
For provider type 201 ICU, HSD applied the inpatient hospital increase (50%) to hospital stays containing the general acute care hospital ICU revenue codes provided within this LOD.

Revenue Code	Description
0200	INTENSIVE CARE (ICU) - GENERAL CLASSIFIC
0201	INTENSIVE CARE (ICU) - SURGICAL
0202	INTENSIVE CARE (ICU) - MEDICAL
0203	INTENSIVE CARE (ICU) - PEDIATRIC
0204	INTENSIVE CARE (ICU) - PSYCHIATRIC
0206	INTENSIVE CARE (ICU) - POST ICU (SUB-ACU
0207	INTENSIVE CARE (ICU) - BURN CARE
0208	INTENSIVE CARE (ICU) - TRAUMA
0209	INTENSIVE CARE (ICU) - OTHER INTENSIVE CARE
0194	SUBACUTE CARE- LEVEL IV- INTENSIVE CARE

Provider Type 202-205 Non-DRG
Provider types 202-205 may be paid using different methodologies from the Medicaid fee-for-service (FFS) program under Centennial Care 2.0. HSD is not directing the MCOs to revise their payment methodologies; however, the increase described in this LOD applies to these non-DRG reimbursed hospital providers at the percentage set forth by the Department below. The MCOs are directed to increase Medicaid reimbursement rates for all inpatient services for provider types 202-205 by increasing their specific hospital percentage by 12.4% for dates of service on January 1, 2023. through March 31, 2023, for utilization incurred by Medicaid enrollees under age 21. The rate increase is applicable for all services including Residential Treatment Services (RTC) that are billed under provider types 202-205.

Outlier Payments
Reimbursement for outlier claims will remain at 90 percent (90%) of the hospital's standardized cost. HSD recognizes that the MCOs may not pay hospitals for outlier claims under the FFS methodology; however, the MCOs should reimburse outliers at 90 percent (90%) of the hospital's standardized cost to correspond with the FFS increase as previously directed. HSD confirms that outlier payments are made for qualifying claims in place of (rather than in addition to) the inpatient payment.

Please note that rates paid under Office of Management and Budget (OMB) Circular A-87 are not being raised as part of this initiative. Indian Health Services (I.H.S.) providers that are reimbursed under an OMB rate are excluded from this LOD; I.H.S. provider types 201-205 that are not reimbursed under an OMB rate are included within this LOD. OMB CIRCULAR A-87 REVISED | The White House.

HCA does not deny encounter claims for taxonomy codes. HCA reviews, adjusts and releases encounters as paid.

Reporting Pediatric DRG & ICU Hospital Inpatient Payment Rate Increases
HSD is not directing CC 2.0 MCOs to reprocess claims for CY23 January 1, 2023-March 31, 2023. The CC 2.0 MCO is required to submit utilization and paid amounts from CY23 January 1, 2023-March 31, 2023, by provider type, rate cohort, and month in which the service occurred for each month and as prescribed below. **MCOs must submit the data no later than 15 days after issuance of this LOD.** After HSD provides payment exhibits based on this LOD, HSD directs the CC 2.0 MCOs to provide weekly updates, via email, to HSD on the status of provider payments every Friday by 5 pm until further directed by HSD to cease reporting. HSD will not provide the MCOs with a prescribed and preformatted template for this reporting requirement. MCOs can use their preferred format so long as the report includes sufficient detail to satisfy the reporting requirement. **MCOs must submit the electronic version of paid claim files to HCA's secure DMZ FTP site using the following filename structure:**

[MCO acronym].[LOD reference].[submission reference].[calendar year reporting cycle].[version number]

Acceptable File Formats:
- Delimited text file (*.txt or *.csv)
- Microsoft Access (*.accdb)

Requirements:
- Table 1 illustrates the data required and information about how the field should be formatted and Table 2 provides an example of the data output.
- **Data should be limited to claims submitted by Provider Type 201-205 with dates of service of January 1, 2023, through March 31, 2023, for utilization incurred by Medicaid enrollees under age 21.**
- The report should be based on adjudicated paid claims with dates of service within the specified period.
- Denied or voided claims should be excluded.
- Rate cohort assignment **must** be based on the cohort assignment for the member as of the date of service of the claim.

Table 1 – Data File Fields:

Field Name	Field Information	Format
Billing Provider NPI	Billing Provider NPI	Number
Month of Service	The date of service must be formatted as 4-character year and 2-character month. "YYYYMM"	Text
Provider Type	Billing Provider Type	Text
Revenue Code	Revenue code associated with the hospital stay	Text
Rate Cohort	This should be the rate cohort assigned by MAD to the member for the month the service was incurred. If a member cohort is changed retroactively by MAD, the report should reflect the cohort assigned as of the date of the report. **Acceptable values align with Financial Reporting Package Rate Cohorts**: 001, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 300, 300B, 300C, 301, 302A, 302B, 302C, 303, 304, 310, 312, 320, 322, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122 (***113 does not exist)***	Text
Paid Units	Units paid for the Procedure Code	Number
Paid Amount	Amount paid by the MCO prior to application of the payment rate increase logic outlined in this LOD	Number
Rate Increase	Increase applied based on payment rate increase logic outlined in this LOD	Number
Final Paid Amount	Amount paid by the MCO after the application of the payment rate increase logic outlined in this LOD	Number

Table 2 - Data File Example:

Billing Provider NPI	Month of Service	Provider Type	Revenue Code	Rate Cohort	Paid Units	Paid Amount	Rate Increase	Final Paid Amount
1689747552	202301	201	0203	002	46	$4,462.92	50.0%	$ 4,463.42
1831218627	202302	202	0100	003	92	$4,781.24	12.4%	$ 4,781.36
1831218627	202302	202	0157	009	81	$7,128.00	12.4%	$7,128.12

The CC 2.0 LOD will sunset upon HCA notification and MCO validation of payment completion for the eligible CY23 January 1, 2023-March 31, 2023, Pediatric DRG & ICU Hospital claims.