HUMAN SERVICES DEPARTMENT

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# Special COVID-19 Letter of Direction #10

**Date:** **May 28, 2020**

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

**From:** **Nicole Comeaux, Director, Medical Assistance Division**

**Subject:** **2020 Hospital Inpatient Payment Rates Effective April 1, 2020**

**Title:** **2020 COVID Hospital Inpatient Payment Rate Increases**

The purpose of this Letter of Direction (LOD) is to provide guidance and directives to the Centennial Care 2.0 Managed Care Organizations (MCOs) for implementation of the inpatient hospital rate increases related to the national public health emergency associated with the 2019 Novel Coronavirus (COVID-19) outbreak. The purpose of this direction is to assure that general acute care hospitals, including critical access hospitals have the resources needed to address the outbreak and Medicaid members receive continuation of essential services with minimal disruption or delay. The hospital increases described in this LOD are in recognition of reduced hospital utilization during the public health emergency. No adjustment will be made to the current MCO CY2020 capitation rates.

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

## Increase in Payment Rates for Inpatient Hospital Services

The MCOs are directed to increase Medicaid reimbursement rates for inpatient hospital services as follows:

- Increase of 50 percent (50%) for ICU; and
- 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).

### a. Provider Type 201

For provider type 201, HSD applied the inpatient hospital increase to Diagnosis-Related Group

(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 were applied to the Provider-Specific Amount and the Pass-Through Amount only*

The MCOs are directed to apply a corresponding 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 www.hsd.state.nm.us/providers/fee-for-service.aspx.

### b. ICU Criteria

| 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 |
| 0194 | SUBACUTE CARE- LEVEL IV- INTENSIVE CARE |

### c. 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 in accordance with the FFS methodology; however, the MCOs are directed to 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 lieu of (rather than in addition to) the inpatient payment.

Please note that rates paid in accordance with OMB Circular A-87 are not being raised as part of this initiative. Also note that these increases do not apply to out-of-state hospitals.

**Rate Increase Implementation Timeframes and Reporting**

The MCOs are directed to implement changes associated with these instructions, including system changes and provider contract negotiations expeditiously and no later than 30 days from the date of issuance of this directive. For any claims submitted after April 1, 2020, but not paid based on these new parameters, the MCOs are directed to readjust payments retroactive to April 1, 2020 no more than 30 days of issuance of this LOD. HSD directs the MCOs to provide weekly updates to HSD on the status of implementation and claim reprocessing every Friday by 5pm until further directed by HSD to cease reporting.

This COVID-19 Letter of Direction will sunset when the Human Services Department determines that the outbreak of the 2019 Novel Coronavirus (COVID-19) associated with the national public health emergency has been contained.

Reporting requirements will cease after the claims run out period (e.g. HSD determines that the national public health emergency ceases on 6/30, the last report submission would be due on 7/20 for the 6/30 reporting period, allowing reporting to include claims payment run out).