


Special COVID-19 Letter of Direction #10-1

Date: October 23, 2020

To: Centennial Care 2.0 Managed Care Organizations

From: Nicole Comeaux, Director, Medical Assistance Division 

Subject: COVID-19 DRG & ICU Hospital Inpatient Payment Rates Effective April 1, 2020
Repeal & Replace Special COVID-19 LOD #10

Title: 2020 COVID-19 DRG & ICU Hospital Inpatient Payment Rate Increases

The purpose of this Letter of Direction (LOD) is to provide guidance 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.

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 are applicable to hospital provider's reimbursement at the rates and percentages set forth by the Department below.

Increase in Payment Rates for Inpatient Hospital Services

The MCOs should 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:

$$\text{DRG Formula} = (\text{Provider-Specific Amount}^* \times \text{DRG Weight}) + \text{Pass-Through Amount}^*$$

**The rate increase percentages were applied to the Provider-Specific Amount and the Pass-Through Amount only*

Accordingly, the MCOs should 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

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 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 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 should 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 LOD. For any claims submitted after April 1, 2020 for Provider Type 201 with dates of service of April 1, 2020 through September 30, but not paid based on these new parameters, the MCOs are 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 on September 30, 2020. Reporting requirements will cease after the claims run out period.