State of New Mexico
Human Services Department
Human Services Register

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NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
INPATIENT HOSPITAL SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division, is proposing amendments to 8.311.3 NMAC, *Methods and Standards for Establishing Payment Inpatient Hospital Services* to clarify regulatory language, accuracy with existing rules and respond to current budgetary constraints.

If implemented as proposed, the following changes to Medicaid inpatient hospitals will affect providers by:

- The payment level for an indirect medical education (IME) adjustment factor is being changed from 1.89 to the federal IME adjustment factor which is set by Congress and changes from year to year. The current federal IME adjustment factor is 1.35.

- Adds a provision that a readmission of an eligible recipient to the same hospital within 24 hours of the discharge for the same or related Diagnosis Related Group (DRG) will be considered as one stay with one DRG rather than two separate hospital stays. If the readmission is a different hospital, the claim will be reviewed to determine if it should be treated as a transfer.

- Out-of-state acute care hospitals will be reimbursed using Diagnosis-Related Groups (DRGs) rather than 70% of billing charges.

The proposed rule also replaces outdated word usage, such as “Medicaid” with “MAD”, the “Medical Assistance Division”.

The changes in the methods and standards rule are being proposed because the Department believes the changes are more in line with the reimbursement typically available from other insurers and that the IME index established by Congress is a reasonable level of reimbursement. Also, at this time there is a serious shortfall in state revenues which has resulted in reductions in many state agency budgets. The New Mexico Medicaid program budget is no exception. Program costs are outpacing available revenues. Therefore, the Department has looked at reimbursement methodology to determine changes that can be made while still providing medically appropriate services.

The reduction in payments for these services in the Medicaid fee-for-service program is estimated to be $2,500,000 annually for the IME adjustment factor change and $8,570,000 annually for other reimbursement changes.

VI. RULES

These proposed rule changes refer to 8.311.3 NMAC of the Medical Assistance Program Policy Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 If you do not have Internet access, a copy of the rules may be requested by contacting the Medical Assistance Division at 505-827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective February 1, 2011.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 10:00 a.m., Wednesday, December 15, 2010, in the ASD conference room at Plaza San Miguel, 729 St. Michael’s Drive, Santa Fe.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department’s TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

These comments must be received no later than 5:00 p.m. on December 15, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 3 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT-INPATIENT HOSPITAL SERVICES

8.311.3.3 STATUTORY AUTHORITY: [~~The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[2-1-95; 8.311.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1-1-01; A, 2-1-11]

8.311.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2-1-95; 8.311.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 1-1-01; A, 2-1-11]

8.311.3.6 OBJECTIVE: [~~The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.~~] The objective of this rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[2-1-95; 8.311.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 1-1-01; A, 2-1-11]

8.311.3.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2-1-95; 8.311.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 1-1-01; A, 2-1-11]

8.311.3.10 GENERAL REIMBURSEMENT POLICY: The state of New Mexico human services department (hereinafter called the department) will reimburse inpatient hospital services rendered on or after October 1, 1989 in the following manner:

A. Covered inpatient services provided to eligible [~~medicaid~~] recipients admitted to in-state acute care hospitals and acute care units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in 8.311.3.12 NMAC of this part, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through [~~E~~] D below.

B. [~~Covered inpatient services provided to eligible recipients in the New Mexico medicaid program, when treated in border area hospitals (i.e., those hospital located within 100 miles of the New Mexico border, Mexico excluded) will be reimbursement at a prospectively set rate as described in 8.311.3.12.C.(16) NMAC of this part.~~] Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located out of state or in border areas (Mexico excluded) will be reimbursed at a prospectively set rate as described in Paragraph (16) of Subsection C of 8.311.12 NMAC of this part, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below or at a negotiated rate not to exceed the rate paid by federal programs such as medicare. Negotiation of rates will only be allowed when the department determines that the hospital provides an unique service required by an eligible recipient.

C. Inpatient services provided in rehabilitation and [~~children's~~] specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in 8.311.3.11 NMAC of this section. [~~Pediatric, psychiatric, substance abuse and rehabilitation cases treated in non-exempt general be included in the PPS.~~]

D. Indian health services hospitals will be reimbursed using a per diem rate established by the federal government.

[~~E. Covered inpatient services provided by out-of-state hospitals (i.e., those hospital located more than 100 miles from the New Mexico border, Mexico excluded) will be reimbursed on a percent of charge basis. All non-border out of state hospital claims will be reimbursed at a rate consisting of 70 percent of the provider's~~

~~allowable charges. Covered inpatient services provided in specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed at 70 percent of billed charges or a negotiated rate, not to exceed the rate paid by federal programs such as CHAMPUS or medicare. Negotiation of rates will only be allowed when the department determines that the specialty hospital or specialty unit provides a unique service required by [medicaid] recipients.~~

~~F.~~] E. New Mexico providers entering the [~~medicaid~~] MAD program will be reimbursed at the peer group median rate for the applicable peer group, until such time as [~~rebasing occurs~~] a distinct rate can be established, unless the hospital meets the criteria for prospective payment exemption as described in Subsection C through [~~E~~] D above.

[~~G.~~] F. All hospitals which meet the criteria in [~~8.311.3.13.A. NMAC~~] Subsection A of 8.311.3.13 NMAC of this part will be eligible for a disproportionate share adjustment.

[~~H.~~] G. Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the department provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals and for infants under [~~age one~~] one year of age in all hospitals. The outlier adjustment for these cases is described in Subsection F of 8.311.3.12 NMAC of this part.

[2-1-95; 8.311.3.10 NMAC - Rn, 8 NMAC 4.MAD.721.D.I, 1-1-01; A, 2-1-11]

8.311.3.11 PAYMENT METHODOLOGY FOR PPS-EXEMPT HOSPITALS AND EXEMPT UNITS WITHIN HOSPITALS

A. **Application of TEFRA principles of reimbursement:**

(1) The principles and methods identified in Public Law 97-248 provision (TEFRA), effective October 1, 1982, regarding allowable payment for inpatient hospital services, and any subsequent changes to such provision shall be used to determine:

(a) the amount payable by the department through its fiscal agent for services covered under the [~~medical assistance~~] MAD program and provided to [~~title XIX~~] eligible recipients; and

(b) the manner of payment and the manner of settlement or overpayments and underpayment for inpatient services provided by hospitals for [~~Title XIX~~] MAD reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983.

(2) The inflation factor used in the calculations will be identical to that used by medicare to update payments to hospitals which are reimbursed using the TEFRA methodology, except for the period October 9, 1991, through September 30, 1992, for which the inflation factor will be .5[%] ~~percent~~ for urban hospitals and 1.5[%] percent for rural hospitals.

(3) In accordance with Section 1902 (s)(3) of the Social Security Act effective July 1, 1991, the TEFRA rate of increase limit for inpatient hospital services will not apply to the delivery of such services to any individual who has not attained their first birthday , (or in the case of such a individual who is an inpatient on his first birthday until such individual is discharged).

B. **Appeals:**

(1) Hospitals may appeal the target rate and application of same, if circumstances beyond the hospitals' control have caused the reimbursement rates to fall at least five percent below actual allowable costs.

(2) Such appeals must be filed in writing within 180 calendar days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not 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 calendar days of receipt of the appeal request, although the state may make a determination to extend such period to a specified date as necessary.

[2-1-95; 8.311.3.11 NMAC - Rn, 8 NMAC 4.MAD.721.D.II, 1-1-01; A, 2-1-11]

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS: Payment for all covered inpatient services rendered to [~~Title XIX~~] eligible recipients admitted to acute care hospitals (other than those identified in Subsection C through [~~E~~] D of 8.311.3.10 NMAC) 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~~] MAD 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~~] MAD discharge. Hospitals may not separately bill the [~~patient~~] eligible recipient or the [~~medicaid~~] MAD 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~~] an eligible recipient or upon completion of the transfer of the [~~patient~~] eligible recipient to another acute care hospital.

(2) The prospective payment rate shall include all services provided to hospital inpatients. These services shall include all items and non-physician services furnished directly or indirectly to hospital inpatients, such as:

(a) laboratory services;

(b) pacemakers and other prosthetic devices, including lenses and artificial limbs, knees and hips;

(c) radiology services, including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to [~~patients~~] an eligible recipient by a physician's office, other hospital or radiology clinic;

(d) transportation (including transportation by ambulance) to and from 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~~] eligible recipient is transferred from one hospital to another and is admitted as an inpatient to the second hospital;

(b) physician services furnished to [~~individual patients~~] an individual eligible recipient.

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~~] MAD hospital claim data. All such claims are included in the relative weight computation, except as described below.

(2) Hospital claim 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~~] MAD inpatient discharges will be classified using the 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 Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(4) Initial relative weights are computed by calculation of the average [~~medicaid~~] MAD charge for each DRG category divided by the average charge for all DRGs.

(5) Where the New Mexico [~~medicaid~~] MAD-specific claims and charge data are insufficient to establish a stable relative weight, a relative weight is imported from other sources such as the CHAMPUS or medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.

(6) The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalculated using [~~whatever~~] the DRG grouper version [~~is currently~~] similar to the one in use by medicare.

C. **Computation of hospital prospective payment rates:**

(1) **Rebasing of rates:** Beginning October 1, 1997 the department [~~has~~] discontinued the rebasing of rates every three years. Hospital rates in effect October 1, 1996 were updated by the most current market basket index (MBI) as determined by the centers for medicare and medicaid services (CMS) for rates effective October 1, 1997 and succeeding years. Thereafter, pursuant to budget availability and at the department's discretion, the application of the MBI inflation factor will be reviewed based upon economic conditions and trends. A notice will be sent out every October 1st, informing the provider whether the MBI will be used for the upcoming year and what the percentage increase will be if the MBI or a percentage up to the MBI is authorized to be applied.

(2) **Base year discharge and cost data:**

(a) The state's fiscal agent will provide the department with [~~title XIX~~] MAD discharges for the provider's last fiscal year which falls in the calendar year prior to year [~~1~~] one.

(b) The state's audit agent will provide [~~title XIX~~] MAD costs incurred, reported, audited, [~~and/or~~] or desk audited for the same period.

(c) To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the department will:

(i) exclude estimated outlier discharges and costs as described in Paragraph (4) of Subsection C of 8.311.3.12 NMAC of this part.

(ii) exclude pass-through costs, as identified in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provisions and further defined in Paragraph (3) of Subsection C of 8.311.3.12 NMAC below.

(3) **Definition of excludable costs per discharge; reduction of excludable capital costs:**

(a) The approach used by the department to define excludable costs parallels medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.

(b) The pass-through capital costs identified using TEFRA provisions will be reduced in a manner similar to that employed by the medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by 15 percent as required by Section 4006 of the Omnibus Budget Reconciliation Act of 1987. However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.

(4) **Outlier adjustment factors:** Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total [~~medicaid~~] MAD inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Paragraph (1) of Subsection F of 8.311.3.12 NMAC of this part.

(5) **Calculation of base year operating cost per discharge:** The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier [~~medicaid~~] MAD discharges to produce the base year operating cost per discharge. The base rate methodology is described below:

BYOR = [~~OC~~ ~~D~~] OC/D

BYOR = base year operating cost per discharge

OC = total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs

D = [~~medicaid~~] MAD discharges for the hospital's base year as provided by the department's fiscal agent, less estimated outlier cases.

(6) **Possible use of interim base year operating cost per discharge rate:**

(a) If the fiscal agent and audit agent have not provided the department with a hospital's base year discharges and costs as of June 1 prior to year 1, the department will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

(b) When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC of this part) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the department will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in year [~~1~~] one, retroactive to the effective date of the interim rate.

(7) **Prohibition against substitution or rearrangement of base year cost reports:**

(a) A hospital's base year cost reports cannot be substituted or rearranged once the department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 calendar days from the date of the notice of proposed rate (NPR) issued by the state's intermediary in the absence of an appeal by the hospital to the intermediary and the state.

(b) In the event of such an appeal, the state must make a written determination on the merits of the appeal within 180 calendar days of receipt, although the state may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to year [~~1~~] one and will not be changed until subsequent rebasing of all hospitals has been completed.

(8) **Application of inflation factors:**

(a) The inflation factors used to update operating costs per discharge will be identical to those established by congress and adopted for use by [~~the centers for medicaid and medicare services (CMS)~~] CMS to update medicare inpatient prospective payment rates. The medicare prospective payment update factor (MPPUF) is determined by CMS, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by CMS.

(b) Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to year [~~1~~] one, using the applicable medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by congress and adopted for use by CMS to update medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to year [~~1~~] one) and ending with the midpoint of operating year [~~1~~] one. For years [~~2 and 3~~] two and three, the inflation factors will be the applicable MPPUF as specified by CMS.

(c) For the period October 9, 1991, through September 30, 1992, an exception to (a) and (b) above was made. The inflation factor used to update rates for that period is .5[~~%~~] percent for urban hospitals and 1.5[~~%~~] percent for rural hospitals.

(9) **Case-mix adjustments for base year operating cost per discharge rate:**

(a) The department will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the DRG methodology established and used by the medicare program.

(b) For each DRG, the department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The department's methodology for computing DRG relative weights was discussed earlier in Subsection B of 8.311.3.12 NMAC. Case-mix adjustments will be computed using the methodology described below:

(c) **Case-mix computation:** Each base year, a hospital's case-mix index will be computed by the department and its fiscal agent as follows:

(i) All [~~title XIX~~] MAD discharges are assigned to appropriate DRGs.

(ii) The case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of title XIX cases at the hospital.

(d) The case-mix adjustment is applied to the base year operating cost per discharge as described in Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC below.

(10) **Limitations on operating cost prospective per discharge rates:**

(a) Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups (teaching, referral, regional, low-volume regional, community and low-volume community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 [~~medicaid~~] MAD discharges per year.)

(b) At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume utilization was dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment (teaching, referral, regional and community).

(c) The department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Paragraph (1) of Subsection D of 8.311.3.12 NMAC of this part.

(d) A ceiling on allowable operating costs will be set at 110 percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).

(e) The case-mix equalization for each hospital in a peer group will be calculated as follows:

PGR = BYOR/CMI
PGR = hospital rate equalized for peer group comparison
BYOR = base year operating cost per discharge
CMI = case-mix index in the base year

(f) The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

(i) the ceiling for the hospital's peer group; or

(ii) the hospital rate resulting from the computation found in Subparagraph (e) of

Paragraph (10) of Subsection C of 8.311.3.12 NMAC above.

(11) **Computation of prospective operating cost per discharge rate:** The following formulas are used to determine the prospective operating cost per discharge rate for years [~~1, 2, and 3~~] one, two and three]:

Year [~~1~~]one

[~~PD01~~] PDO1 = HSR x (1 + MPPUF)

[~~PD01~~] PDO1 = per discharge operating cost rate for year [~~1~~] one

HSR = the hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

Year [~~2~~] two

PDO2 = PDO1 x (1 + MPPUF)

PDO2 = per discharge operating cost rate for year [~~2~~] two

PDO1 = per discharge operating cost rate for year [~~1~~] one

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

Year [~~3~~] three

PDO3 = PDO2 x (1 + MPPUF)

PDO3 = per discharge operating cost rate for year [~~3~~] three

PDO2 = per discharge operating cost rate for year [~~2~~] two

MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(12) **Computation of excludable cost per discharge rate:** Total [~~medicaid~~] MAD excludable cost, as identified in TEFRA, with excludable capital costs reduced as indicated in Paragraph (3) of Subsection C of 8.311.3.12 NMAC, will be paid in the following manner:

(a) An excludable cost per discharge rate is computed using the following methodology:

ER = ECP/DCY

ER = excludable cost per discharge rate

ECP = excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent

DCY = [~~medicaid~~] MAD discharges for the calendar year prior to the rate year, as determined by the department's fiscal agent

(b) The retrospective settlement will be determined based on a percentage of the actual allowable amount of [~~medicaid~~] MAD excludable costs incurred by a hospital during the hospital's fiscal year as determined by the department.

(13) **Computation of prospective per discharge rate:** The excludable cost per discharge, as described in Paragraph (12) of Subsection C of 8.311.3.12 NMAC above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

(14) **Effective dates of prospective rates:** Rates were implemented October 1, 1989 and continue to be effective as of October 1 of each year for each hospital.

(15) **Effect on prospective payment rates of a change of hospital ownership:** When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

(16) **Rate setting for border-area hospitals:** Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the regional peer group.

D. **Changes to prospective rates:**

(1) **Appeals:** Hospitals may appeal for a change in the operating component of the prospective payment rate, including a change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

(a) the following five requirements are satisfied:

(i) the hospital inpatient service mix for [~~medicaid~~] MAD admissions has changed due to a major change in scope of facilities and services provided by the hospital;

(ii) the change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply;

(iii) the expanded services were a) not available to [~~medicaid patients~~] eligible recipients in the area or b) are now provided to [~~medicaid patients~~] eligible recipients by the hospital at a lower reimbursement

rate than would be obtained in other hospitals providing the service;

(iv) the magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed 105 percent of the rate that would have otherwise been paid to the hospital;

(v) in addition to requirements Items (i) through (iv) above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate.

(b) the appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable. In making its decision on any appeal, the department shall be limited to the following options:

(i) reject the appeal on the basis of a failure of the appellant to demonstrate necessary conditions and documentation for an appeal as specified in Subparagraph (a) of Paragraph (1) of Subsection D of 8.311.3.12 NMAC above; or

(ii) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

(iii) adopt modified versions of the recommendations as stated in the appeal; or

(iv) reject all of the recommendations in the appeal.

(c) hospitals are limited to one appeal per year, which must be filed in writing with the [~~medical assistance division~~] MAD director by a duly authorized officer of the hospital no later than July 1 of each year; within 15 calendar days of the filing date, the department shall offer the appellant the opportunity for hearing of the appeal; if such a hearing is requested, it shall occur within 30 calendar days of the filing date; the department shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. **Retroactive settlement:**

(1) Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required. For year [~~1~~] one, the department's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 calendar days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

(2) **Underpayments:** In the event that the interim rate for year [~~1~~] one is less than the final rate, the department will include the amount of underpayment in a subsequent payment to the facility within 30 calendar days of notification of underpayment.

(3) **Overpayments:** In the event that the interim rate exceeds the final rate, the following procedure will be implemented: the facility will have 30 calendar 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:**

(a) 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 calendar days or more, when such services are provided to eligible children up to age six in disproportionate share hospitals, and to eligible infants under age one in all hospitals. These cases will be removed from the DRG payment system and paid at an amount equal to 90[~~%~~] percent 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.

(b) 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 a 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 included in the PPS.

(i) A hospital inpatient shall be considered "transferred" when [~~he or she~~] an eligible recipient has been moved from one DRG acute inpatient facility to another DRG acute inpatient facility. Movement of [~~a patient~~] an eligible recipient from one unit to another unit within the same hospital shall not constitute a transfer, unless the [~~patient~~] eligible recipient is being moved to a PPS exempt unit within the hospital.

(ii) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in Subsection F of 8.311.3.12 NMAC of this part. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

(iii) The receiving hospital which ultimately discharges the [~~patient~~] eligible recipient will receive the full DRG payment amount, or, if applicable, any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the [~~patient~~] eligible recipient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.

(c) If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

(3) **Payment for readmissions:**

(a) Readmissions that occur within 24 hours of the previous discharge of an eligible recipient with the same or related diagnosis related group (DRG) will be considered part of the prior admission and not paid separately when the admissions are to the same hospital. When the second admission is to a different hospital, the claims may be reviewed to determine if the initial claim should be considered as a transfer.

(b) Readmissions occurring within 15 calendar days of prior acute care admission for a related condition [~~will~~] may be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the department.

(4) **Payment for inappropriate brief admissions:** Hospital stays of up to two calendar days in length [~~will~~] may be reviewed for medical necessity and appropriateness of care. (Discharges involving eligible recipient healthy mothers and healthy newborns are excluded from this review [~~requirement~~] provision.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the department.

(5) **Payment for non-medically warranted days:**

(a) Reimbursement for [~~hospital patients~~] eligible recipients admitted to a hospital receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the [~~medicaid~~] MAD program is determined based only upon medical necessity for an acute level of hospital care.

(b) When it is determined that an [~~individual~~] eligible recipient no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, [~~the~~] a DRG hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the department in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the [~~individual~~] eligible recipient as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

(6) **Sole community hospital payment adjustment:** Effective for the quarter beginning July 1, 1993, in-state care hospitals that qualify as sole community hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:

(a) To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the medicare classification criteria for a sole community hospital as set forth at 42 CFR 412.92. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community hospital designation from medicare this designation will be accepted by the [~~medicaid~~] MAD program. If for some reason, the hospital elected not to apply for sole community hospital designation under medicare but [~~wished~~] wishes to apply for [~~medicaid~~] MAD purposes only, such application must be made directly to the [~~medicaid~~] MAD program. The [~~medicaid~~] MAD program will review the application in accordance with the criteria contained at 42 CFR 412.92.

(b) For an in-state acute care hospital that qualifies as a sole community hospital in accordance

with [~~paragraph (6)(a)~~] Subparagraph (a) of Paragraph (6) above, the department will make a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under [~~paragraph (6)(c)~~] Subparagraph (c) of Paragraph (6) below. For subsequent years, the amount will be the amount calculated under[~~paragraph (6)(d) through (6)(f)~~] Subparagraphs (c) and (f) of Paragraph (6) below.

(c) For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC of this part. Verification of the base year amount will be made from the official report of expenditures by each county. [~~Hospital~~] A hospital will have the opportunity to challenge the amount by filing an appeal with the department within 30 calendar days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation at a date later than the effective date of the plan amendment, [~~the medicaid~~] MAD program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that quarter.

(d) For each subsequent plan year, the sole community hospital is required to submit to the department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30-calendar day extension. Such requests must be received prior to the January 15 deadline.

(e) The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

(f) For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the [~~lessor~~] lesser of the amount paid by the department for the previous year trended forward. The department will use the market basket forecast published periodically in the CMS regional medical services letter, or an amount mutually agreed upon by the hospital and the county government.

(g) The department will calculate the medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the department. Should the amounts requested from the hospitals exceed the amount available under the upper limit, the amounts will be prorated and distributed based on the amount of the request received by the department.

(7) **State-operated teaching hospital adjustment:** Teaching hospitals (as defined in section 4.19-(A)(III)(F)(8)(a) of the state plan operated by the state of New Mexico or an agency thereof) shall qualify for an inpatient state operated teaching hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's medicare-related upper payment limit (specified at 42 CFR 447.272). The department will calculate the medicare upper payment limit for state-operated teaching hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the department to the state-operated teaching hospital. The adjustment shall be calculated as follows:

(a) Each federal fiscal year, the department shall determine each state-operated teaching hospital's medicare per discharge rate and [~~medicaid~~] MAD per discharge rate. The medicare [~~and/or~~] or [~~medicaid~~] MAD discharge rate will be adjusted to reflect any acuity differences that exist between the medicare and [~~medicaid patients~~] eligible recipients served. Acuity differences will be determined from the medicare and [~~medicaid~~] MAD case-mix indices (CMI) for [~~medicaid~~] MAD discharges at the hospital using medicare and [~~medicaid~~] MAD DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).

(b) The [~~medicaid~~] MAD per discharge rate shall be subtracted from the medicare per discharge rate.

(c) The difference shall be multiplied by the number of [~~medicaid~~] MAD discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the state-operated teaching hospital adjustment for the current federal fiscal year.

(d) For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.

(e) In the event that the state-operated teaching adjustment amount exceeds the medicare-related upper payment limit for that year, the state-operated teaching hospital adjustment will be revised by the difference.

(8) **Indirect medical education (IME) adjustment:** Effective August 1, 1992, each acute care

hospital that qualifies as a teaching hospital will receive an indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

(a) In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

(i) be licensed by the state of New Mexico; and

(ii) be reimbursed on a DRG basis under the plan; and

(iii) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(b) Determination of a hospital's eligibility for an IME adjustment will be done annually by the department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met.

(c) The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$1.89*((1+R)^{.405}-1)$

where R equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery and neonatal bassinets). Full-time equivalent residents are counted in accordance with 42 CFR 412.105(f). For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for [~~medicaid~~] MAD managed care enrollees if those persons had not been enrolled in managed care.

(d) Quarterly IME payments will be made to qualifying hospital at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the [~~medicaid~~] MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

(9) **Payment for direct graduate medical education (GME):** Effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

(a) To be counted for [~~medicaid~~] MAD reimbursement, a resident must be participating in an approved residency program, as defined by medicare in 42 CFR 413.86. With regard to categorizing residents, as described in paragraph (9)(b) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.86. Resident FTEs whose costs will be reimbursed by the department as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for [~~medicaid~~] MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a [~~medicaid~~] MAD provider, and must have achieved a [~~medicaid~~] MAD inpatient utilization rate of 5[~~%~~] percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the [~~medicaid~~] MAD inpatient utilization rate will be calculated as the ratio of New Mexico [~~medicaid~~] MAD eligible days, including inpatient days paid under [~~medicaid~~] MAD managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for [~~medicaid~~] MAD GME payment:

(i) **Primary care/obstetrics resident.** Primary care is defined per 42 CFR 413.86(b).

(ii) **Rural health resident.** A resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.

(iii) **Other approved resident.** Any resident not meeting the criteria in subparagraphs (i) or (ii), above.

(c) [**~~Medicaid~~**] **MAD GME payment amount per resident FTE:**

(i) The annual [~~medicaid~~] MAD payment amount per resident FTE for state fiscal year 1999 is as follows:

Primary care/obstetrics resident: $22,000

Rural health resident: $25,000
Other resident: $21,000

(ii) The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC.

(d) **Annual inflation update factor:**

(i) Effective for state fiscal years 2000 and beyond, the department has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

(ii) The department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. [~~The medical assistance division~~] MAD will determine the percentage of funds available for GME payments to eligible hospitals.

(e) **Annual upper limits on GME payments:**

(i) Total annual [~~medicaid~~] MAD GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC:

(ii) Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with Subparagraph (d) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC).

state fiscal year 1999	58.3[~~%~~] percent
state fiscal year 2000	56.8[~~%~~] percent
state fiscal year 2001	53.3[~~%~~] percent
state fiscal year 2002	50.7[~~%~~] percent
state fiscal year 2003	48.0[~~%~~] percent
state fiscal year 2004	45.5[~~%~~] percent
state fiscal year 2005	43.0[~~%~~] percent
state fiscal year 2006	40.4[~~%~~] percent

(f) **Reporting and payment schedule:**

(i) Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The department may require hospitals to provide documentation necessary to support the summary counts provided.

(ii) The department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.12 NMAC, the amount payable to each will be proportionately reduced.

(iii) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

(iv) Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (9) of Subsection F of 8.311.3.12 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.12 NMAC, after prospective payment amounts to timely filing facilities have been established.

[2-1-95, 10-31-97, 6-30-98, 9-1-98, 1-1-99, 8.311.3.12 NMAC - Rn, 8 NMAC 4.MAD.721.D.III & A, 1-1-01; A, 10-1-02; A, 7-1-04; A, 2-1-11]

8.311.3.13 DISPROPORTIONATE SHARE HOSPITALS: To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

A. **Criteria for deeming hospitals eligible for a disproportionate share payment:**

(1) Determination of each hospital's eligibility for a disproportionate share payment for the [~~medicaid~~] MAD inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospitals most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the department by March 31 of each year.

(2) In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

(3) The following criteria must be met before a hospital is deemed to be eligible:

(a) Minimum criteria: The hospital must have:

(i) a [~~medicaid~~] MAD inpatient utilization rate greater than the mean [~~medicaid~~] MAD inpatient utilization rate for hospitals receiving [~~medicaid~~] MAD payments in the state; or

(ii) a low-income utilization rate exceeding 25 percent. [~~(Refer to 8.311.3.13.A.(3)(b) NMAC~~] (Refer to Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC for definitions of these criteria.)

(iii) the hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to [~~individuals~~] eligible recipients entitled to such services under [~~medicaid~~] MAD; in the case of a hospital located in a rural area (defined as an area outside of a metropolitan statistical area (MSA), as defined by the U.S. executive office of management and budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;

(iv) [~~8.311.3.13.A.(3)(iii) NMAC~~] Item (iii) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC does not apply to a hospital which meets the following criteria: the inpatients are predominantly individuals under 18 years of age; or the hospital did not offer non-emergency obstetric services as of December 22, 1987;

(v) the hospital must have, at a minimum, a [~~medicaid~~] MAD inpatient utilization rate (MUR) of one percent.

(b) **Definitions of criteria:**

(i) [~~Medicaid~~] MAD inpatient utilization: For a hospital, the total number of its [~~medicaid~~] MAD inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period. These include both [~~medicaid~~] MAD managed care and non-managed care [~~medicaid~~] MAD inpatient days.

(ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: The sum of total [~~medicaid~~] MAD inpatient and outpatient net revenues (this includes [~~medicaid~~] MAD managed care and non-managed care revenues) paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period; and the total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved [~~medicaid~~] MAD state plan), that is, reductions in charges given to other third-party payers, such as HMOs, medicare, or Blue Cross.

(iii) The medicaid utilization rate (MUR) is computed as follows:

MUR % = 100 x M/T

M = hospital's number of inpatient days attributable to [~~patients who for these days were eligible for medical assistance~~] eligible recipients under the MAD state plan. These include [~~medicaid~~] MAD managed care and non-managed care days.

T = hospital's total inpatient days

(iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributable to individuals eligible for medicaid in another state are included. [~~Medicaid~~] MAD inpatient days includes both [~~medicaid~~] MAD managed care and non-managed care patient days.

(v) The numerator (M) does not include days attributable to [~~medicaid patients~~] recipients 21 or older in institutions for mental disease (IMD) as these patients are not eligible for [~~medicaid~~] MAD

coverage in IMDs under the New Mexico state plan and cannot be considered a [~~medicaid~~] MAD day.

B. **Inpatient disproportionate share pools:** Section 1923 of the Social Security Act allows qualifying hospitals to receive a disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in [~~8.311.3.13.A NMAC~~] Subsection A of 8.311.3.13 NMAC. Qualifying hospitals will be classified into one of [~~3~~] three disproportionate share hospital pools: Teaching PPS hospitals, non-teaching PPS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a [4th] fourth pool: reserve pool, as explained in this [~~8.311.3.13.C. NMAC~~] Subsection C of 8.311.3.13 NMAC below.

(1) To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:

(a) be licensed by the state of New Mexico; and

(b) reimbursed, or be eligible to be reimbursed, under the DRG basis under the plan; and

(c) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(2) A non-teaching PPS (DRG) hospital qualifies if it is an instate acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

(3) A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA (Tax Equity and Finance Reduction Act) methodology as described in 8.311.3.11 NMAC of this policy.

(4) The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and [~~medicaid~~] MAD-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in [~~8.311.3.13.A.(3)(b)(ii) NMAC~~] Item (ii) pf Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC, exceeds 20 percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

C. **Disproportionate share hospital payments:**

(1) The DSH funds allocated to each pool are paid to qualifying hospitals based on the number of [~~medicaid~~] MAD discharges. These include both [~~medicaid~~] MAD managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to another hospital or nursing home.

(2) Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on [~~medicaid~~] MAD discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools 1, 2, or 3 will be computed by dividing the number of [~~medicaid~~] MAD discharges for that hospital by the total number of [~~medicaid~~] MAD discharges from all hospitals qualifying for that DSH pool and then multiplying this pro-rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in parts [~~8.311.3.13.E. NMAC and 8.311.3.13.F NMAC~~] Subsections E and F of 8.311.3.13 NMAC.

(3) [~~The medical assistance division~~] MAD will review the allocation of DSH funds prior to the start of each state fiscal year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of [~~medicaid~~] MAD and low-income/indigent care patients.

(4) The percentages allocated to each pool for state fiscal year 98 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the medicare prospective payment update factor (MPPUF) [~~and/or~~] or the DSH budget as defined by [HSD] the department. The base year DSH budget for state fiscal year 98 is $22,000,000.00.

(a) The teaching PPS hospital DSH pool is 56[~~%~~] percent of the overall DSH budget, as defined by HSD.

(b) The non-teaching PPS (DRG) hospital DSH pool is 22.5[~~%~~] percent of the overall DSH budget, as defined by HSD.

(c) The PPS-exempt hospital (TEFRA) DSH pool is 1.5[~~%~~] percent of the overall DSH budget, as defined by HSD.

(d) The reserve DSH pool is 20[~~%~~] percent of the overall DSH budget, as defined by HSD. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of N dollars per [~~medicaid~~] MAD discharge, where N is equal to the fraction described in [~~8.311.3.13.A.(3)(b)(ii) NMAC~~] Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC of this part minus 20[~~%~~] percent, multiplied by $1,750.

D. **Request for DSH payment procedures:** Hospitals must submit to the department the number of

[~~medicaid~~] MAD discharges (both managed care and fee for service discharges), which they have incurred 30 calendar days after the end of each quarter. The department will review the hospital's documentation supporting their discharge information. Any requests received later than 60 calendar days from the end of the quarter will be denied as untimely.

E. **DSH limits:**

(1) Pursuant to section 1923 (g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined in [~~subsections 8.311.3.13.B NMAC through 8.311.3.13.D. NMAC~~] Subsections B and D of 8.311.3.13 NMAC shall not exceed that hospital's hospital-specific DSH limit, as determined under [~~8.311.3.13.E. NMAC~~] Subsection E of 8.311.3.13 NMAC. This limit is calculated as follows:

DSH Limit = M + U

M = Cost of services to [~~medicaid patients~~] eligible recipients, less the amount paid by the [~~medicaid~~] MAD program under the non-DSH payment provisions of this plan.

U = Cost of services to uninsured patients, less any cash payments made by them.

(2) The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The "costs of services" are defined as those costs determined allowable under this plan. "Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

F. **Limitations in New Mexico DSH allotment:** If the DSH payment amounts as described in [~~parts 8.311.3.13.C. NMAC through 8.311.3.13.E. NMAC~~] Subsections C and E of 8.311.3.13 NMAC above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

[2-1-95, 1-31-96, 7-31-97; 8.311.3.13 NMAC - Rn, 8 NMAC 4.MAD.721.D.IV, 1-1-01; A, 9-1-01; A, 2-1-11].

8.311.3.14 DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS

A. **Adequate cost data**

(1) All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. **Reporting year:** For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. **Cost reporting:** At the end of each of its fiscal years, the hospital will provide to the department or it audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico [~~title XIX~~] MAD cost reporting form. The cost report must be submitted within 90 calendar days after the close of the hospital's fiscal year. Failure to file a report within the 90 calendar day limit, unless an extension is granted, will result in suspension of [~~title XIX~~] MAD payments, until such time as the report is received.

D. **Retention of records:**

(1) Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the New Mexico [~~title XIX~~] MAD cost report to the department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the department, the state of New Mexico audit agent, or the United States department of health and human services.

(2) The department or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such reports.

E. **Audits:**

(1) **Desk audit:** Each cost report submitted will be subjected to a comprehensive desk audit by the state's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the department.

(2) **Field audit:** Field audits will be performed on all facilities [~~ad~~] and per the auditing schedule established by medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report [~~are~~] is accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the department. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the department for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable federal regulations.

F. **Overpayments:** All overpayments found in audits will be accounted for on the [~~HCFA-64~~] CMS-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. **Allowable and non-allowable costs:** Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the [~~HIM-15~~] medicare health insurance manual (HIM-15).

[2-1-95; 8.311.3.14 NMAC - Rn, 8 NMAC 4.MAD.721.D.V, 1-1-01; A, 2-1-11]

8.311.3.15 PUBLIC DISCLOSURE OF COST REPORTS

A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the medical assistance program audit agent. Disclosure information is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the [~~medical assistance program~~] MAD audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 calendar days in which to comment to the requestor before the cost report is released.

D. The cost for copying will be charged to the requestor.

[2-1-95; 8.311.3.15 NMAC - Rn, 8 NMAC 4.MAD.721.D.VI, 1-1-01; A, 2-1-11]