REQUEST FOR PROPOSALS

ISSUED BY
THE NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

FOR

MEDICAID AUDIT AGENT

State of New Mexico
Human Services Department
Medical Assistance Division
P. O. Box 2348
Santa Fe, New Mexico  87504

ISSUE DATE: April 26, 2013
Solicitation No.:13-630-8000-0007
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I. INTRODUCTION

A. PURPOSE AND INFORMATION

The State of New Mexico’s Human Services Department, Medical Assistance Division (MAD) is requesting proposals for an audit agent for Hospitals, Home Health Agencies, Federally Qualified Health Centers, Rural Health Clinics, and Long Term Care Institutional Facilities (Nursing Facilities and Intermediate Care for the Mentally Retarded) which participate in the New Mexico Medical Program.

The purpose of this Request for Proposals (RFP) is to select Offerors with experience and knowledge to perform audits and consultation services as described in the Scope of Work, Contract Terms and Conditions, attached as Appendix 8. Work will be performed at the direction of the Project Manager.

B. SUMMARY SCOPE OF WORK

The Scope of Work for this procurement shall include, but not be limited to, the following:

1. Performance of Audits

   The audit agent will perform audits of the Hospitals, Home Health Agencies, Federally Qualified Health Centers, Rural Health Clinics, and Long Term Care Facilities which participates in the New Mexico Medical Program. The audits will include Desk Audits and Field Audits and complete reports of the audits submitted to the Department on a timely basis.

2. Planning and Development

   The objective of the planning and development task is to plan the Offeror’s activities for the duration of the contract and to develop working procedures to carry out the work required of Offerors by this RFP. This includes, but is not limited to:

   a. Audit objectives
   b. Audit procedures
   c. Audit instructions
   d. Audit forms
   e. Time frames for completing audits
   f. Reporting audit results to the department.

3. Operations

   a. Calculate DRG rates for applicable hospitals
b. Compute initial rates for new providers
c. Compute TEFRA target rates
d. Compute all ceilings as described in the State Plan
e. Rebase rates for ICF/MR providers every 3 years.
f. Calculate new rates for Nursing Facilities
g. Assist the Department in the development and implementation of a new reimbursement methodology for Nursing Facilities.
h. Participate in appeals and requests for reconsideration
i. Monitor timely submission of cost reports
j. Maintain and distribute cost reporting forms
k. Provide training as necessary
l. Submit monthly status reports
m. Refer any material irregularities or suspicion of fraud
n. Attend regularly scheduled contract management meetings
o. Track repayments and recoupments
p. Perform monitoring of the cost to charge ratio and calculate interim rates as needed.
q. Determine which hospitals qualify for Disproportionate Share Program (DSH) payments and calculate amounts.
r. Perform annual DSH audits to ensure that hospitals do not exceed their DSH limit as outlined in Federal Rules.
s. On an annual basis, calculate FQHC and RHC rates based on a methodology outlined in the State Plan.
t. Calculate annual reconciliation amounts for FQHC and RHC providers
u. Compute applicable final settlements and issue notice of settlements to providers
v. Compute quarterly Indirect Medical Education (IME) payments and Graduate Medical Education (GME) Payments.
w. Assist the Department in the transition of current programs to the new Centennial Care Program (i.e. The Sole Community Provider Fund Program).
x. Provide planning activities related to Electronic Health Records (EHR) such a pre-payment verification process for EHR eligibility, and development of a post payment audit strategy for State 1 “meaningful use” attestations and State 2 and Stage 3 attestations. Also, provide audit activities for the EHR Program.
y. Provide for audits of the MCO Contractor’s financial records at the discretion of the Department.

4. Training

Provide training for appropriate state officials and providers on an as needed basis.
5. **Consultation**

Provide upon request consultation and assistance relating to revision of or development of regulations, compliance with Federal requirements or other consultation as requested.

C. **SCOPE OF PROCUREMENT**

The scope of procurement shall encompass the defined Scope of Work detained in the Sample Professional Services Contract (Appendix 8) of this RFP. The contract is scheduled to begin on July 1, 2013 or upon receiving all required state approvals whichever is later, and end on July 30, 2015. The contract may be extended for two (2) additional one (1) year periods. In no circumstance shall the contract exceed a total of four (4) years in duration.

D. **OFFEROR QUALIFICATIONS / CONFLICT OF INTEREST**

This RFP is open to any Offeror capable of performing the work described in the Contract Terms and Conditions (Appendix 8) of this RFP, subject to the following stipulations:

1. Offerors shall not contract with HSD for consultation services covered under the Medicaid program that would conflict with the requirements of this procurement.

2. Pursuant to the Governmental Conduct Act, Sections 10-16-1 et. Seq (NMSA 1978). Offerors shall have no direct interest which conflicts with the performance of services covered under this Agreement.

3. Pursuant to 13-19-191, 20-41-1 through 30-41-3 (NMSA 1978), Offerors may not provide or offer bribes, gratuities, or kickbacks to applicable State personnel.

4. Offerors shall ensure that no elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from the successful awards of the contract to Offerors. No individual employed by the State of New Mexico shall be admitted to any share or part of the contract or to any benefits that may arise there from; and,

5. The burden is on Offerors to present sufficient assurance to HSD that the award of the Contract to Offerors shall not create conflict of interest.

Offerors must meet the following conditions to be an eligible candidate for contract award:

1. Offerors shall not be a New Mexico Medicaid Provider;
2. Offerors shall not be a prime or subcontractor with any other company performing Medicaid services for the Department;

3. Offerors shall not have a contract with any state or local government entity that is a Medicaid provider or contractor;

4. Offerors shall not process Medicaid claims for the Department; and,

5. Offerors shall not function as auditors for any in-state or border Hospital, Home Health Agency (HHA), Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Long Term Care Facility (NF, ICF/MR) participating in the New Mexico Medicaid Program.

E. PROCUREMENT MANAGER

The Department has designated a Procurement Manager who is responsible for the conduct of this procurement whose name, address, and telephone number is as follows:

   Melissa Lopez  
   Procurement Manager – Human Services Department  
   P.O. Box 2348  
   Santa Fe, NM 87504-2348  
   Telephone: (505) 476-7030  
   Fax Number (505) 827-7236  
   Melissa.lopez@state.nm.us

All deliveries via express carrier should be addressed as follows:

   Melissa Lopez  
   Procurement Manager – Human Services Department  
   Ark Plaza Building, Room B-100  
   2025 S. Pacheco Street  
   Santa Fe, NM 87505

Any inquires or requests regarding this procurement should be submitted in writing ONLY to the Procurement Manager. Questions shall be clearly labeled and shall cite the specific RFP or contract section, which form the basis of the questions. Offeror may contact ONLY the Procurement Manager regarding the procurement. Other State Employees do not have the authority to respond on behalf of HSD. HSD shall not assume responsibility for any answers or clarifications received from other HSD staff or any other State staff. Any contact with anyone other than the Procurement Manager may result in disqualification.
F. DEFINITIONS OF TERMINOLOGY

The paragraph contains definitions that are meaningful to the administration of the Medicaid program, including appropriate abbreviations.

“Agency”: The Department administering the RFP.

“Audit Agent”: The selected Contractor.

“Centers for Medicare & Medicaid Services (CMS)”: The Federal agency of the Department of Health and Human Services responsible for administering Medicare and Medicaid.

“Contractor”: The successful Offeror.

“Contract Year”: The period beginning July 1 of each year and ending June 30.

“Department”: The Human Services Department of the State of New Mexico.

“Desk Review”: An in-house analysis of cost report data submitted by the provider. The purpose of the desk review is to arrive at an opinion as to whether the costs appear to be reasonable and allowable for reimbursement under relevant Federal and State regulations.

“Determination”: The written documentation of a decision of a procurement manager including findings of facts required to support a decision. A determination becomes part of the procurement file to which it pertains.

“Desirable”: The terms “may”, “can”, “preferably”, or “prefer” identify a desirable or discretionary item or factor.

“DFA”: The Department of Finance and Administration for the State of New Mexico.

“Division”: The Medical Assistance Division of the Human Services Department.

“Evaluation Committee”: A body appointed by HSD Management to perform the evaluation of Offeror proposals.

“Evaluation Committee Report”: A report prepared by the Procurement Manager and the Evaluation Committee for submission to the Secretary of HSD for contract award. The report contains all written decisions resulting from the conduct of a procurement requiring the evaluation of competitive sealed proposals.

“Field Audit”: An on-site analysis of cost report data submitted by a provider. This constitutes an in-depth review of the providers’ financial and statistical records to verify data submitted on the cost report is accurate, complete, allowable and reasonable.
“Human Services Department (HSD)”: The executive department in New Mexico responsible for the administration of Title XIX (Medicaid). The term HSD may also indicate the Department’s designee, as applicable.

“In-State”: Any facility operating within New Mexico.

“Mandatory”: The terms “must”, “will”, “shall”, “is required”, or “are required” identify a mandatory item or factor.

“Medicaid”: The Medical Assistance Program, authorized under Section XIX of the Social Security Act, furnished to New Mexico residents who meet specific eligibility requirements.

“Medical Assistance Division (MAD)”: The Division at the Human Services Department administering the Medicaid Program.

“Offeror”: Any person, corporation, or partnership which chooses to submit a proposal.

“Procurement Manual”: The person or designee authorized by HSD to manage or administer a procurement requiring the evaluation of competitive sealed proposals.


“Provider”: A Hospital, Home Health Agency, Federally Qualified Health Center, Rural Health Clinic, or Long Term Care provider certified by the Department to provide Medicaid services to a recipient under the Department’s regulations.

“Recipient”: A person who received Medicaid services under the Department Regulations.

“Request for Proposals (RFP)”: All documents, including those attached or incorporated by reference, used for soliciting proposals.

“Responsible Offeror”: Offerors who submit a responsive proposal and who has furnished, when required, information and data to provide the financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

“Responsive Offer” or “Responsive Proposal”: An offer or proposal that conforms in all material respects to the requirements set forth in the request for proposals. The term “material respects: includes, but is not limited to, the prices, quality, quantity, or delivery requirements of the relevant product or services.

“Secretary”: The Cabinet Secretary of the New Mexico Human Services Department.
“Services Schedule”: A complete list, accompanied by the descriptive narrative, grouped by service categories, of services provided by Offerors.

“Settlement”: A final determination of reimbursable cost and/or the establishment of a prospective per diem rate for a provider.

G. NOTICE TO OFFEROR

This procurement is governed by the Procurement Code, NMSA 1978, Section 13-1-28 through 13-1-199 and General Services Department Procurement Code Regulations 1.4.1 NMAC. The Procurement Code imposes civil and criminal penalties for its violation. In addition, New Mexico criminal statutes imposes felony penalties for bribes, gratuities, and kickbacks.

H. BACKGROUND INFORMATION

This section provides background on the department and the MAD that may be helpful to Offerors in preparing a proposal. The information is provided as an overview and is not intended to be a complete and exhaustive description.

1. HSD Goals:
   - Modernize and Improve New Mexico’s Medical Assistance Programs.
   - Help New Mexicans Get Back to Work.
   - Assist Parents with their Child Support Responsibilities.
   - Improve Behavioral Health Services.
   - Improve Administrative Effectiveness and Simplicity.

2. HSD Mission:
   To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

3. HSD Resources and Locations: Approximately seventy percent (70%) of HSD’s Medicaid Revenue is from federal sources, twenty – eight percent (28%) is from the state general fund, and two percent (2%) is from other state funds.

4. Organization of HSD: HSD is a cabinet – level agency in the Executive Branch of New Mexico State Government, headed by a Cabinet Secretary who is appointed by the Governor and confirmed by the New Mexico Senate. HSD consists of the Office of the Secretary and four program Divisions: Medical Assistance Division (MAD), Income Support Division (ISD), Child Support Enforcement Division (CSED), and Behavioral Health Services Division (BHSD).

The Human Services Department is also a key member of the NM Behavioral Health Collaborative and works across state agencies to collaborate on behavioral health issues.
5. Overview of the Medicaid Program: The MAD manages and administers the Medicaid Program for the State of New Mexico. Medicaid is authorized under Title XIX of the Social Security Act. The program provides access to medically necessary health services for eligible individuals. The program is jointly funded by the federal and state governments with the federal contribution determined by the relative national ranking of the state in per capita income.

The fee-for-service Medicaid program has traditionally represented one of the fastest growing segments of the state’s budget. Annual growth rates have far outpaced growth in the general fund revenues needed to support the state’s share of the program. HSD has now met the challenge of reducing the growth rate of the Medicaid program costs by implementing SALUD!, the New Mexico Medicaid managed care program which was implemented on July 1, 1997. At this time, the Medicaid Program is approximately 80% Managed Care and 20% Fee for Service.

Effective January 1, 2014, The Department is moving into a predominantly managed care program called Centennial Care. The design creates a single, comprehensive delivery system through four managed care plans, allowing for greater administrative simplicity. It emphasizes care coordination. The newly eligible population under Medicaid expansion will be enrolled under Centennial Care.

While New Mexico’s Medicaid Program covers more than 40 eligibility categories, the following are the major groups of persons eligible for Medicaid: **individuals** in households receiving TANF under welfare reform; blind and disabled individuals receiving Supplemental Security Income (SSI); certain aged, blind, and disabled individuals requiring nursing home care; children under the jurisdiction of the state; pregnant women in households with incomes at or below 185 percent of the Federal Poverty Level; and, in 1999, children in households with income up to 235 percent of the Federal Poverty Level under Title XXI. The remainders of the categories are related to special circumstances and / or type of service needed.

As of Fiscal Year 2013, approximately 524,616 individuals in New Mexico had Medicaid eligibility for at least part of the year.

Medicaid program regulations allow reimbursement for a broad array of health services and providers. Mandated services include: general acute inpatient hospital care; outpatient hospital services; physician services provided in a variety of settings; nursing home care; home health care; hospice care, rural health clinic services including services in federally qualified health centers, laboratory and radiology; nurse practitioner services; medically necessary Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for clients under age 21; family planning; nurse mid-wife services; and emergency and non-emergency transportation.
Optional services covered in New Mexico include specialty inpatient hospital services, outpatient drugs; rehabilitation services; dental services; medical supplies and durable medical equipment; case management; home and community based waiver services; optometry and related services; prosthetics; and intermediate care services for the mentally retarded.

The managed care benefit package includes most, but not all, of these services, which are currently covered under the Medicaid fee-for-service program. The managed care program is a fully capitated, risk-based system under contract with seven managed care organizations (MCOs).

The program uses several reimbursement methods for its providers. Acute hospitals are paid on a prospective basis. Most residential mental health providers are paid on a per diem; other providers are paid based on fee schedules. Some fee schedules are related to Medicare reimbursement policy. Others are State determined.

Effective October 1, 1989 the New Mexico Medicaid Program began reimbursing covered inpatient hospital services using a prospective reimbursement system. This prospective reimbursement system compensated hospitals on a designated amount “per discharge”, classified according to the Diagnosis Related Group (DRG) methodology. Specialty hospitals and certified special units within the hospital are reimbursed on a TEFRA basis. Unless otherwise specified in the Medicare Provider Manual HCFA (Pub-15), the Department Plan will serve to facilitate the audit agent in determining allowable and reasonable costs. The Department plan sections which describe the reimbursement system for hospitals (Appendix 3), Long Term Care Facilities (Appendix 4) home health agencies (Appendix 5), federally qualified health centers and rural health clinics (Appendix 6) are attached for reference.

Beginning August 1, 2008, the Nursing Facilities and Home and Community Based Waivers began a phase-in to the Coordination of Long Term Services (CoLTS) Program. The phase in was complete within one year.

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are reimbursed on a prospective reimbursement system and are rebased every three years.

I. PROCUREMENT LIBRARY

The Procurement Manager has established a Procurement Library in the Medical Assistance Division building located at 2025 S. Pacheco St., Room B-100; Santa Fe, New Mexico. Offerors are encouraged to review the material contained in the Procurement Library by contacting the Procurement Manager or her designee and scheduling an appointment.

Offerors are welcome to take notes in the Procurement library. All of the materials are available for review only and may not be copied or removed from the library.
The library contains the information listed below which may be supplemented by the Procurement Manager at her discretion:

- Procurement Regulations 1.4.1 NMAC (also available online at http://www.generalservices.state.nm.us/spd/)
- Current Audit Agent Contract
- Federal Regulations
## II. CONDITIONS GOVERNING THE PROCUREMENT

### A. SEQUENCE OF EVENTS

The Procurement Manager will make every effort to adhere the following schedule in the procurement of the audit agent services. The Department reserves the right to revise the dates on this schedule without the need to amend the RFP. Revise dates will be shared with Offerors in advance.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Issuance of RFP</td>
<td>Department</td>
<td>04/26/2013</td>
</tr>
<tr>
<td>2. Pre-Proposal Conference</td>
<td>Department, Potential Offerors</td>
<td>05/01/2013</td>
</tr>
<tr>
<td>3. Distribution List Response</td>
<td>Potential Offerors</td>
<td>05/01/2013</td>
</tr>
<tr>
<td>4. Deadline to Submit Questions</td>
<td>Potential Offerors</td>
<td>05/07/2013</td>
</tr>
<tr>
<td>5. Response to Written Questions / RFP Amendments</td>
<td>Department</td>
<td>05/10/2013</td>
</tr>
<tr>
<td>6. Submission of Proposal</td>
<td>Offerors</td>
<td>05/28/2013</td>
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<tr>
<td>7. Proposal Evaluation</td>
<td>Evaluation Committee</td>
<td>05/29/2013</td>
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<td></td>
<td></td>
<td>06/04/2013</td>
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<tr>
<td>8. Selection of Finalists</td>
<td>Evaluation Committee</td>
<td>06/05/2013</td>
</tr>
<tr>
<td>9. Best and Final Offers from Finalists</td>
<td>Offerors</td>
<td>06/07/2013</td>
</tr>
<tr>
<td>10. Oral Presentations (if necessary)</td>
<td>Offerors</td>
<td>06/12-13/2013</td>
</tr>
<tr>
<td>11. Contractor Selection</td>
<td>Department</td>
<td>06/14/2013</td>
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<tr>
<td>12. Contract Negotiations</td>
<td>Department / Offerors</td>
<td>06/18/2013</td>
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<tr>
<td>13. Contract Award</td>
<td>DFA</td>
<td>07/01/2013</td>
</tr>
<tr>
<td>14. Protest Deadline</td>
<td>Offerors</td>
<td>15 Days after the contract is awarded</td>
</tr>
</tbody>
</table>

Dates subject to change based on number of responses to evaluate and final approval from federal partners, if applicable.
B. **EXPLANATION OF EVENTS**

The following paragraphs describe the activities listed in the sequence of events shown in Section II, Paragraph A.

1. **Issuance of RFP**
   This RFP is being issued by the New Mexico Human Services Department as described in Section Sequence of Events.

2. **Pre-Proposal Conference**
   A pre-proposal conference will be held on as described in Section II, A. Sequence of Events at 9:00 am Mountain Standard Time at the Medical Assistance Division Conference Room, Ark Plaza, 2025 S. Pacheco Street, Santa Fe, New Mexico. A public log will be kept of the names of potential offerors that attended the pre-proposal conference.

   **Attendance at the pre-proposal conference is not mandatory but highly encouraged.**

3. **Distribution List Response Due**
   Potential offerors should hand-deliver, fax, or mail the “Acknowledgement of Receipt of Request For Proposals Form” (See Appendix 2) to have their organization placed on the procurement distribution list. The form should be signed by an authorized representative of the organization.

   The procurement distribution list will be used for the distribution of written responses to questions and any RFP amendments.

   Failure to return this form may constitute a presumption of receipt and rejection of the RFP, and the potential offeror’s organization name may not appear on the distribution list.

4. **Deadline to Submit Written Questions**
   Offerors may submit written questions as to the intent or clarity of this RPF. All written questions must be addressed to the Procurement Manager (See Section 1, Paragraph E).

5. **Response to Written Questions / RFP Amendments**
   Written responses to written questions and any RFP amendments will be distributed to all potential offerors whose organization name appears on the procurement distribution list. An Acknowledgement of Receipt Form will accompany the distribution package. The form should be signed by Offeror’s representative, dated, and hand-delivered or return by facsimile or by register or certified mail by the date indicated thereon. Failure to return this form shall constitute a presumption of receipt and withdrawal from the procurement process. Therefore, Offeror’s organization name shall be deleted from the procurement distribution list.

6. **Submission of Proposal**
   **ALL PROPOSALS MUST BE RECEIVED FOR REVIEW AND EVALUATION NO LATER THAN 2:00 PM MOUNTAIN STANDARD TIME ON AS DESCRIBED IN SECTION II, A. SEQUENCE OF EVENTS.**
   Proposals received after the deadline will not be accepted. The date and time will be recorded on each proposal. Proposals must be addressed and delivered to the Procurement Manager at the address listed in Section 1, Paragraph E. Proposals must be sealed and labeled on the outside of the package to clearly indication they are in response to the MEDICAID AUDIT AGENT.
Request for Proposals. Proposals submitted by facsimile or other electronic means will not be accepted.

A public log will be kept of the names of all offeror organizations that submitted proposals. Pursuant to Section 13-1-116 NMSA 1978, the contents of any proposal shall not be disclosed to competing offerors prior to contract award.

7. Proposal Evaluation
The evaluation of proposals will be performed by an evaluation committee appointed by Department Management. During this time, the Procurement Manager may initiate discussions with offerors for the purpose of clarifying aspects of the proposals. Discussions SHALL NOT be initiated by Offerors.

8. Selection of Finalists
The Evaluation Committee will select and the Procurement Manager will notify the finalist offerors. Only finalists will be invited to participate in the subsequent steps of the procurement.

9. Best and Final Offers from Finalists
Finalist offerors may be asked to submit revisions to their proposals for the purpose of obtaining best and final offers. Best and final offers may be clarified and amended at the finalist offeror’s oral presentation (if necessary).

10. Oral Presentation by Finalists
Finalists may be required to present their proposals to the Evaluation Committee. The Procurement Manager will schedule the time for each presentation. All presentations will be held in Medical Assistance Divisions’ Conference Room, Ark Plaza, 20205 S. Pacheco Street, Santa Fe, New Mexico. Each presentation will be limited to two (2) hours in duration. The need for an Oral Presentation will be determined by the Procurement Manager and the Evaluation Committee.

11. Notice of Contractor Selection
The Department shall send a notice of intent to award to the selected offeror(s). However, the department reserves the right to delay the contract award until after that date if such a delay is in the best interest of the State.

The actual award of the contract shall not occur until all required approvals are obtained including the Department of Finance and Administration (DFA).

12. Contract Negotiations
Contract negotiations will be conducted with the selected offeror(s). In the event that mutually agreeable terms cannot be reached with the time specified, the department reserves the right to finalize a contract with the next most advantageous offeror without undertaking a new procurement process.

13. Contract Award
The anticipated contract start date is July 1, 2013 or upon DFA’s approval. No work shall be performed by Offerors until the contract is fully executed. The department assumes no liability
for any work performed by the selected offeror in anticipation of a binding contract prior to the approval date from DFA.

14. **Protest Deadline**
Any protest by Offerors must be timely and conformance with Section 13-1-172 NMSA 1978 and applicable procurement regulations. The fifteen (15) day protest period of responsive offerors shall begin on the day following the contract award. Protests must be written and must include the name and address of the protestor and the request for proposals number. It must also contain a statement of grounds for protest including appropriate supporting exhibit, and it must specify the ruling requested from the Department. The protest must be delivered to:

Danny Sandoval, Director  
Administrative Services Division / Human Services Department  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348  
Telephone: 505-827-9412  
e-mail: danny.sandoval@state.nm.us  
Fax: 595-827-8199
C. GENERAL REQUIREMENTS

This procurement shall be conducted in accordance with the New Mexico Procurement Code procurement regulations, GSD Procurement Regulations 1.4.1 NMAC.

1. Acceptance of Conditions Governing the Procurement
Offerors shall indicate their acceptance of the Conditions Governing the Procurement section of the RFP in the Letter of Transmittal. Submission of a proposal constitutes acceptance of the Evaluation Factors contained in Section IV of this RFP.

2. Incurring Cost
Any cost incurred by Offerors in preparation, transmittal and presentation of any proposal or material submitted in response to this RFP shall be born solely by Offerors.

3. Prime Contractor Responsibility
Any contract that may result from this RFP shall specify that the Prime Contractor is solely responsible for fulfillment of the contract with HSD. HSD shall make contract payments to only the prime contractor and shall consider the selected Offeror to be the sole point of contact with regard to any final contract.

4. Subcontractors
Use of subcontractors shall be clearly explained in Offeror’s proposal. If subcontractors are used, however, Offerors, as prime contractor, will be held fully responsible for fulfillment of the contract.

5. Amended Proposal
Offerors may submit an amended proposal before the deadline for receipt of proposals. Such amended proposal shall be a complete replacement for a previously submitted proposal and shall be clearly identified as such in the transmittal letter. HSD personnel shall not merge, collate, or assemble proposal materials.

6. Offeror’s Rights to Withdraw Proposal
Offerors shall be allowed to withdraw their proposals at any time prior to the deadline for receipt of proposals. Offerors shall submit a written withdrawal request signed by Offeror’s duty authorized representative and addressed to the Procurement Manager.

7. Proposal Offer Firm
Response to this RFP shall be signed by an individual authorized to be Offerors. The cover letter shall state that the offer, including proposal prices, remains valid for ninety (90) days after the due date for receipt of proposals or sixty (60) days after receipts of the best and final offer, if one is submitted.

8. Disclosure of Proposal Contents
The proposals shall be kept confidential until after the contract award. At that time, all proposals and documents pertaining to the proposals shall be open to the public, except for the material that is propriety or confidential.

All information for which Offerors request confidential or proprietary treatment shall be identified by stamp or imprint. Proprietary or confidential material shall be readily separable from the proposal in order to facilitate eventual public inspection of the non-confidential portion of the proposal. Confidential materials are normally restricted to confidential financial information concerning Offeror’s
organization and data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act, 57-3A-1 to 57-3A-7 NMSA 1978.

If a request is received for disclosure of material for which Offerors has made a written request for confidentiality, the Procurement Manager shall examine Offeror’s request and make a written determination that specifies which portions of the proposal should be disclosed. Unless Offeror takes legal action to prevent the disclosure. The proposal shall be open to public inspection subject to any continuing prohibition on the disclosure of confidential data.

9. No Obligation
This procurement in no manner obligates the State of New Mexico or any of its agencies to the eventual purchase of services offered until valid written contracts are fully executed and approved by DFA and other appropriate Federal and State authorities.

10. Termination
This RFP may be canceled at any time and any and all proposals may be rejected in whole or in part when HSD determines such action to be in the best interest of the State of New Mexico.

11. Sufficient Appropriation
Any contract awarded as a result of this RFP process may be terminated or modified if sufficient appropriations or authorizations do not exist. Such termination shall be effected by sending written notice to the Contractor. HSD’s decision as to whether sufficient appropriations and authorizations are available shall be accepted by the Contractor as final.

12. Legal Review
HSD requires that all Offerors agree to be bound by the General Requirements contained in this RFP. Any Offeror’s concerns shall be promptly brought to the attention of the Procurement Manager.

13. Governing Law
This procurement and any agreement with Offerors that may result shall be governed by the laws of the State of New Mexico.

14. Basis For Proposal
Only information supplied by HSD in writing through the Procurement Manager or in this RFP should be used as the basis for the preparation of Offeror proposals.

15. Contract Terms and Conditions
The contract between HSD and a Contractor shall follow the format specified by HSD and contain the terms and conditions set forth in Appendix 8, “Contract Terms and Conditions.” HSD reserves the right to initiate negotiations with a successful Offeror of provisions in addition to those contained in this RFP. The contents of this RFP, as revised and / or supplemented, and the successful Offeror’s proposal shall be incorporated into the contract.

Should Offerors object to any of HSD’s Contract Terms and Conditions as contained in Appendix 8, in the response the Offeror shall specifically identify objectionable terms and conditions, policies, or standards. Offerors shall propose specific alternative language that would be acceptable to HSD. General references by Offerors to the terms and conditions or attempts at complete substitutions are not acceptable to HSD and shall result in disqualification of Offeror’s proposal.
Offerors shall provide a brief discussion of the purpose and impact, if any, of each proposed change followed by the specific proposed alternate wording. HSD shall accept or reject the proposed changes to the Term and Conditions, policy and standards for all Offerors and, in most instances, Offeror’s Best and Final Offer shall incorporate the final language.

All contracts for professional services are subject to the review and approval of the Department of Finance and Administration pursuant to 13-1-118 NMSA 1978 and DFA Rule 2NMAC40.2.

16. Contract Deviations
Any additional terms and conditions, which may be the subject of negotiation, shall be discussed only between HSD and the selected Offeror and shall not be deemed an opportunity to amend Offeror’s proposal.

17. Offeror Qualifications
The Evaluation Committee may make such investigations as necessary to determine the ability of Offerors to adhere to the requirements specified within this RFP. The Procurement Manager shall reject the proposal of any Offeror who is not a responsible Offeror or fails to submit a responsive offer as defined in Sections 13-1-83 and 13-1-85 NMSA 1978.

18. Right to Waive Minor Irregularities
The Evaluation Committee, at its sole discretion, reserves the right to waive minor irregularities. The Evaluation Committee also reserves the right to waive mandatory requirements provided that all of the otherwise responsive proposals failed to meet the mandatory requirements and/or does not otherwise materially affect the procurement. This right is at the sole discretion of the Evaluation Committee.

19. Change in Contractor Representative
HSD reserves the right to require a change in contractor representatives if the assigned representative is not, in the opinion of HSD, adequately performing the scope of work specified in the contract.

20. Notice
The Procurement Code, Sections 13-1-28 through 13-2-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities, or kickbacks.

21. Department Rights
HSD reserves the right to cancel the procurement, to accept all or a portion of Offeror’s proposal, and to reject any or all proposals received in response to this RFP when it is in the best interest of the State to do so.

22. Right to Publish
Throughout the duration of this procurement process and contract terms, Potential Offerors, Offerors, and Contractors shall secure from HSD written approval prior to the release of any information that pertains to the potential work or activities covered by the procurement of the subsequent contract. Failure to adhere to this requirement may result in disqualification of Offeror’s proposal or termination of the contract.

23. Ownership of Proposals
HSD shall retain ownership of all copies of each Offeror’s response to this RFP.
24. **Electronic Mail Address Required**
A large part of the communication regarding this procurement will be conducted by electronic mail (e-mail). Offeror must have a valid e-mail address to receive this correspondence.

25. **Use of Electronic Versions of this RFP**
This RFP is being made available by electronic means. If accepted by such means, Offerors acknowledge and accept full responsibility to insure that no changes are made to the RFP. IN the event of conflict between a version of the RFP in Offeror’s possession and the version maintained by the Department, the versions maintained by the Department shall govern.

26. **Suspension and Debarment Requirement**
Offerors shall certify, by signing the agreement attached hereto as Appendix 9, that to the best of its knowledge and belief that Offerors and / or its Principals are not or have not been debarred, suspended, proposed for debarment or declared ineligible for the award of contracts by an Federal department or agency.

### III. RESPONSE FORMAT AND ORGANIZATION

A. **NUMBER OF RESPONSES**
Offerors shall submit only one proposal.

B. **NUMBER OF COPIES**
Offerors shall provide one original and (5) identical copies of their technical proposal (Binder 1), one original and five(5) copies of the cost proposal (Binder 2), and one (1) copy of supporting technical documentation (Binder 3) to the location specified in Section 1, Paragraph E, or before the closing date and time for receipt of proposals.

C. **PROPOSAL FORMAT**
All technical proposals shall be typewritten on standard 8 ½ x 11 paper and placed within a binder with tabs delineating each section. Larger paper is permissible for charts, spreadsheets, and other graphics.

D. **PROPOSAL ORGANIZATION**
Within each section of their proposal, Offeror’s should address the items in the order in which they appear in this RFP. All forms provided in the RFP must be complete and included in the appropriate section of the proposal. All discussion of proposed costs, rates, or expenses, must occur only in the cost response form.

Any proposal that does not adhere to these requirements will be deemed non-responsive and rejected on that basis.

Offerors may attach other material they feel may improve the quality of their responses. However, these materials should be included as items only in Binder 3.

The technical proposal shall be organized and indexed in the following format and shall contain, at a minimum, all listed items in the sequence indicated.

1. **Letter of Transmittal**
Each proposal shall be accompanied by a letter of transmittal. The letter of transmittal shall:

a. Identify the submitting organization:
b. Identify the name, title, and telephone number of the person(s) authorized by the organization to be contacted for clarification, negotiate the contract on behalf of the organization, and contractually obligate the organization.
c. Be signed by the person authorized to contractually obligate the organization; and,
d. Acknowledged receipt of any and all amendments to this RFP, if applicable.

2. Table of Contents
The table of contents shall contain a list of material in the proposal and the page number where the information can be found.

3. Proposal Summary
A proposal summary is optional and may be included by Offerors to provide the Evaluation Committee with an overview of the qualifications and other features of the proposal. This material will not be used in the evaluation process unless specifically referenced from other portions of Offeror’s proposal.

4. Specifications
Specifications will be scored on a two step process. 1. Response to Offeror Experience mandatory. 2. Points will be awarded based on responses.

a. Offeror Experience

1. Corporate Experience [Up to 200 points may be awarded]
   a) Offerors must submit in a narrative format of corporate experience including experience with contracted efforts similar to the one proposed in this RFP.
   b) In a narrative format, please describe the experience of proposed subcontractors.
   c) Offerors must submit five (5) references of previous clients who have received similar services as described in this RFP. Each reference must include the name of a contact person, address, telephone number, and description of services provided.
   d) Offerors must submit an organizational chart displaying Offeror’s overall structure.

2. Staff Experience [Up to 250 points may be awarded]
   a) Personnel Resumes – Resumes of the project director, project manager, and key personnel, including previous experience relative to this project must be included.
   b) In a narrative format, offerors must identify the staff member(s) proposed to perform each task required by the scope of work in order to enable the
Evaluation Committee to match and evaluate the proposed staff member(s) qualifications to perform the required task.

Offerors must provide a statement of concurrence to the following requirements:

**Project Director:** The Project Director will have direct experience in audit agent work related to hospitals, home health agencies, and federally qualified health centers and rural health clinics. The Director will serve as the point of contact for all contract work.

**Project Manager:** The Project Manager will have direct experience related to hospital, home health agencies, federally qualified health centers, rural health clinics, and cost accounting. Responsibilities will also include day-to-day project management and coordination, technical directions, and supervision of the supporting staff. The Project Manager will direct the development of procedures and systems necessary to successfully perform the various desk review, audit, rate settings, and related services requested under this RFP.

**Staff Members** will have direct experience with cost report reviews and on site audits.

**Information:** Offeror’s staffing plan will provide adequate personnel to accomplish all work described in the Scope of Work. The successful Offeror must possess extensive knowledge and experience in financial accounting auditing; have working knowledge of and experience in, hospital, home health agencies, federally qualified health centers, and rural health clinics including, but not limited to, other healthcare organizations; and have direct working knowledge and experience in cost accounting.

“Audits of Providers of Health Care services,” issued by the American Institute of Certified Public Accountants provides guidance on procedures to be applied and identifies other authoritative literature to be used in the design of audits (desk / field).

Staff location will depend on the nature of ongoing tasks. Meetings will normally be conducted at the MAD facilities in Santa Fe, New Mexico.

3. **Work Plan [Up to 300 points may be awarded]**

Offerors must demonstrate its ability to ensure successful and timely completion of all requirements as stated in this RFP. Offerors shall provide a description of how the project will be organized and managed including:

1) **Planning, Development, and Implementation Stage** – Showing all personnel to be assigned to the planning, development and initial implementation state of this project and the relationship of this project’s and the personnel to the corporate structure. Give a brief narrative of each individual’s responsibilities.
Pursuant to the contract, the Department will have the prerogative of requiring personnel replacements as necessary.

2) Operations Stage – Showing all personnel to be assigned to the operation of the tasks of the scope of work and the relationship of these personnel and this portion of the project to the corporate structure. Give a brief narrative of each individual’s responsibilities.

3) In a narrative format, Offerors shall address the methodology that will be used to carry out the work required by this RFP. This includes, but is not limited to:

   a. audit objectives
   b. audit procedures
   c. audit instructions
   d. audit forms
   e. time frames for completing audits; and
   f. reporting audit results to the Department in a timely manner.

4) In a narrative form, Offerors must describe how items identified in the summary scope of work will be accomplished.

5) Offerors must include a timetable and approach for phasing in all aspects of the work required by this RFP.

6) In a narrative format, Offerors must provide training, philosophy including training seminars including a description of the type of personnel which would conduct such training. Training shall include, but not be limited to, advising providers on specific Medicaid accounting and cost accounting techniques and practices.

7) Offerors must describe how confidentiality and security of information will be maintained in accordance with Federal regulations.

C. Statement of Concurrence

   1) Offerors shall provide a statement of concurrence that explicitly indicates acceptance of the Conditions Governing the Procedures stated in Section II and that Offerors agree to comply with all requirements as described in this RFP, including all appendices, attachments, written clarifications, and amendments provided during the procurement process. Offerors shall specifically address acceptance of the Contract Terms and Conditions attached as Appendix 8 in the Compliance Statement.

D. Responses to Suspension and Debarment Requirement

Offerors must complete the form set out as Appendix 9 to certify compliance with the Federal Regulations relating to Suspension and Debarment.

E. Other Support Material (Optional)
This section is optional. Offerors may include any other relevant materials in Binder 3. No additional points will be awarded for this material.

Samples of material used in previous or similar projects may be submitted in Binder 3.

4. **Mandatory Cost Specifications**

Offerors must propose a total cost of a two year contract. The proposed cost will be evaluated using the following:

\[ A + B(X) = C1 \]

- **A** = Price for conducting typical audit work for the two years
- **B** = Hourly rate of consultation
- **X** = Eighty hours of consultation
- **C1** = Total price for the two year contract

The Department will then evaluate the total price of the contract using the following:

\[ C1 + C2 + C3 = T \]

- **C1** = Total prices for a two year contract
- **C2** = **C1** plus inflator
- **C3** = **C2** plus inflator
- **T** = Total price of the two year contract plus two (2) one (1) year options.

The total price for the contract will be based on the number of facilities contained in the attached list of providers (Appendix 1). Should the number of facilities increase or decrease during the course of the contract, the average cost per facility and average cost per hour reported through “A” above will be used to amend the contract price.

Offerors must supply and define the inflator to be used. The inflator shall be a set figure and must be the same for years three and four of the contract.

The Department recognizes that compensation rates for consultation will vary according to the level of factor A. A breakdown of average per facility cost and average per hour cost is a requirement. These amounts will be used to increase or decrease the contract amount if providers enter or leave the program.

**Information:** For each of the first two contract years, pursuant to Article 2 of the Contract Terms and Conditions, the Department shall pay the Contractor the agreed upon annual rate for the performance of the typical audit, prorated monthly. The Department shall pay the Contract for subsequent contract years, if extended the relevant contract year rate plus an agreed upon inflator percentage. Costs are subject to modifications based on the increase or decrease in the number of facilities. Payment for audit services includes all Contractor related expenses and applicable New Mexico gross receipts taxes.

The Department shall pay the Contractor equal monthly installments for the typical scope of audit services upon receipt of an invoice and a satisfactory detailed status report detailing work performed.
The status report shall include at a minimum the following information: name of facility; type of service to be completed (desk review or field audit); date cost report due, date cost report received, date service (desk review or field audit) completed.

The Contractor shall submit separate billing statements for consultation and assistance services as described in Appendix 8. These services require prior written approval by appropriate Department staff. The billing statement shall be provided with monthly statement by the Contractor and shall identify the date of the request, the subject matter of the requests, date(s) and type of service rendered, the number of hours billed and the total charge.

Do not include gross receipts taxes in the calculation. Gross receipts taxes will be a pass through from the State to the Contractor and be paid by the Contractor. The Contractor will be responsible for making all required tax payments.

The cost report form, which is included as Appendix 10 of this RFP, must be included as the last page of Offeror’s Cost Proposal.

IV. EVALUATION

The Department shall conduct a comprehensive, fair, and impartial evaluation of the proposal received in response to this RFP. HSD shall be the sole judge in the selection of Offerors. HSD shall establish an Evaluation Committee, which shall evaluate proposals. The Committee shall consist of members who are familiar with particular aspects of this procurement and standards of criteria for the specific areas of the RFP. HSD may, at its discretion, designate members of the Committee who are not employees of HSD and who have experience in specific areas of the RFP. The Committee shall evaluate each qualifying proposal on the basis of technical merit. Cost proposals shall only be reviewed for Offerors achieving an adequate score on technical merit.

A. EVALUATION PROCESS

1. All Offeror proposals will be reviewed for compliance with the mandatory requirements as stipulated within the RFP. Proposals deemed non-responsive will be eliminated from further consideration.

2. The Evaluation Committee may, at its option waive requirements as specified in Section II.

3. The Procurement Manager may, at her option, contact Offerors for clarification of responses.

4. The Evaluation Committee has the option of contacting references in addition to those given by Offerors.

5. Responsive proposals will be evaluated on the factors in Section IV, B that have been assigned a point value. Note, however, that a serious deficiency in the response to any one factor may be grounds for rejection regardless of the overall score. The responsible
Offerors with the highest scores will be selected as finalists. Offerors who are asked to submit revised proposals for the purpose of making offers, will have their points recalculated accordingly. Points awarded from the oral presentation, if done, will be added to the previously awarded points to attain final scores. The responsible Offeror whose proposal is most advantageous to the Department, taking into consideration the evaluation factors in Section IV, will be recommended for contract award to the Department Secretary. The most advantageous proposal may not have the most points.

6. The contract award is subject to the successful negotiation of the contract.

B. EVALUATION SUMMARY

The following is a summary of evaluation factors and the point value assigned to each. These weighted factors will be used in the evaluation of the individual Offeror proposals. Only finalist Offerors will receive points for the oral presentation, if one is conducted.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>Specifications:</td>
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<td>1. Offeror Experience</td>
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<td>I. Corporate Experience</td>
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<td>II. Staff Experience</td>
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<td>III. Work Plan</td>
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<tr>
<td>2. Compliance and Acceptance Statement</td>
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<tr>
<td>3. Response to Suspension / Debarment Requirement</td>
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<td>4. Other Support Materials (Optional)</td>
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<td>5. Cost</td>
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<td>6. Oral Presentation</td>
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<td>Total:</td>
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</table>

C. EVALUATION FACTORS

Points will be awarded on the basis of the following evaluation factors:

1. Offeror Experience

   I. Corporate Experience (200 Points)
Offeror’s relevant corporate experience, including experience of proposed subcontractors. Offeror’s relevant organizational experience in auditing, based on descriptions of similar prior projects by Offerors and the comparability of that experience.

II. Staff Experience (250 Points)

Points will be awarded based on an evaluation of Offeror’s personnel assigned to the contract and Offeror’s corporate management and oversight of the personnel and this project.

III. Work Plan (300 Points)

1.) Offeror’s proposed planning, development, and implementation.
2.) Offeror’s proposed operations stage.
3.) Offeror’s proposed methodology of audits and other contractual tasks.
4.) Detail Scope of Work.

Points will be awarded based on Offeror’s demonstrated understanding of overall scope of work and the proposed approach for accomplishing the tasks.

2. Compliance and Acceptance Statement (Accept / Reject)

3. Response to Suspension / Debarment Requirement (Accept / Reject)

4. Other Support Materials (Optional - 0 Points)

5. Cost (250 Points)

The evaluation of each Offeror’s cost proposal will be conducted using the following formula:

\[
\text{Award Points} = \frac{\text{Lowest Responsive Offer} \times 250}{\text{Offeror’s Total Cost}}
\]

6. Oral Presentation (Optional – 0 Points)

The oral presentation will be an evaluation of the qualifications of the proposed staff, effective communication, technical knowledge, experience with similar contracts and the quality of the responses to questions. The oral presentation will only be required if deemed necessary by the Procurement Manager and the Evaluation Committee.

D. EVALUATION PROCESS

1. All Offerors’ proposals will be reviewed for compliance with the mandatory requirements stated within the RFP. Proposals deemed non-responsive will be eliminated from further consideration.

2. The Procurement Manager may contact Offerors for clarification of the response.
3. The Evaluation Committee may use other sources of information to perform the evaluation as specified.

4. Responsive Proposals will be evaluated on the factors in Section IV that have been assigned a point value. The responsible Offerors with the highest scores will be selected as finalist Offerors based upon the proposals submitted. Finalist Offerors who are asked or choose to submit revised proposals for the purpose of obtaining best and final offers will have their points recalculated accordingly. Points awarded from the oral presentations will be added to the previously assigned points to attain final scores. The responsible Offeror whose proposal is most advantageous to the Agency, taking into consideration the evaluation factors in Section IV, will be recommended for contract award as specified. Please note, however, that a serious deficiency in the response to any one factor may be grounds for rejections regardless of overall score.
APPENDIX 1

PROVIDER LISTING OF HOSPITALS, HOME HEALTH AGENCIES,
FEDERALLY QUALIFIED HEALTH CENTERS,
RURAL HEALTH CLINICS, NURSING FACILITIES, AND INTERMEDIATE CARE FACILITIES FOR THE
MENTALLY RETARDED.
<table>
<thead>
<tr>
<th>Facility Name</th>
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<th>Provider #</th>
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<tr>
<td>Advanced Health Care of Albuquerque</td>
<td>2701 Richmond Dr. NE, Albuquerque, NM 87107</td>
<td>(505) 967-4200</td>
<td>82551839</td>
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<tr>
<td>Casa del Sol Senior Care Center/Rehabilitation Ctr</td>
<td>2905 East Missouri, Las Cruces, NM 88011</td>
<td>(505) 522-0404</td>
<td>72952032</td>
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<tr>
<td>Albuquerque Heights Healthcare &amp; Rehab. Center LLC</td>
<td>103 Hospital Loop NE, Albuquerque, NM 87109</td>
<td>(505) 348-8300</td>
<td>21301221</td>
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<tr>
<td>Casa Maria Health Care and Pecos Valley</td>
<td>1601 South Main Street, Roswell, NM 88203</td>
<td>(505) 623-6008</td>
<td>46450840</td>
</tr>
<tr>
<td>Belen Meadows Healthcare &amp; Rehab. Center</td>
<td>1831 Camino De Llano, Belen, NM 87002</td>
<td>(505) 864-1600</td>
<td>53508319</td>
</tr>
<tr>
<td>Casa Real Nursing Center</td>
<td>1650 Galisteo Street, Santa Fe, NM 87505</td>
<td>(505) 984-8313</td>
<td>68500238</td>
</tr>
<tr>
<td>Bloomfield Nursing &amp; Rehabilitation Center</td>
<td>803 Hacienda Lane, Bloomfield, NM 87413</td>
<td>(505) 632-1823</td>
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<tr>
<td>CedarRidge Inn Inc</td>
<td>800 Saguaro Trail, Farmington, NM 87401</td>
<td>(505) 598-6000</td>
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<tr>
<td>Canyon Transitional Rehabilitation Center</td>
<td>10101 Lagrima De Oro NE, Albuquerque, NM 87111</td>
<td>(505) 298-1231</td>
<td>33759014</td>
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<tr>
<td>Clayton Nursing &amp; Rehabilitation Ctr</td>
<td>419 Harding, Clayton, NM 88415</td>
<td>(505) 374-2353</td>
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<tr>
<td>Casa Arena Blanca Nursing Center</td>
<td>205 Moonglow, Alamogordo, NM 88310</td>
<td>(505) 434-4510</td>
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<tr>
<td>Clovis Healthcare and Rehabilitation Ctr LLC</td>
<td>1201 N. Norris Street, Clovis, NM 88101</td>
<td>(505) 762-3753</td>
<td>47952563</td>
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<tr>
<td>Casa de Oro Care Center/Rehabilitation Ctr</td>
<td>1005 Lujan Hill Road, Las Cruces, NM 88007</td>
<td>(505) 523-4573</td>
<td>59602295</td>
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<tr>
<td>Colfax General Hospital ICF</td>
<td>615 Prospect Avenue, Springer, NM 87747</td>
<td>(505) 483-2443</td>
<td>I-0274</td>
</tr>
<tr>
<td>Country Cottage Care Rehab Center</td>
<td>2101 Bensing Road, Hobbs, NM 88240</td>
<td>(505) 397-1113</td>
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</tr>
</tbody>
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03/26/2013
Española Valley Nursing Rehabilitation Ctr
720 Hacienda Street
Española, NM 87532
Phone: (505) 753-6769
Provider #: 03381536

Fort Bayard Medical Center
41 Fort Bayard Road
Fort Bayard, NM 88026
Phone: (575) 537-8600
Provider #: 51972786

Four Corners Good Samaritan Village
500 Care Lane
Aztec, NM 87410
Phone: (505) 334-9445
Provider #: 1-0308

Good Samaritan Society - Betty Dare
3101 North Florida Avenue
Alamogordo, NM 88310
Phone: (575) 434-0033
Provider #: 1-0233

Good Samaritan Society - Grants
840 Lobo Canyon Road
Grants, NM 87020
Phone: (505) 287-8868
Provider #: 1-0316

Good Samaritan Society - Manzano del Sol Village
5201 Roma Avenue NE
Albuquerque, NM 87108
Phone: (505) 262-2311
Provider #: 1-0449

Good Samaritan Society - Las Cruces
3025 Terrace Drive
Las Cruces, NM 88011
Phone: (575) 522-1362
Provider #: 1-0621

Heartland Care of Artesia
1402 W. Gilchrist Avenue
Artesia, NM 88210
Phone: (575) 746-6006
Provider #: 28054016

Heartland Continuing Care Center
1604 West 18th Street
Portales, NM 88130
Phone: (575) 359-4726
Provider #: 1-1567

Hobbs Health Care Center
5715 Lovington Highway
Hobbs, NM 88240
Phone: (575) 392-6845
Provider #: 90430239

La Vida Llena Lifecare Retirement Community
10501 Lagrima de Oro NE
Albuquerque, NM 87111
Phone: (505) 291-3410
Provider #: I-0100

Ladera Care/Rehabilitation Center
5901 Ouray Road NW
Albuquerque, NM 87120
Phone: (505) 836-0023
Provider #: 09280740

Laguna Rainbow Corporation
I-40 Exit 108
Casa Blanca, NM 87007
Phone: (505) 552-6034
Provider #: I-0365

Landsun Homes, Inc.
1900 Westridge Road
Carlsbad, NM 88220
Phone: (575) 885-8150
Provider #: I-0399

Las Cruces Nursing Center
2029 Sagecrest Court
Las Cruces, NM 88001
Phone: (505) 522-7000
Provider #: 03139018

Las Palomas Care/Rehabilitation Center
8100 Palomas NE
Albuquerque, NM 87109
Phone: (505) 821-4200
Provider #: 93303254

Life Care Center of Farmington
1101 West Murray Drive
Farmington, NM 87401
Phone: (505) 326-1600
Provider #: I-1275

Lovingston Good Samaritan Center
1600 West Avenue I
Lovingston, NM 88260
Phone: (575) 396-5212
Provider #: I-0431

03/26/2013
McKinley Care/Rehabilitation Ctr  
224 Nizhoni Blvd.  
Gallup, NM 87301  
Phone: (505) 863-9551  
Provider #: 81629800  

Mescalero Care Center  
454 Lipan Ave.  
Mescalero, NM 88340  
Phone: (575) 464-4802  
Provider #: 67601081  

Mimbres Memorial Nursing Home  
900 West Ash Street  
Deming, NM 88031  
Phone: (575) 546-5886  
Provider #: 1-1286  

Miners Colfax Medical Center  
900 S. 6th Street  
Raton, NM 87740  
Phone: (575) 445-3661  
Provider #: 1-0472  

Mission Arch Care/Rehabilitation Ctr  
3200 Mission Arch Drive  
Roswell, NM 88201  
Phone: (575) 624-2583  
Provider #: 62221001  

New Mexico Behavioral Health Institute  
3695 Hot Springs Blvd.  
Las Vegas, NM 87701  
Phone: (505) 425-6711  
Provider #: 1-0126  

New Mexico State Veterans Center  
392 South Broadway Street  
T or C, NM 87901  
Phone: (575) 894-4200  
Provider #: 1-0480  

Northgate Unit of Lakeview Christian Home of SW  
1905 West Pierce Street  
Carlsbad, NM 88220  
Phone: (575) 885-3161  
Provider #: 1-0381  

Paloma Blanca Health Care Assocs  
1509 University Boulevard NE  
Albuquerque, NM 87102  
Phone: (505) 243-2257  
Provider #: 96323795  

Presbyterian Healthcare Services  
1100 Central Avenue SE  
Albuquerque, NM 87106  
Phone: (505) 841-1042  
Provider #: 1-0897  

Presbyterian Kaseman Kaseman Subacute and Rehabilitation  
8300 Constitution NE  
Albuquerque, NM 87110  
Phone: (505) 291-2750  
Provider #: 1-1521  

Princeton Place  
500 Louisana Boulevard NE  
Albuquerque, NM 87108  
Phone: (505) 255-1717  
Provider #: 02983834  

Raton Nursing & Rehabilitation Ctr.  
1660 Hospital Drive  
Raton, NM 87740  
Phone: (505) 445-2734  
Provider #: 91983738  

Red Rocks Care Center  
3720 Church Rock Street  
Gallup, NM 87301  
Phone: (505) 722-2261  
Provider #: 96902256  

Rehabilitation Center of Albuquerque LLC  
5900 Forest Hills Drive NE  
Albuquerque, NM 87109  
Phone: (505) 822-6000  
Provider #: 80507816  

Retirement Ranches, Inc.  
2221 Dillon Road  
Clovis, NM 88101  
Phone: (575) 762-4495  
Provider #: 1-0514  

Rio Rancho Care/Rehabilitation Ctr.  
4210 Sabana Grande Ave. NE  
Rio Rancho, NM 87124  
Phone: (505) 892-6603  
Provider #: 48279315  

San Juan Medical  
806 W Maple  
Farmington, NM 87401  
Phone: (505) 325-2910  
Provider #: 11802260  

03/26/2013
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<tr>
<th>Santa Fe Care Center</th>
<th>St. John Healthcare &amp; Rehabilitation Ctr.</th>
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<tr>
<td>635 Harkle Road</td>
<td>2216 Lester Drive NE</td>
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<tr>
<td>Santa Fe, NM 87505</td>
<td>Albuquerque, NM 87112</td>
</tr>
<tr>
<td>Phone: (505) 982-2574</td>
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<td>Provider #: 96786825</td>
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<td>Sierra Health Care Center</td>
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<td>1400 Silver</td>
<td>7900 Constitution Ave. NE</td>
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<td>T or C, NM 87901</td>
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<tr>
<td>Phone: (575) 894-7855</td>
<td>Phone: (505) 296-5565</td>
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<tr>
<td>3514 Fowler Avenue</td>
<td>1515 South Sunset</td>
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<tr>
<td>Silver City, NM 88061</td>
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<tr>
<td>Phone: (575) 388-3127</td>
<td>Phone: (575) 623-7097</td>
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<td>9150 McMahon NW</td>
<td>9150 McMahon NW</td>
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<tr>
<td>Albuquerque, NM 87114</td>
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<tr>
<td>Phone: (505) 898-7986</td>
<td>Phone: (505) 898-7986</td>
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<td>Provider #: 69930325</td>
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<td>1203 Hwy 60 W</td>
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<td>Phone: (575) 835-2724</td>
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<td>Provider #: I-0563</td>
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<td>Sombrillo Nursing Facility</td>
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<td>1011 Sombrillo Court</td>
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<tr>
<td>Los Alamos, NM 87544</td>
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<tr>
<td>Phone: (505) 662-4300</td>
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<td>South Valley Care Center LLC</td>
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<td>1629 Bowe Lane SW</td>
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<tr>
<td>Albuquerque, NM 87105</td>
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<tr>
<td>Phone: (505) 877-2200</td>
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<tr>
<td>Provider #: 75120232</td>
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<td>St. Anthony Healthcare &amp; Rehabilitation Ctr.</td>
<td>St. Anthony Healthcare &amp; Rehabilitation Ctr.</td>
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<td>1400 West 21st Street</td>
<td>1400 West 21st Street</td>
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<td>Clovis, NM 88101</td>
<td>Clovis, NM 88101</td>
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<tr>
<td>Phone: (575) 762-4705</td>
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<td>Provider #: 65708270</td>
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<td>St. Catherine Healthcare &amp; Rehab. Ctr.</td>
<td>Vida Encantada Rehab &amp; Nursing</td>
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<td>5123 Juan Tabo Blvd. NE</td>
<td>2301 Collins Drive</td>
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<tr>
<td>Albuquerque, NM 87111</td>
<td>Las Vegas, NM 87701</td>
</tr>
<tr>
<td>Phone: (505) 292-3333</td>
<td>Phone: (505) 425-9362</td>
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<td>Provider #: 37900226</td>
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<td>Sunset Villa Care Center</td>
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<td>603 Hadeco Drive</td>
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<td>Lordsburg, NM 88045</td>
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<tr>
<td>Phone: (505) 542-3539</td>
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<tr>
<td>Provider #: 15978575</td>
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<td>1340 Maestas Road</td>
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<tr>
<td>Taos, NM 87571</td>
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<tr>
<td>Phone: (575) 758-2300</td>
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<tr>
<td>Provider #: I-1322</td>
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<tr>
<td>The Rehabilitation Center of Albuquerque</td>
<td>The Rehabilitation Center of Albuquerque</td>
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<tr>
<td>5900 Forest Hills Drive NE</td>
<td>5900 Forest Hills Drive NE</td>
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<td>Albuquerque, NM 87109</td>
<td>Albuquerque, NM 87109</td>
</tr>
<tr>
<td>Phone: (505) 822-6000</td>
<td>Phone: (505) 822-6000</td>
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<tr>
<td>Provider #: 80507816</td>
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<td>Vida Encantada Rehab &amp; Nursing</td>
<td>Vida Encantada Rehab &amp; Nursing</td>
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<tr>
<td>2301 Collins Drive</td>
<td>2301 Collins Drive</td>
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<tr>
<td>Las Vegas, NM 87701</td>
<td>Las Vegas, NM 87701</td>
</tr>
<tr>
<td>Phone: (505) 425-9362</td>
<td>Phone: (505) 425-9362</td>
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<tr>
<td>Provider #: 72654899</td>
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</tbody>
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03/26/2013
ICF/MR FACILITIES

CARC Farm
P.O. Drawer 1808
Carlsbad, NM 88221-1808
Administrator: Mark Shinnerer
Phone: (575) 887-1570

Linebery:
Mabee Home:
Scarborough:
Spence Home:
Washington Ranch 1:
Washington Ranch 2:
Guadalupe No. 7:
M-0428
M-2143
M-4065
M-2176
M-1228
M-0592
20803818

Casa Angelica
5629 Isleta Boulevard SW
Albuquerque, NM 87105
Administrator: Louise Turner
Phone: (505) 877-5763
Provider: M-0664

ARCA Group Homes
11300 Lomas NE
Albuquerque, NM 87112
Administrator: Vince Smith
Phone: (505) 332-6814

Copper A & B Home:
Corrales:
Gibson A Home:
Gun Club ICF/MR:
Louisiana ICF/MR:
Park ICF/MR:
South Valley A & B Home:
Trumbull Home:
M-0303
M-4107
M-0444
M-0493
M-3265
M-5013
M-0295
M-0386

Los Lunas Community Program Behavior Service Center
445 Camino Del Rey, Ste. A
Los Lunas, NM 87031
Administrator:
Phone: (505) 222-0900
Provider: M-2402

New Horizons Development Center
P.O. Box 187
Carrizozo, NM 88301
Administrator: Laura Rose
Phone: (575) 648-2379

Casa del Sol:
Casa Linda:
M-4388
M-6029

03/26/13
Santa Maria El Mirador
10 A Van Nu Po
Santa Fe, NM 87508
Administrator: Mark Johnson
Phone: (505) 424-7700

Alamosa: M-1451
Alcalde House: M-2343
Calle Amelia: M-1176
Camino De Vaca: M-1269
Camino Espuela: M-1468
Camino Rio Vista: M-1995
Chacoma Vista 1: M-2226
Chacoma Vista 2: M-2296
Cheyenne Circle: M-1474
Cottage “A” House: M-1202
Cottage “B” House: M-4099
Cottage “C” House: M-6185
Fairview: M-1609
Mutt Nelson: 75302373
Nizhoni: M-2395
Paseo de las Acequia M-2372
Ponderosa Lane: M-1486
Ranchos de Taos: M-2431
San Mateo: M-1281
Vuelta Del Sur: M-2337

03/26/13
DRG HOSPITALS

**Highlighted Facilities indicate Sole Community Hospitals**

**Alta Vista Regional Hospital - For Profit**
104 Legion Drive
Las Vegas, NM 87701
Telephone: (505) 426-3500
Provider #: 76546
NPI: 1396716643

**Artesia General Hospital - Not For Profit**
702 North 13th Street
Artesia, NM 88210
Telephone: (575) 748-3333
Provider #: B-3279
NPI: 14372896044

**Carlsbad Medical Center - For Profit**
2430 West Pierce Street
Carlsbad, NM 88220
Telephone: (575) 887-4109
Provider #: B-3186
NPI: 1790722346

**Cibola General Hospital - Not For Profit**
1016 Roosevelt Avenue
Grants, NM 87020
Telephone: (505) 287-4446
Provider #: 729
NPI: 1780677039

**Dan C. Trigg Memorial Hospital - For Profit**
301 East Meille de Luna
Tucumcari, NM 88401
Telephone: (575) 461-0141
Provider #: 646
NPI: 1962488304

**Eastern NM Medical Center - For Profit**
405 County Club Road
Roswell, NM 88201
Telephone: (575) 624-8722
Provider #: B-2978
NPI: 1447221742

**Española Hospital - Not For Profit**
1010 Spruce Street
Española, NM 87532
Telephone: (575) 753-7111
Provider #: 265
NPI: 1154307593

**Gerald Champion Regional Medical Ctr. - Not For Profit**
2669 N. Scenic Drive
Alamogordo, NM 88310
Telephone: (575) 439-6100
Provider #: 18
NPI: 1861450579

**Gila Regional Medical Center - For Profit**
1313 East 32nd Street
Silver City, NM 88061
Telephone: (575) 388-1591
Provider #: 570
NPI: 1336220839

**Guadalupe County Hospital - For Profit**
535 Lake Drive
Santa Rosa, NM 88435
Telephone: (505) 472-3417
Provider #: B-5936
NPI: 1346249968

**Heart Hospital of New Mexico**
504 Elm Street NE
Albuquerque, NM 87102
Telephone: (505) 724-2012
Provider #: 72264

**Holy Cross Hospital - For Profit**
1397 Wemer Road
Taos, NM 87571
Telephone: (575) 758-8883
Provider #: 760
NPI: 1194751958

03/26/2013
Lea Regional Medical Center — For Profit
5419 N. Lovington Hwy
Hobbs, NM 88240
Telephone: (575) 492-5000
Provider #: B-3139
NPI: 1285688697

Lincoln County Medical Center — Not For Profit
211 Sudderth
Ruidoso, NM 88345
Telephone: (575) 622-1110
Provider #: 521
NPI: 1558347708

Los Alamos Medical Center — For Profit
3917 West Road
Los Alamos, NM 87544
Telephone: (505) 662-4201
Provider #: 04924258
NPI: 1285701623

Loveland Medical Center - Downtown
601 Dr. Martin Luther King Jr. Avenue NE
Albuquerque, NM 87102
Telephone: (505) 727-4729
Provider #: 31427871

Loveland Westside Hospital
10501 Golf Course Rd. NW
Albuquerque, NM 87114
Telephone: (505) 727-2000
Provider #: 42555868

Loveland Women’s Hospital
4701 Montgomery Blvd. NE
Albuquerque, NM 87109
Telephone: (505) 727-7800
Provider #: 73824062

Memorial Medical Center — For Profit
2450 South Telshor Boulevard
Las Cruces, NM 88011
Telephone: (575) 521-2258
Provider #: 67939864
NPI: 1700821808

Mimbres Memorial Hospital — For Profit
900 West Ash
Deming, NM 88030
Telephone: (575) 546-2761
Provider #: B-2113
NPI: 1881665594

Miners Colfax Medical Ctr — Not For Profit
203 Hospital Drive
Raton, NM 87740
Telephone: (575) 445-3661
Provider #: 968
NPI: 1083931109

Mountainview Reg. Med. Ctr — For Profit
4311 East Lohman Avenue
Las Cruces, NM 88011
Telephone: (575) 556-7600
Provider #: 95804528
NPI: 1205882503

Nor-Lea General Hospital — Not For Profit
1600 North Main
Lovington, NM 88260
Telephone: (575) 396-6611
Provider #: 901
NPI: 1881630036

Physicians Med Ctr of Santa Fe LLC (Christus)
2990 Rodeo Park Drive East
Santa Fe, NM 87505
Telephone: (505) 428-5400
Provider #: 20001878

Plains Reg. Med Ctr—Clovis — Not For Profit
2100 N. DR MLK JR Blvd
Clovis, NM 88101
Telephone: (575) 769-2141
Provider #: 224
NPI: 1629053509

Presbyterian Hospital
1100 Central Ave SE
Albuquerque, NM 87102
Telephone: (505) 841-1234
Provider #: 109

03/26/2013
Rehoboth McKinley Christian Health Care Services - Not For Profit
1901 Red Rock Drive
Gallup, NM 87301
Telephone: (575) 863-7000
Provider #: 331
NPI: 1720084999

Roosevelt General Hosp. - Not For Profit
42121 US 70
Portales, NM 88130
Telephone: (575) 359-1800
Provider #: G-8465
NPI: 1073517058

Lovelace - Roswell Regional Hospital - For Profit
117 East 19th St.
Roswell, NM 88201
Telephone: (505) 627-7000
Provider #: 07707576
NPI: 1114934254

San Juan Reg. Med. Ctr. - Not For Profit
801 West Maple Street
Farmington, NM 87401
Telephone: (505) 325-5011
Provider #: 299
NPI: 1427058510

Sierra Vista Hospital - Not For Profit
800 E. 9th Street
Torc., NM 87901
Telephone: (575) 894-2111
Provider #: 216
NPI: 1750446009

Socorro General Hospital - Not For Profit
1202 Highway 60 West
Socorro, NM 87801
Telephone: (575) 835-1140
Provider #: 695
NPI: 1790761138

St. Vincent Hospital - Not For Profit
455 St. Michaels Drive
Santa Fe, NM 87505
Telephone: (505) 983-3361
Provider #: 547
NPI: 1578587150

Union County General Hospital - Not for Profit
301 Harding Street
Clayton, NM 88415
Telephone: (575) 374-2585
Provider #: B-2253
NPI: 1427051002

University of NM Hospital
2211 Lomas Boulevard NE
Albuquerque, NM 87106
Telephone: (505) 843-2131
Provider #: 67

03/26/2013
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<th>Hospital Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Provider #</th>
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<td>Albuquerque Care Hospital of Southern NM</td>
<td>4451 E. Lohman Avenue</td>
<td>(575) 521-6600</td>
<td>89088778</td>
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<td>Gila Regional Medical Center/Psych Unit</td>
<td>1313 E. 32nd Street</td>
<td>(575) 538-4000</td>
<td>554</td>
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<td>Healthsouth Rehabilitation Hospital</td>
<td>7000 Jefferson Street NE</td>
<td>(505) 344-9478</td>
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<td>Kindred Healthcare Inc.</td>
<td>700 High Street NE</td>
<td>(505) 242-4444</td>
<td>B-1267</td>
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<td>Lea Regional Hospital LLC PPS Exempt Psyc Unit</td>
<td>5419 N. Lovington Highway</td>
<td>(575) 492-5000</td>
<td>B-3197</td>
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<td>Lovelace Rehabilitation Hospital</td>
<td>505 Elm St.</td>
<td>(505) 727-4781</td>
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<td>Mesilla Valley Hospital</td>
<td>3751 Del Rey Blvd.</td>
<td>(575) 382-3500</td>
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<td>Memorial Hospital</td>
<td>806 Central Avenue SE</td>
<td>(505) 247-0220</td>
<td>52438066</td>
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<td>Mountain View Regional Medical Ctr.</td>
<td>4311 East Lohman</td>
<td>(575) 556-7600</td>
<td>32525028</td>
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<td>New Mexico Rehabilitation Center PC</td>
<td>71 Gail Harris Avenue</td>
<td>(575) 347-3452</td>
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<td>Peak Psychiatric Hospital</td>
<td>5065 McNutt Rd.</td>
<td>(575) 589-3000</td>
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<td>Presbyterian Kaseman Hospital</td>
<td>8300 Constitution NE</td>
<td>(505) 291-2114</td>
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<td>4441 E. Lohman Ave.</td>
<td>(575) 521-6400</td>
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<td>Rehoboth McKinley Christian RMCHCS Behavioral Health Svc</td>
<td>650 Vanden Bosch Parkway</td>
<td>(505) 726-6901</td>
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<td>San Juan Regional Rehab. Hospital</td>
<td>525 South Schwartz Street</td>
<td>(505) 609-2625</td>
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<td>St. Vincent Behavioral Hospital Science Ctr.</td>
<td>455 St. Michaels Drive</td>
<td>(505) 983-3361</td>
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03/26/2013
St. Vincent Hospital Rehab. Unit
455 St. Michaels Drive
Santa Fe, NM 87501
Phone: (505) 983-3361
Provider #: 865

Specialty Hospital of Albuquerque
235 Elm Street NE
Albuquerque, NM 87102
Phone: (505) 842-5550
Provider #: 19882513

University Psychiatric Hospital
2600 Marble NE
Albuquerque, NM 87131
Phone: (505) 272-2861
Provider #: 92

03/26/2013
HOME HEALTH AGENCIES

Access Home Health LLC
1211 8th Street, Ste. A
Alamogordo, NM 88310
Telephone: (575) 434-6222
Provider #: 02472562

Advanced Home Care of Roswell
315 W. Country Club Road
Roswell, NM 88201
Telephone: (505) 627-6256
Provider #: N-3288

Advantage Home Care, Inc.
4600 Montgomery NE, Bldg. B, Ste.203
Albuquerque, NM 87109
Telephone: (505) 828-0232
Provider #: 88085830

Alamogordo Home Care
1859 Indian Wells Road
Alamogordo, NM 88310
Telephone: (575) 437-3500
Provider #: N-2993

Alliance Home Health Care LLC
5981 Jefferson Road NE
Albuquerque, NM 87110
Telephone: (505) 884-4080
Provider #: 53703260

Altomar New Mexico LLC
5312 Rio Bravo Drive #6
Santa Teresa, NM 88008
Telephone: (877) 328-2211
Provider #: 24029262

Altura Homecare and Rehab of Albuquerque
4308 Carlisle Blvd. NE #202
Albuquerque, NM 87107
Telephone #: (505) 881-0425
Provider #: 44856873

Ambercare Home Health
420 N. Main Street
Belen, NM 87002
Telephone: (505) 861-0060
Provider #: N-2415

Amedisys Home Health of Albuquerque
4401 Lomas Blvd. NE
Albuquerque, NM 87110
Telephone: (505) 265-5161
Provider #: 65855361

Basin Home Health, Inc.
200 North Orchard
Farmington, NM 87401
Telephone: 325-8231
Provider #: N-2145

Caridad de San Antonio Home Health
P.O. Box 209
Mora, NM 87732
Telephone: (575) 387-6078
Provider #: N-1433

Clayton Hospital Home Care
301 Harding Street
Clayton, NM 88415
Telephone: (575) 374-0114
Provider #: N-2941

Clovis Homecare, Inc.
1944 West 21st Street
Clovis, NM 88101
Telephone: (505) 769-2244
Provider #: N-2725

Coordinated Home Health Skill Care
205 W. Boutz, Bldg. 5
Las Cruces, NM 88005
Telephone: (575) 523-8885
Provider #: 39105857

Coordinated Home Health Skilled Care
200 N. Arizona Street
Silver City, NM 88062
Telephone: (505) 539-0912
Provider #: 24400734

Del & Associates Nursing Service
418 N. Turner Street
Hobbs, NM 88240
Telephone: (575) 353-7355
Provider #: N-1915

03/26/2013
Elite Home Health LLC  
1508 N. Dal Paso  
Hobbs, NM 88240  
Telephone: (575) 393-9281  
Provider #: 66376211

Encompass Home Health of NM  
850 N. Motel Blvd., Ste. B  
Las Cruces, NM 88007  
Telephone: (575) 524-8302  
Provider #: N-2876

Encompass Home Health of NM  
110 W. College Blvd., Ste. A  
Roswell, NM 88201  
Telephone: (575) 622-9355  
Provider #: 94701369

Española Hospital Home Care  
1010 Spruce Street  
Española, NM 87532  
Telephone: (505) 753-1510  
Provider #: N-3207

Esperanza Home Health Care  
Hwy 518  
Buena Vista, NM 87712  
Telephone: (575) 387-2215  
Provider #: B-7678

Frontier Medical Home Care Inc.  
217-A N. Main Street  
Roswell, NM 88201  
Telephone: (505) 627-1112  
Provider #: 06089798

Gentiva Health Services  
6400 Jefferson NE, Ste. 101  
Albuquerque, NM 87109  
Telephone: (505) 345-3754  
Provider #: N-1425

Gila Regional Medical Ctr - Home Health  
1400 Hwy 180 East  
Silver City, NM 88061  
Telephone: 574-4948  
Provider #: N-1714

Golden Services, LTD  
800 W. Pierce  
Carlsbad, NM 88220  
Telephone: (575) 885-3082  
Provider #: N-1797

Guardian Angel Home Health  
4801 N. Butler, Bldg. 2000  
Farmington, NM 87401  
Telephone: (505) 564-9002  
Provider #: 51629861

Harmony Home Health  
5700 Harper Dr. NE, Suite 450  
Albuquerque, NM 87109  
Telephone: (505) 828-2273  
Provider #: 79831281

Healthsouth Home Health of Albuquerque  
7000 Jefferson Street NE  
Albuquerque, NM 87109  
Telephone: (505) 344-9478  
Provider #: 24732028

Heritage Home Healthcare Inc.  
3721 Rutledge Road NE  
Albuquerque, NM 87109  
Telephone: (505) 796-3200  
Provider #: N-2403

Home Care Connection  
513 S. Canal  
Carlsbad, NM 88220  
Telephone: (575) 887-6050  
Provider #: Z-0606

Home Health Unlimited  
506 Wingfield Street  
Ruidoso, NM 88345  
Telephone: (575) 257-4577  
Provider #: 05700752

Home Kare, Inc. of Dona Ana  
1853 E. Lohman Avenue  
Las Cruces, NM 88001  
Telephone: (575) 521-2663  
Provider #: N-2514

Horizon Home Care  
727 E. Ute  
Farmington, NM 87401  
Telephone: (505) 326-2525  
Provider #: A-8441

Horizon Home Health Inc.  
1260 E. 32nd Street  
Silver City, NM 88061  
Telephone: (575) 388-1801  
Provider #: 76234070

03/26/2013
FQHC Facilities

Alamo Navajo Health Center
Hwy 169
Magdalena, NM 87825
Telephone: (575) 854-2626
Provider #: S-1408

Albuquerque Health Care for the Homeless Inc.
1217 1st Street NW
Albuquerque, NM 87102
Telephone: (505) 766-5197
Provider #: 45385

Ben Archer Health Center – Hatch Area
Health CNCL
255 Hwy 187
Hatch, NM 87937
Telephone: (575) 267-3088
Provider #: 47738

Ben Archer Health Center LC
1600 Thorpe Road
Las Cruces, NM 88012
Telephone: (575) 382-9292
Provider #: 69788

Ben Archer Health Center
626 Taft
Columbus, NM 88029
Telephone: (575) 531-2165
Provider #: T-9358

Ben Archer Health Center
1960 N. Date Street
T or C, NM 87901
Telephone: (575) 894-7662
Provider #: 46455

Ben Archer Health Center
1950 Date Street
T or C, NM 87901
Phone #: (575) 267-3088
Provider #: 88838307

Ben Archer Health Center
2150 Hwy 54 S.
Alamogordo, NM 88310
Telephone: (575) 443-8133
Provider #: B-5924

Ben Archer Health Center
125 Chaparral NW
Deming, NM 88030
Telephone: (575) 267-3088
Provider #: 44403879

Ben Archer Health Center
403 West Hall Street
Hatch, NM 87937
Telephone: (575) 267-3088
Provider #: 47708859

Ben Archer Health Center
12080 LB Linbeck Road
Radium Springs, NM 88054
Telephone: (575) 526-6200
Provider #: 61359335

De Baca FPC/FQHC
500 N 10th
Fort Sumner, NM 88119
Telephone: (575) 355-2414
Provider #: S-7012

El Centro Family Health – Dr JI Dunham Memorial Clinic
211 Pine Street
Chama, NM 87520
Telephone: (575) 756-2143
Provider #: S-9696

El Centro Family Health - Highlands
901 Baca
Las Vegas, NM 87701
Telephone: (505) 454-3218
Provider #: E-2396

El Centro Family Health – Coyote Clinic
P.O. Box 40
Coyote, NM 87012
Telephone: (575) 638-5487
Provider #: 47142

El Centro Family Health - Embudo
Hwy 68 2243 Rinconada
Embudo, NM 87531
Telephone: (505) 579-4255
Provider #: 47498

03/26/2013
El Centro Family Health – Española Dental
608 B La Joya Street
Española, NM 87532
Telephone: (505) 753-9454
Provider #: 47953063

El Centro Family Health - Bond Clinic
620 Coronado Street
Española, NM 87532
Telephone: (505) 753-7395
Provider #: 50146

El Centro Family Health - La Loma
P.O. Box 1
Anton Chico, NM 88711
Telephone: (575) 427-5036
Provider #: 47084

El Centro Family Health - Las Vegas
1235 8th Street
Las Vegas, NM 87701
Telephone: (505) 425-6788
Provider #: 50062

El Centro Family Health - Peñasco
15136 S. Street Rd 75
Peñasco, NM 87553
Telephone: (575) 587-2205
Provider #: 47092

El Centro Family Health - Roy Clinic
585 Wagon Mound Hwy
Roy, NM 87743
Telephone: (575) 485-2484
Provider #: 45542

El Centro Family Health - San Miguel
State Rd 3
Ribera, NM 87560
Telephone: (575) 421-1113
Provider #: 47100

El Centro Family Health - Truchas Clinic
P.O. Box 330
Truchas, NM 87578
Telephone: (505) 689-2461
Provider #: 46920

El Centro Family Health - Wagon Mound
604 Catron Avenue
Wagon Mound, NM 87752
Telephone: (575) 666-2288
Provider #: 47670

El Centro Family Health - Springer
400 Prospect
Springer, NM 87747
Telephone: (575) 483-0282
Provider #: L-1947

First Choice Community Healthcare –
Alameda Clinic
7704-A 2nd Street NW
Albuquerque, NM 87107
Telephone: (505) 890-1458
Provider #: 43950

First Choice Community Healthcare –
Clinic 1
2001 Centro Familiar
Albuquerque, NM 87105
Telephone: (505) 873-7400
Provider #: 47464

First Choice Community Healthcare –
South Broadway Clinic
1401 William Street SE
Albuquerque, NM 87102
Telephone: (505) 768-5450
Provider #: 47472

First Choice Community Healthcare - Mtn. &
Valley Regional Health Ctr.
No 8 Medical Center Rd.
Edgewood, NM 87015
Telephone: (505) 281-3406
Provider #: 54905737

First Choice Community Healthcare –
Clinic 3
1231 Candelaria NW
Albuquerque, NM 87107
Telephone: (505) 345-3244
Provider #: 47480

First Choice Community Healthcare –
Clinic 4
2127 Los Padillas Road
Albuquerque, NM 87105
Telephone: (505) 452-8633
Provider #: 47845

First Choice Community Healthcare –
Clinic 5
1259 Hwy 314
Los Lunas, NM 87031
Telephone: (505) 865-4618
Provider #: 46557

03/26/2013
First Choice Community Healthcare – Belen Medical & Dental Center
120 S. 5th Street
Belen, NM 87002
Telephone: (505) 861-1013
Provider #: 47816

First Choice Community Health Care Inc
6900 Gonzales Rd SW
Albuquerque, NM 87121
Telephone: (505) 831-4245
Provider #: A-2872

First Choice Comm. Healthcare - Rio Grande High School Based Center
2300 Arenal Rd. SW
Albuquerque, NM 87105
Telephone: (505) 873-4577
Provider #: 84976331

First Nations Comm. Health Source
5608 Zuni SE
Albuquerque, NM 87108
Telephone: (505) 262-6560
Provider #: 46912

Hidalgo Med. Svc. - Cliff Gila Comm. Health Center
Hwy 211
Gila, NM 88038
Telephone: (575) 535-4384
Provider #: 12007269

Hidalgo Medical Services
500 E DeMoss Street
Lordsburg, NM 88045
Telephone: (575) 542-8384
Provider #: S-6325

Hidalgo Medical Services - Animas Clinic
#1 Panther Blvd.
Animas, NM 88020
Telephone: (575) 542-8384
Provider #: E-1329

Hidalgo Medical Svc. – Bayard Community Center
805 Tom Foy Blvd.
Bayard, NM 88023
Telephone: (575) 537-5068
Provider #: 98652834

Hidalgo Medical Svc. – Cobre Health Clinic
P.O. Box 1389
Bayard, NM 88023
Telephone: (575) 542-8384
Provider #: 42074878

Hidalgo Medical Svcs. – Med Square
114 West 11th Street
Silver City, NM 88061
Telephone: (575) 542-8384
Provider #: 04473876

Hidalgo Medical Svc. – Copper Medical
3185 North Leslie Rd.
Silver City, NM 88061
Telephone: (575) 388-3393
Provider #: 81582366

Hidalgo Medical Svc. - Mimbres Valley Clinic
2743 - B Hwy 35N
Mimbres, NM 88049
Telephone: (575) 536-3990
Provider #: 69173273

Hidalgo Medical Svc. - Lordsburg High School Health Center
501 W. 4th Street
Lordsburg, NM 88045
Telephone: (575) 542-3389
Provider #: 78001064

Hidalgo Medical Svc. - Silver High School Wellness Ctr.
3200 N. Silver Street
Silver City, NM 88061
Telephone: (575) 534-1015
Provider #: 11602384

Hidalgo Medical Svc. - Silver High Mental Health Clinic
301 W. College Avenue
Silver City, NM 88061
Telephone: (575) 313-8222
Provider #: 41805755

La Casa de Buena Salud, Inc.
1515 West Fir
Portales, NM 88130
Telephone: (575) 356-6695
Provider #: 48033

La Casa De Buena Salud - Chavez County Comm. H. C.
1511 South Grand
Roswell, NM 88201
Telephone: (575) 623-3255
Provider #: 70275

La Casa De Buena Salud - Manuel A. Lopez Family Health Center
1521 West 13th Street
Clovis, NM 88101
Telephone: (575) 769-0888
Provider #: 46976

03/26/2013
<table>
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<tr>
<th>Name of the Clinic</th>
<th>Address</th>
<th>City, State</th>
<th>Phone Number</th>
<th>Provider #</th>
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<tr>
<td>La Clinica de Familia Inc LLC</td>
<td>1160 Mall Dr, Ste. B</td>
<td>Las Cruces, NM 88005</td>
<td>(575) 526-1105</td>
<td>R-8197</td>
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<tr>
<td>Las Clinicas del Norte</td>
<td>P.O. Box 237</td>
<td>El Rito, NM 87530</td>
<td>(575) 581-4728</td>
<td>47704</td>
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<td>La Clinica de Familia Inc – Womens</td>
<td>385 Calle De Alegra B</td>
<td>Las Cruces, NM 88005</td>
<td>(575)526-1105</td>
<td>78225</td>
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<tr>
<td>Wellness Clinic</td>
<td></td>
<td>Las Cruces, NM 88005</td>
<td>(575) 373-9202</td>
<td>K-6652</td>
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<td>La Clinica de Familia East Inc – Mesa Clinic</td>
<td>8600 Bataan Memorial East</td>
<td>Las Cruces, NM 88012</td>
<td>(575) 526-1105</td>
<td>47552</td>
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<tr>
<td>La Clinica de Familia Inc</td>
<td>510 E. Lisa Drive</td>
<td>Chaparral, NM 88081</td>
<td>(575) 526-1105</td>
<td>R-8204</td>
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<td>La Clinica de Familia Inc</td>
<td>2625 McNutt Road</td>
<td>Sunland Park, NM 88063</td>
<td>(575) 526-1105</td>
<td>48025</td>
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<tr>
<td>La Clinica de Familia Inc</td>
<td>855 Anthony Drive</td>
<td>Anthony, NM 88021</td>
<td>(575) 526-1105</td>
<td>48025</td>
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<tr>
<td>La Clinica de Familia Inc</td>
<td>18424 S. Hwy 28</td>
<td>San Miguel, NM 88058</td>
<td>(575) 526-1105</td>
<td>48215</td>
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<tr>
<td>La Clinica de Familia Inc</td>
<td>1160 Mall Drive</td>
<td>Las Cruces, NM 88011</td>
<td>(575) 521-7181</td>
<td>74481</td>
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<td>Las Clinicas del Norte – Abiqui</td>
<td>P.O. Box 757 Hwy 84 #185</td>
<td>Abiqui, NM 87510</td>
<td>(575) 685-4479</td>
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<td>Las Clinicas del Norte – Ojo Caliente</td>
<td>Hwy 285, Bldg. 35282</td>
<td>Ojo Caliente, NM 87519</td>
<td>(505) 583-2191</td>
<td>70311</td>
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<td>La Clinica del Pueblo de Rio Arriba</td>
<td>#14 County Rod 0324 US Hwy 84</td>
<td>Tierra Amarilla, NM 87575</td>
<td>(575) 588-7252</td>
<td>50740</td>
</tr>
<tr>
<td>La Familia Medical Center Inc</td>
<td>1035 Alto Street</td>
<td>Santa Fe, NM 87501</td>
<td>(505) 982-4425</td>
<td>F-8002</td>
</tr>
<tr>
<td>La Familia Medical Center Southside Clinic</td>
<td>2145 Caja del Oro Grant Road</td>
<td>Santa Fe, NM 87507</td>
<td>(505) 982-4599</td>
<td>B-3367</td>
</tr>
<tr>
<td>Mora Valley Community Health Services Inc</td>
<td>State Hwy 518 MM 26</td>
<td>Mora, NM 87732</td>
<td>(575) 387-2201</td>
<td>48504</td>
</tr>
<tr>
<td>Pecos Valley Medical Center Inc</td>
<td>P.O. Box 710 Hwy 50</td>
<td>Pecos, NM 87552</td>
<td>(505) 757-6482</td>
<td>46623</td>
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<td>Pine Hill Health Center</td>
<td>BIA Rt. 125, M P 12 5</td>
<td>Pine Hill, NM 87357</td>
<td>(505) 775-3271</td>
<td>S-1396</td>
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<tr>
<td>PMS – Artesia Health Resources</td>
<td>1105 Memorial Drive</td>
<td>Artesia, NM 88210</td>
<td>(575) 746-9848</td>
<td>F-4902</td>
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<td>Provider Name</td>
<td>Address</td>
<td>City, State Zip</td>
<td>Telephone</td>
<td>Provider #</td>
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<td>PMS - Capital High Teen Health Ctr.</td>
<td>4851 Paseo Del Sol</td>
<td>Santa Fe, NM 87507</td>
<td>(505) 467-1081</td>
<td>70935521</td>
</tr>
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<td>PMS - Carlsbad Family Health Center</td>
<td>2013 San Jose Blvd.</td>
<td>Carlsbad, NM 88220</td>
<td>(505) 887-2455</td>
<td>50419</td>
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<td>PMS - Catron County Clinic</td>
<td>1 Foster Lane</td>
<td>Reserve, NM 87830</td>
<td>(505) 533-6456</td>
<td>51839</td>
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<tr>
<td>PMS - Counselor Clinic</td>
<td>9837 State Hwy 44</td>
<td>Counselor, NM 87018</td>
<td>(505) 568-4328</td>
<td>48322</td>
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<tr>
<td>PMS - Cuba Health Center</td>
<td>6349 Hwy 44</td>
<td>Cuba, NM 87013</td>
<td>(505) 289-3291</td>
<td>47209</td>
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<td>PMS - Deming Health Center</td>
<td>300 S. Diamond Ave.</td>
<td>Deming, NM 88030</td>
<td>(505) 982-5565</td>
<td>39850081</td>
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<td>PMS - Deming School Based Health Center</td>
<td>501 W. Florida</td>
<td>Deming, NM 88030</td>
<td>(505) 546-8841</td>
<td>91408024</td>
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<td>PMS - Esperanza Family Health Center</td>
<td>903C 5th Street</td>
<td>Estancia, NM 87106</td>
<td>(505) 384-2777</td>
<td>48058</td>
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<tr>
<td>PMS - Farmington Community Health Center</td>
<td>1001 W. Broadway Ste. D</td>
<td>Farmington, NM 87401</td>
<td>(505) 327-4796</td>
<td>44933</td>
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<tr>
<td>PMS - Hobbs Family Health Center</td>
<td>200 W. Lea</td>
<td>Hobbs, NM 88240</td>
<td>(575) 820-3466</td>
<td>11689803</td>
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<tr>
<td>PMS - Jemez Valley Medical Clinic</td>
<td>8372 State Hwy 4</td>
<td>Canyon, NM 87024</td>
<td>(575) 834-0802</td>
<td>47944</td>
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<tr>
<td>PMS - Loving Clinic</td>
<td>602 S 4th Street</td>
<td>Loving, NM 88256</td>
<td>(575) 745-3573</td>
<td>50361</td>
</tr>
<tr>
<td>PMS - Magdalena Area Health Center</td>
<td>108 N. Main</td>
<td>Magdalena, NM 87825</td>
<td>(575) 854-3161</td>
<td>Z-5896</td>
</tr>
<tr>
<td>PMS - Mountainair Family Health</td>
<td>105 E. Piñon Street</td>
<td>Mountainair, NM 87036</td>
<td>(505) 847-2271</td>
<td>S-7556</td>
</tr>
<tr>
<td>PMS - Ojo Encino Clinic</td>
<td>#2 Ojo Encino Chapter Road</td>
<td>Cuba, NM 87013</td>
<td>(505) 731-2268</td>
<td>48421</td>
</tr>
<tr>
<td>PMS - Ortiz Mountain Health Center</td>
<td>08A Main Street</td>
<td>Cerrillos, NM 87010</td>
<td>(505) 471-6266</td>
<td>F-4919</td>
</tr>
<tr>
<td>PMS - Quay County Family Health Center</td>
<td>1302 E. Main Street</td>
<td>Tucumcari, NM 88401</td>
<td>(575) 461-2200</td>
<td>87001284</td>
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<tr>
<td>PMS - Questa Health Center</td>
<td>2537 State Hwy 522</td>
<td>Questa, NM 87556</td>
<td>(575) 586-0322</td>
<td>47225</td>
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03/26/2013
PMS - Rio Rancho Family Health Center
184 Unser Blvd NE
Rio Rancho, NM 87124
Telephone: (505) 896-0928
Provider #: J-4492

PMS - Santa Fe High Teen Health Center
2100 Yucca Street
Santa Fe, NM 87505
Telephone: (505) 467-2439
Provider #: 51672821

PMS - Socorro Community Health Center
1300 Enterprise
Socorro, NM 87801
Telephone: (575) 835-4444
Provider #: 31637809

PMS - Sacramento Mountain Health Center
102 Hwy 82
Cloudcroft, NM 88317
Telephone: (575) 682-2542
Provider #: S-7573

PMS - Santa Fe Community Guide Center
820 Paseo de Peralta
Santa Fe, NM 87501
Telephone: (505) 986-9633
Provider #: 70298

PMS - Torreon Clinic
2500 State Hwy 197
Torreon, NM 87013
Telephone: (505) 731-2284
Provider #: 48439

PMS - Tularosa Health Center
111 Central Avenue
Tularosa, NM 88352
Telephone: (575) 585-1250
Provider #: S-7585

PMS - Western NM Medical Group - Gallup
610 N 5th Street
Gallup, NM 87301
Telephone: (505) 863-3120
Provider #: 50526

PMS - Western NM Medical Group - Grants
1217 Bonita Street
Grants, NM 87020
Telephone: (505) 287-2958
Provider #: 43620

PMS - Western NM Medical Group - Thoreau
15 Navarre Blvd
Thoreau, NM 87323
Telephone: (505) 862-7417
Provider #: 50162

03/26/2013
RHC CONTACT LIST

Memorial Family Practice
at Artesia General
702 N. 13th Street
Artesia, NM 88210
Telephone: (575) 746-3119
Provider #: 79708

Carrizozo Health Center
710 Avenue E
Carrizozo, NM 88301
Phone #: (575) 648-2317
Provider #: 47894

Corona Health Clinic
471 Main Street
Corona, NM 88318
Telephone: (505) 849-1561
Provider #: 07773242

Eunice Health Clinic
1109 Main Street
Eunice, NM 88231
Telephone: (575) 394-1091
Provider #: 21877050

Holy Cross Hospital Rural
#24 Hwy 73
Peñasco, NM 87553
Phone #: (575) 587-1833
Provider #: S-5239

Lovingston Clinic Nor-Lea Hospital
1600 A North Main
Lovington, NM 88260
Phone #: (575) 396-3529
Provider #: F-3295

Muleshoe Family Medicine Clinic
701 S. 1st Street
Muleshoe, Texas 79347
Telephone: (806) 272-7531
Provider #: J-6125

Sierra Vista Community Health Center
800 E. 9th Avenue
T or C, NM 87901
Telephone: (575) 894-3221
Provider #: 39804577

Tatum Medical Building
204 N. Main
Tatum, NM 88267
Phone #: (575) 398-2111
Provider #: 45260

Union County Medical Center
P.O. Box 565
Clayton, NM 88415
Phone #: (505) 374-8313
Provider #: 45785

Valley Health Clinic
116 E. 2nd Street
Dexter, NM 88230
Phone #: (575) 622-1309
Provider #: S-3929

03/26/13
APPENDIX 2
ACKNOWLEDGEMENT OF RECEIPT FORM

In acknowledgement of receipt of this Request for Proposals, the undersigned agrees that he / she has received a complete copy, beginning with the title page and table of contents, and ending with Appendix 10.

The acknowledgement of receipt should be signed and returned to the Procurement Manager no later than 2:00 p.m. Mountain Standard Time on the date as described in Section II, A. Sequence of Events. Only potential Offerors who elect to return this form completed with the indicated intention of submitting a proposal will receive copies of all Offeror written questions and the Department’s written responses to those questions as well as RFP amendments, if any are issued.

FIRM:__________________________________________________________

REPRESENTED BY:________________________________________________

TITLE:_________________________________ PHONE NO:________________________

E-MAIL________________________________ FAX NO:________________________

ADDRESS: ___________________________________________________________________

CITY: _________________________________ STATE: ________ ZIP CODE: ______________

SIGNATURE: __________________________________________ DATE: ___________________

This name and address will be used for all correspondence related in the Request for Proposals.

Firm does / does no (circle one) intend to respond to this Request for Proposals.

Mailed requests should be sent to the post office box address at:

Melissa Lopez – Procurement Manager
New Mexico Human Services Department
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM  87504-2348
Telephone Number: (505) 476-7030
Fax Number:  (505) 827-7236

All deliveries via express carrier should be address to:

Melissa Lopez – Procurement Manager
New Mexico Human Services Department
Medical Assistance Division
Ark Plaza Building, Room B-100
2025 S. Pacheco Street
Santa Fe, NM  87505
APPENDIX 3

PROVIDER POLICIES
HOSPITAL SERVICES

and

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
INPATIENT HOSPITAL SERVICES
INDEX

8.311.2 HOSPITAL SERVICES

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8.311.2 NMAC INDEX

INDEX
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8.311.2.1 ISSUING AGENCY: Human Services Department (HSD).

[8.311.2.1 NMAC - Rp/E, 8 NMAC 4.MAD.000.1, 1/1/09]

8.311.2.2 SCOPE: This rule applies to the general public.

[8.311.2.2 NMAC - Rp/E, 8 NMAC 4.MAD.000.2, 1/1/09]

8.311.2.3 STATUTORY AUTHORITY: 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.

[8.311.2.3 NMAC - Rp/E, 8 NMAC 4.MAD.000.3, 1/1/09; A, 11/1/10]

8.311.2.4 DURATION: Permanent

[8.311.2.4 NMAC - Rp/E, 8 NMAC 4.MAD.000.4, 1/1/09]

8.311.2.5 EFFECTIVE DATE: January 1, 2009, unless a later date is cited at the end of a section.

[8.311.2.5 NMAC - Rp/E, 8 NMAC 4.MAD.000.5, 1/1/09]

8.311.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.

[8.311.2.6 NMAC - Rp/E, 8 NMAC 4.MAD.000.6, 1/1/09; A, 11/1/10]

8.311.2.7 DEFINITIONS: [RESERVED]

8.311.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.311.2.8 NMAC - Rp/E, 8 NMAC 4.MAD 002, 1/1/09; A, 11/1/10; A, 2/1/12]

8.311.2.9 HOSPITAL SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings.

[8.311.2.9 NMAC - Rp/E, 8 NMAC 4.MAD 721, 1/1/09; A, 11/1/10]

8.311.2.10 ELIGIBLE PROVIDERS Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider’s responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital:
   (1) licensed by the New Mexico department of health (DOH), and
   (2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));
C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see 8.321.2 NMAC, Inpatient Psychiatric Care in Free-Standing Hospital;

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

[8.311.2.11 NMAC - Rp/E, 8 NMAC 4.MAD 721.1, 1/1/09; A, 11/1/10]

8.311.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, as well as current program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient’s enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, General Provider Policies.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed between the provider and MCOs when the provider enters into contracts with MCOs contracting with HSD for the provision of managed care services to the MAD population.

1. If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, 100 percent of the “applicable reimbursement rate” based on the provider type for services rendered under both emergency and non-emergency situations.

2. The “applicable reimbursement rate” is defined as the rate paid by HSD to the provider participating in medicaid or other medical assistance programs administered by HSD and excludes disproportionate share hospital and medical education payments.

D. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor’s instructions for billing and for authorization of services.

[8.311.2.11 NMAC - Rp/E, 8 NMAC 4.MAD.721.2, 1/1/09; A, 11/1/10]

8.311.2.12 COVERED SERVICES MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.

[8.311.2.12 NMAC - Rp/E, 8 NMAC 4.MAD 721.3, 1/1/09; A, 11/1/10]

8.311.2.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. It is the provider’s responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor’s instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. A procedure that requires prior authorization is primarily one for which the medical necessity may be uncertain, which may be for cosmetic purposes, or which may be of questionable effectiveness or long-term benefit.

8.311.2 NMAC
(1) All transfers from one acute care DRG reimbursed hospital to another DRG reimbursed hospital.
(2) All inpatient stays for a PPS-exempt psychiatric unit of a general acute care hospital requires admission and continued stay reviews.
(3) All inpatient stays in a rehabilitation hospital, a PPS-exempt rehabilitation unit in a general acute care hospital, and an extended care or other specialty hospital requires admission and continued stay reviews.
(4) Outpatient physical, occupational, and speech therapies services require prior authorization.
(5) Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. A provider must verify that an individual is eligible for the MAD services at the time services are furnished and determine if an eligible recipient has other health insurance.

C. Consideration: A provider who disagrees with a prior authorization request denial or another review decision may request a re-review and a reconsideration. See MAD-953, Reconsideration of Utilization Review Decisions.

8.311.2.13 INPATIENT SERVICES: MAD coverage of some inpatient services may be conditional or limited.

A. Medically warranted days: A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. Awaiting placement days:
(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).
(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.
(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, Prior Authorization and Utilization Review. A separate claim form must be submitted for awaiting placement days.
(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits or, in the case of the eligible recipient under 21 years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in these limitations.

C. Private rooms: A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. Services performed in an outpatient setting: MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.
(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.
(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. Observation stay: If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.
(1) The following are exemptions to the general observation stay definition:
   (a) the eligible recipient dies;
   (b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;
(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one- or two-day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953, Reconsideration of Utilization Review Decisions.

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. **Review of hospital admissions:** All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. **Non-covered services:** MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765, Experimental or Investigational Procedures or Therapies;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. **Covered services in hospitals certified for emergency services-only:** Certain inpatient and outpatient services may be furnished by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services-only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.
Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HSD. No retroactive adjustments are made.

I. **Patient self determination act:** An adult eligible recipient must be informed of his right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, General Provider Policies.

J. **Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals:** Services furnished to an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may be waived when all of the following conditions are met:

1. the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; and
2. at the time of admission, a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located; and
3. another facility which is able to furnish a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and
4. the admission is for stabilization only and transfer arrangements to the care of a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. **Reimbursement for inpatient services:** MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services.

1. All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies; an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.
2. A physician’s services are not reimbursed to a hospital under Hospital Services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, Medical Services Providers, for information on the professional component of services.
3. Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.
   a. Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.
   b. Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, Transportation Services.

L. **Reimbursement limitations for capital costs:** Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

1. The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.
2. The cost of construction is expected to include only the cost of buildings and fixed equipment.
3. A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC – Rp/E, 8 NMAC 4.MAD 721.5, 1/1/09; A, 11/1/10]

**8.311.2.15 OUTPATIENT SERVICES:** MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.
A. **Outpatient covered services:** Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization.*

B. **Outpatient noncovered services:** MAD does not cover the following specific outpatient benefits:

1. outpatient hospital services not considered medically necessary for the condition of the eligible recipient;
2. outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;
3. outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;
4. experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies;*
5. drugs classified as "ineffective" by the federal food and drug administration;
6. laboratory specimen handling or mailing charges; and
7. formal educational or vocational services which relate to traditional academic subjects or training for employment.

C. **MCO payment rates:** If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HSD to the provider participating in Medicaid or other medical assistance programs administered by HSD and excludes disproportionate share hospital and medical education payments.

D. **Prior authorization:** Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization.

E. **Reimbursement for outpatient services:** Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed services are based on the medicare ambulatory payment classification (APC) methodology.

1. Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.
2. Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services.*
3. For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider’s reported cost to charge ratio reported in the provider’s most recently filed cost report prior to February 1, 2012.
4. For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is established by MAD. A rate of payment for providers not subject to the cost settlement process is also established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider’s cost to charge ratio reported in the provider’s most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

[8.311.2.15 NMAC - Rp/E, 8 NMAC 4.MAD 721.6, 1/1/09; A, 11/1/10; A, 2/1/12]

**8.311.2.16 EMERGENCY ROOM SERVICES:** MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the MAD program.
A. **Covered emergency services:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

B. **Retrospective review:** An emergency room service may be subject to prepayment or post-payment review. A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CFR 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient’s condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. **Prior authorization:** Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

D. **Noncovered emergency services:** MAD does not cover the following specific emergency services:

1. diagnostic and ancillary services which are not considered medically necessary as emergency services;
2. emergency services furnished to individuals who were not eligible for MAD services on the date of service;
3. experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;
4. drugs classified as "ineffective" by the federal food and drug administration; and
5. laboratory specimen handling or mailing charges.

E. **Reimbursement for emergency room service:** An emergency service furnished by an eligible provider is reimbursed as outpatient hospital services. See Subsection D of 8.311.2.15 NMAC, *reimbursement for outpatient services*.

1. An emergency room service furnished in a DRG-reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.
2. A physician’s service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.
3. A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.

HISTORY OF 8.311.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

- ISD 310.0200, Hospital Services, filed 1/9/80.
- ISD 310.0200, Hospital Services, filed 12/8/90.
- ISD 310.0200, Hospital Services, filed 12/30/81.
- ISD 310.0200, Hospital Services, filed 4/2/82.
- ISD 310.0200, Hospital Services, filed 7/8/82.
- ISD Rule 310.0200, Hospital Services, filed 4/5/83.
- ISD Rule 310.0200, Hospital Services, filed 2/15/84.
- ISD Rule 310.0200, Hospital Services, filed 4/26/84.
- ISD Rule 310.0200, Hospital Services, filed 2/21/86.
- MAD Rule 310.02, Hospital Services, filed 12/1/87.
- MAD Rule 310.02, Hospital Services, filed 4/27/88.

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MAD Rule 310.02, Hospital Services, filed 5/23/88.
MAD Rule 310.02, Hospital Services, filed 8/18/88.
MAD Rule 310.02, Hospital Services, filed 3/20/89.
MAD Rule 310.02, Hospital Services, filed 7/2/90.
MAD Rule 310.02, Hospital Services, filed 3/27/92.
MAD Rule 310.02, Hospital Services, filed 4/21/92.
MAD Rule 310.02, Hospital Services, filed 5/1/92.
MAD Rule 310.02, Hospital Services, filed 7/14/93.
MAD Rule 310.02, Hospital Services, filed 3/10/94.
MAD Rule 310.02, Hospital Services, filed 6/15/94.
MAD Rule 310.02, Hospital Services, filed 12/8/94.

History of Repealed Material:
MAD Rule 310.02, Hospital Services, filed 12/8/94 - Repealed effective 2/1/95.
8 NMAC 4.MAD.721, Hospital Services, filed 1/18/95 - Repealed effective 1/1/2009.
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
INPATIENT HOSPITAL SERVICES

ISSUING AGENCY: Human Services Department
[2-1-95; 8.311.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 1-1-01]

SCOPE: This rule applies to the general public.
[2-1-95; 8.311.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 1-1-01]

STATUTORY AUTHORITY: 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, 4-1-111

DURATION: Permanent
[2-1-95; 8.311.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 1-1-01]

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, 4-1-11]

OBJECTIVE: The objective of this rule 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, 4-1-11]

DEFINITIONS: [RESERVED]

MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by
providing support services that help families break the cycle of dependency on public assistance.
[2-1-95; 8.311.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 1-1-01; A, 4-1-11; A, 2-1-12]

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT
HOSPITAL SERVICES: The New Mexico title XIX program reimburses appropriately licensed and certified
acute care hospitals for inpatient services as outlined in this part. Procedures and policies governing state licensure,
certification of providers, utilization review and any other aspect of state regulation of the title XIX program not
relating to the method of computing payment rates for inpatient services are not affected by this part.
[2-1-95; 8.311.3.9 NMAC - Rn, 8 NMAC 4.MAD.721.D, 1-1-01]

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 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, unless the hospital or unit is classified into one of the prospective
payment system (PPS) exempt categories outlined in Subsection C through D below.

B. 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, unless the hospital or unit
is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsections 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 a unique service required by an
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Eligible recipient.

C. Inpatient services provided in rehabilitation and 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.

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

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

F. All hospitals which meet the criteria in Subsection A of 8.311.3.13 NMAC will be eligible for a
   disproportionate share adjustment.

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 one year
   of age in all hospitals. The outlier adjustment for these cases is described in Subsection F of 8.311.3.12 NMAC.

H. MAD covered inpatient services provided in specialty hospitals will be reimbursed at an interim
   rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement
   TEFRA principals. If a provider is not cost settled, the reimbursement rate will be at the provider’s cost to charge
   ratio reported in the provider’s most recently filed cost report prior to February 1, 2012. Otherwise, rates are
   established after considering available cost to charge ratios, payment levels made by other payers, and MAD
   payment levels for services of similar cost, complexity and duration.

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 MAD program and provided to eligible recipients; and

       (b) the manner of payment and the manner of settlement or overpayments and underpayment
           for inpatient services provided by hospitals for 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(a)(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, 4-1-11]

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS: Payment for all covered inpatient services rendered to eligible recipients admitted to acute care hospitals (other than those identified in Subsection C through 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 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 MAD discharge. Hospitals may not separately bill the eligible recipient or the 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 an eligible recipient or upon completion of the transfer of the 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 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 eligible recipient is transferred from one hospital to another and is admitted as an inpatient to the second hospital;
(b) physician services furnished to 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 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 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 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 MAD charge for each DRG category divided by the average charge for all DRGs.

(5) Where the New Mexico 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 the DRG grouper version similar to the one in use by
C. Computation of hospital prospective payment rates:

(1) Rebasing of rates: Beginning October 1, 1997 the department 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 MAD discharges for the provider's last fiscal year which falls in the calendar year prior to year one.

(b) The state's audit agent will provide MAD costs incurred, reported, audited, 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;

(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 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.

(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 MAD discharges to produce the base year operating cost per discharge. The base rate methodology is described below:

\[
\text{BYOR} = \frac{\text{OC}}{D}
\]

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 = 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 one, 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) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the
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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 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 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 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 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 one) and ending with the midpoint of operating year one. For years 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 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 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.

(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:

\[ \text{PGR} = \frac{\text{BYOR}}{\text{CMI}} \]

\[ \text{PGR} = \text{hospital rate equalized for peer group comparison} \]

\[ \text{BYOR} = \text{base year operating cost per discharge} \]

\[ \text{CMI} = \text{case-mix index in the base year} \]

(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 one, two and three:

**Year one**

\[ \text{PDO1} = \text{HSR} \times (1 + \text{MPPUF}) \]

\[ \text{PDO1} = \text{per discharge operating cost rate for year one} \]

\[ \text{HSR} = \text{the hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison} \]

\[ \text{MPPUF} = \text{the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.} \]

**Year two**

\[ \text{PDO2} = \text{PDO1} \times (1 + \text{MPPUF}) \]

\[ \text{PDO2} = \text{per discharge operating cost rate for year two} \]

**Year three**

\[ \text{PDO3} = \text{PDO2} \times (1 + \text{MPPUF}) \]

\[ \text{PDO3} = \text{per discharge operating cost rate for year three} \]

\[ \text{PDO2} = \text{per discharge operating cost rate for year two} \]

\[ \text{MPPUF} = \text{the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.} \]

(12) Computation of excludable cost per discharge rate: Total 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:

\[ \text{ER} = \frac{\text{ECP}}{\text{DCY}} \]

\[ \text{ER} = \text{excludable cost per discharge rate} \]

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

\[ \text{DCY} = \text{MAD discharges for the calendar year prior to the rate year, as determined by the department's fiscal agent} \]

(b) The retrospective settlement will be determined based on a percentage of the actual allowable amount of 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 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 eligible recipients in the area or b) are now provided to 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 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 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 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 an eligible recipient has been moved from one DRG acute inpatient facility to another DRG acute inpatient facility. Movement of an eligible recipient from one unit to another unit within the same hospital shall not constitute a transfer, unless the 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. 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 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 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 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 may be reviewed for medical necessity and appropriateness of care. (Discharges involving eligible recipient healthy mothers and healthy newborns are excluded from this review 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 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 MAD program is determined based only upon medical necessity for an acute level of hospital care.

(b) When it is determined that an 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, 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 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 MAD program. If for some reason, the hospital elected not to apply for sole community hospital designation under Medicare but wishes to apply for MAD purposes only, such application must be made directly to the MAD program. The 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 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 Subparagraph (c) of Paragraph (6) below. For subsequent years, the amount will be the amount calculated under Subparagraphs (c) through (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. Verification of the base year amount will be made from the official report of expenditures by each county. 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, 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 the years subsequent to the initial payment year, the sole community hospital payment adjustment will be the lesser of the hospital's payment request amount mutually agreed upon by the hospital and the county government for each year or the amount for the previous year trended forward, provided that if any year the department utilizes any portion of the funds provided by the county to make a refund to the federal government of the federal share of previous payments, the calculation of the base amount paid by the department for the previous year shall include the portion of the county transferred funds used to make the refund plus the federal share that those funds would have earned had they been used for payments to the hospital. The department will use the market basket forecast published periodically in the CMS regional medical services.

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(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 MAD per discharge rate. The medicare or MAD discharge rate will be adjusted to reflect any acuity differences that exist between the medicare and eligible recipients served. Acuity differences will be determined from the medicare and MAD case-mix indices (CMI) for MAD discharges at the hospital using medicare and 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 MAD per discharge rate shall be subtracted from the medicare per discharge rate.

(c) The difference shall be multiplied by the number of 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:

\[1.89\times((1+R)^{0.67}-1)\]

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 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 MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due.
(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 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 Subparagraph (b) of Paragraph (9) 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 MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a MAD provider, and must have achieved a MAD inpatient utilization rate of 5 percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the MAD inpatient utilization rate will be calculated as the ratio of New Mexico MAD eligible days, including inpatient days paid under MAD managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for 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 Items (i) or (ii), above.

(c) **MAD GME payment amount per resident FTE:**

(i) The annual 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. MAD will determine the percentage of funds available for GME payments to eligible hospitals.

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

(i) Total annual 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).
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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.

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 MAD inpatient utilization rate as listed below, will be done annually by the department’s audit agent, based on the hospital’s 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 MAD inpatient utilization rate greater than the mean MAD inpatient utilization rate for hospitals receiving MAD payments in the state; or
   (ii) a low-income utilization rate exceeding 25 percent; (refer to Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC for definitions of these criteria).

(b) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to eligible recipients entitled to such services under 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.

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privileges at the hospital to perform non-emergency obstetric procedures;

(iv) Item (iii) of Subparagraph (a) 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 MAD inpatient utilization rate (MUR) of one percent.

(b) Definitions of criteria:

(i) MAD inpatient utilization: For a hospital, the total number of its 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 MAD managed care and non-managed care 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 MAD inpatient and outpatient net revenues (this includes 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 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:

\[
MUR \% = \frac{100 \times M}{T}
\]

\[M = \text{Hospital's number of inpatient days attributable to eligible recipients under the MAD state plan. These include MAD managed care and non-managed care days.}
\]

\[T = \text{Hospital's total inpatient days}
\]

(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. MAD inpatient days includes both MAD managed care and non-managed care patient days.

(v) The numerator (M) does not include days attributable to recipients 21 or older in institutions for mental disease (IMD) as these patients are not eligible for MAD coverage in IMDs under the New Mexico state plan and cannot be considered a 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 Subsection A of 8.311.3.13 NMAC. Qualifying hospitals will be classified into one of three disproportionate share hospital pools: Teaching hospitals, non-teaching PHS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a fourth pool: reserve pool, as explained in this 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 PHS (DRG) hospital qualifies if it is an in-state 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.
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(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 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 Item (ii) of 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 MAD discharges. These include both 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 MAD discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools one, two, or three will be computed by dividing the number of MAD discharges for that hospital by the total number of 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 Subsection E and F of 8.311.3.13 NMAC.

(3) 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 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 (MPUF) or the DSH budget as defined by 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 MAD discharge, where N is equal to the fraction described in Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC minus 20 percent, multiplied by $1,750.

D. Request for DSH payment procedures: Hospitals must submit to the department the number of 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 B through D of 8.311.3.13 NMAC shall not exceed that hospital’s hospital-specific DSH limit, as determined under Subsection E of 8.311.3.13 NMAC. This limit is calculated as follows:

\[ \text{DSH limit} = \text{M + U} \]

\[ \text{M} = \text{Cost of services to eligible recipients, less the amount paid by the MAD program under the non-DSH payment provisions of this plan.} \]

\[ \text{U} = \text{Cost of services to uninsured patients, less any cash payments made by them.} \]

(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
Subsections C through 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, 4-1-11].

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 its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico 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 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 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 and per the auditing schedule
established by medcare. 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 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
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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 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 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, 4-1-11]

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 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, 4-1-11]

8.311.3.16 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[2-1-95; 8.311.3.16 NMAC - Rn, 8 NMAC 4.MAD.721.D.VII, 1-1-01]

HISTORY OF 8.311.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

SP-Rule 004.1901, General Program Administration Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care, 1-17-85.
SP-Rule 004.1901, Section 4, General Program Administration Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care, 7-2-85.
SP-Rule 004.1901, Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services, 8-25-86.
ISD 306.4000, Providers Protesting Certified Cost Reimbursement Rates, 1-7-80.
SP-004.1901, Section 4, General Program Administration Methods and Standards For Establishing Payment Rates - Inpatient Hospital Care, 6-10-81.
8 NMAC 4.MAD.721.D, Provider Policies, Reimbursement Methodology, Methods and Standards For Establishing Payment Rates-Inpatient Hospital Services, 1-18-95.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section IV], 1-17-96.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section IV], 7-17-97.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section III], 10-17-97.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section III], 6-15-98.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section III], 7-31-98.
8 NMAC 4.MAD.721.D., Amendment to 8 NMAC 4.MAD.721.D [Section III], 12-14-98.

History of Repealed Material: [RESERVED]
APPENDIX 4
Provider Policies
NURSING FACILITIES
AND
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED
INDEX

8.312.2 NURSING FACILITIES

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TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 2 NURSING FACILITIES

8.312.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[2/1/95; 8.312.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 6/15/10; Repealed, 10/15/12]

8.312.2.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.312.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 6/15/10; Repealed, 10/15/12]

8.312.2.3 STATUTORY AUTHORITY: 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; 8.312.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 6/15/10; Repealed, 10/15/12]

8.312.2.4 DURATION: Permanent
[2/1/95; 8.312.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 6/15/10; Repealed, 10/15/12]

8.312.2.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[2/1/95; 8.312.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 6/15/10; Repealed, 10/15/12]

8.312.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.312.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6 & A, 6/15/10; Repealed, 10/15/12]

8.312.2.7 DEFINITIONS: [RESERVED]

8.312.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[2/1/95; 8.312.2.8 NMAC - Rn, 8 NMAC 4.MAD.002 & A, 6/15/10; Repealed, 10/15/12]

8.312.2.9 NURSING FACILITIES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for services furnished in nursing facilities.
[2/1/95; 8.312.2.9 NMAC - Rn, 8 NMAC 4.MAD.731, 6/15/10; Repealed, 10/15/12]

8.312.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. nursing facilities (NF) which:
   (1) are currently licensed and certified by the department of health (DOH) to meet MAD nursing facility conditions of participation; see 42 CFR Part 483, as amended;
   (2) comply with the MAD recipients' personal funds rules;

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(3) comply with the MAD utilization review process and agree to operate in accordance with all MAD rules, including the performance of discharge planning;

(4) comply with the MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program;

B. the above requirements can be waived if the NF meets one of the following conditions:

(1) the NF is located in a rural area and is unable to attract therapists as required by the medicare program; for a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(2) the NF has obtained a waiver of the RN staffing requirement from DOH, in accordance with applicable federal regulations; or

C. services must be provided within the scope of the practice and licensure for each provider and must be in compliance with the statutes, rules and regulations of the applicable practice and with the MAD program policy manual.

8.312.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicare or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient’s enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor’s instructions for billing and for authorization of services. See 8.302.1 NMAC, General Provider Policies.

8.312.2.12 REQUIRED NURSING FACILITY SERVICES: Nursing facilities are required to provide the following to a MAD eligible recipient resident:

A. room and board;

B. professional nursing services 24 hours a day, seven days a week; professional nursing services are those services which are performed directly by a registered nurse (RN) or a licensed practical nurse (LPN), under the direction of a medical practitioner;

C. services of an RN on an eight hours a day, seven days a week basis, and at least the services of a LPN at all other times; and

D. personal assistance services on a 24 hours a day, seven days a week basis; personal assistance services are those services, other than professional nursing services, that are provided to an eligible recipient who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish activities of daily living.

8.312.2 NMAC
8.312.13 COVERED SERVICES:
   A. MAD covers NF services identified as allowable costs. See 8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities.
   B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient residing in a NF in the following manner:
      (1) if the eligible recipient is also eligible for medicare and the facility does part B billing, the co-payment or deductible is processed by MAD for services is paid by MAD;
      (2) if the eligible recipient receives high NF level services, services are included in the MAD facility rate; or
      (3) if eligible, the recipient receives low NF level services, services are billed separately by participating therapy providers.

8.312.14 NONCOVERED SERVICES: NF services are subject to the limitations and coverage restrictions which exist for other MAD services. See also 8.301.3 NMAC, General Noncovered Services; 8.312.3.11 NMAC, determination of actual, allowable and reasonable costs and setting of prospective rates; and 8.324.4 NMAC, Pharmacy Services, for covered pharmacy services which are billed directly by pharmacy providers.

8.312.15 RECIPIENT PERSONAL FUND ACCOUNTS:
   A. As a condition for MAD provider participation, each NF must establish and maintain an acceptable system of accounting for a MAD eligible recipient resident’s personal funds when a MAD eligible recipient requests that his or her personal funds be cared for by the facility. See 42 CFR Section 483.10(c). See Subsection D of 7.9.2.22 NMAC.
      (1) Requests for a NF to care or not care for an eligible recipient resident’s funds must be made in writing and secured by a request to handle recipient funds form or letter signed by the eligible recipient or his or her authorized representative. The form or letter is kept in the eligible recipient’s file at the facility.
      (2) An eligible recipient’s personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient resident receives any income in excess of this allowance, the excess is applied to the cost of the eligible recipient resident’s medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.
      (3) A NF must have procedures on the handling of eligible recipient residents’ funds. These procedures must not allow the facility to commingle eligible recipient residents’ funds with facility funds.
      (4) A NF should use these applicable federal regulations and state rules to develop procedures for handling resident funds.
      (5) An eligible recipient resident has the right to manage his/her financial affairs and no facility can require an eligible recipient resident to deposit his/her personal funds with the facility.
      (6) A NF must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the facility.
      (7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.
   B. Fund custodians: A NF must designate a full-time employee and an alternate to serve as fund custodians for handling an eligible recipient resident’s money on a daily basis. See Subsection D of 7.9.2.22 NMAC.
      (1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:
         (a) reconcile balances of each eligible recipient’s accounts with the collective bank account;
         (d) periodically audit and reconcile the petty cash fund; and
         (c) authorize checks for the withdrawal of funds from the bank account.
      (2) A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident’s personal funds entrusted to facilities on the eligible recipient resident’s behalf.
C. **Bank account:** A NF must establish a bank account for the deposit of all money for each eligible recipient resident who requests the NF to handle his or her funds. An eligible recipient’s personal funds are to be held separately and not commingled with the NF funds. See Subsection D of 7.9.2.22 NMAC.

   (1) A NF must deposit an eligible recipient resident’s personal funds of more than $50 dollars in an interest bearing account that is separate from any of the NF operating accounts and which credits all interest earned on the eligible recipient resident’s account to that account. An eligible recipient resident must have convenient access to these funds.

   (2) A NF must maintain an eligible recipient resident’s personal funds up to $50 in an interest bearing account or a petty cash fund that is separate from any of the NF operating accounts. An eligible recipient resident must have convenient access to these funds.

   (3) Individual financial records must be available on the request of an eligible recipient resident or his or her legal representative.

   (4) Within 30 calendar days of the death of an eligible recipient resident whose personal funds are deposited with the facility, a NF must convey the deceased eligible recipient resident’s funds and a final accounting of these funds to the individual or probate jurisdiction administering the deceased eligible recipient resident’s estate.

D. **Establishment of individual accounts:** A NF must establish accounts for each eligible recipient resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or looseleaf binder. See Subsection D of 7.9.2.22 NMAC.

   (1) For money received, the source, amount and date must be recorded. The NF must provide the eligible recipient resident or his/her representative receipts for the money. The NF retains a copy of the deposit in the eligible recipient resident’s individual account file.

   (2) The purpose, amount and date of all disbursements to or on behalf of an eligible recipient resident must be recorded. All money spent either on behalf of the eligible recipient resident or withdrawn by the eligible recipient resident or his/her representative must be validated by receipts or signatures on each eligible recipient resident’s individual ledger sheet.

   (3) The NF must notify each eligible recipient resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the eligible recipient resident’s other nonexempt resources reach the SSI resource limit for one person, the eligible recipient resident can lose eligibility for medicaid or SSI.

E. **Personal fund reconciliation:** The NF must balance each eligible recipient resident’s individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish each eligible recipient resident or his/her representative with an accounting of the eligible recipient residents’ funds at least quarterly. Copies of each eligible recipient resident’s individual account records can be used to furnish this information. See Subsection D of 7.9.2.22 NMAC.

F. **Petty cash fund:** The NF must maintain a cash fund in the facility to accommodate the small cash requirements of an eligible recipient resident. Five dollars or less per each eligible recipient resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of NF residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund. See Subsection D of 7.9.2.22 NMAC.

   (1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

   (2) To use the petty cash fund, the following procedures should be established:
      
   (a) an eligible recipient resident or his/her authorized representative request small amounts of spending money;

   (b) the amount disbursed is entered on each eligible recipient resident’s individual ledger record; and

   (c) the eligible recipient resident or his/her representative signs an account record and receives a receipt.

   (3) To replenish the petty cash fund, the following procedures should be used.
      
   (a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

   (b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

   (4) To reconcile the fund, the following procedures should be used once each month:
      
   (a) count money at hand; and
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(b) total cash disbursed either from receipts or each eligible recipient resident’s individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close each eligible recipient resident account, the NF should do the following:
(a) enter date of and reason for closing the account;
(b) write a check against the collective bank account for the balance shown on each eligible recipient resident’s individual account record;
(c) get signature of the eligible recipient resident or his/her authorized representative on the eligible recipient resident’s individual account record, as receipt of payment; and
(d) notify the local ISD office if closure is caused by death of an eligible recipient resident so that prompt action can be taken to terminate assistance; within 30 days of the death of an eligible recipient resident who has no relatives, the NF conveys the eligible recipient resident’s funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident’s estate. See 42 CFR Section 483.10(c)(6).

G. Retention of records: All account records are retained for at least six years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of residents’ personal funds: Non-acceptable uses of an eligible recipient resident’s personal funds include the following:
(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs; see 8.312.3.11 NMAC, determination of actual, allowable and reasonable costs and setting of prospective rates;
(2) difference between the NF’s billed charge and the MAD payment; and
(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns;
(4) a NF cannot impose charges against eligible recipient resident’s personal funds for any item or service for which payment is made by MAD or for any item the eligible recipient resident or his/her representative did not request;
(5) a NF must not require eligible recipient resident or his/her representative to request any item or service as a condition of admission or continued stay;
(6) a NF must inform an eligible recipient resident or his/her representative who requests noncovered items or services that there is a charge for the item and the amount of the charge.

I. Monitoring of residents’ personal funds: NPs must make all files and records involving an eligible recipient resident’s personal funds available for inspection by authorized state or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient resident’s personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected. See Subsection D of 7.9.2.22 NMAC.

[2/1/95; 8.312.2.15 NMAC - Rn, 8 NMAC 4.MAD.731.6, 6/15/10; Repealed, 10/15/12]

8.312.2.16 RESERVE BED DAYS: MAD pays to hold or reserve a bed for an MAD eligible recipient resident in a NF to allow for the eligible recipient resident to make a brief home visit, for acclimation to a new environment, or for hospitalization according to the limits and conditions outlined below.

A. Coverage of reserve bed days: MAD covers six reserve bed days per calendar year for every long term care eligible recipient resident for hospitalization without prior approval. MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. MAD covers an additional six reserve bed days per calendar year with prior approval to support a MAD eligible recipient resident to adjust to a new environment as part of the discharge plan.

(1) An eligible recipient resident’s discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.
(2) The prior approval request must include the eligible recipient resident’s name, medicaid identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient resident during the visit or placement and a written medical order for trial placement.

B. Documentation of reserve bed days: When an eligible recipient resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient resident’s chart. A medical order must be obtained if the eligible recipient resident is hospitalized, requests a home visit or a trial placement.

C. Level of care determinations: A new level of care determination must be performed by the MAD utilization review (UR) contractor if an eligible recipient resident is gone from the NF for more than three midnights. An abstract must be completed, including information on the reason for the eligible recipient resident’s absence, outcome of the leave and any other pertinent information concerning the leave.

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D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for the level of care medically necessary for the eligible recipient resident, as determined and approved by MAD or its designee. The reserve bed day reimbursement is equal to 50 percent of the regular payment rate for MAD fee-for-service or as otherwise negotiated between the NF provider and the MAD designated contractor. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. MAD or its designated contractor, pays for the admission day but not for the discharge day.

8.312.2.17 LEVEL OF CARE DETERMINATION: Medical necessity, level of care, and length of stay determinations are carried out in accordance with MAD utilization review (UR) policy and procedures, as authorized under Title XIX of the Social Security Act. See 8.302.5 NMAC, Prior Authorization and Utilization Review, and 8.350.4 NMAC, Reconsideration of Audit Settlements.

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS: As part of the initial abstract for a new admission or as part of a subsequent specified review as determined by PASRR, or a significant change review as indicated by the minimum data set (MDS) for an eligible recipient resident with identified mental illness or intellectually challenged, the NF must complete a level I PASRR screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42CFRSection 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. Pre-admission screens not required: Pre-admission screens do not need to be performed on the following eligible recipient resident:
   (1) when admitted from the hospital whose attending physicians certify before admission to the NF that the eligible recipient resident is likely to require NF care for less than 30 days (as determined by PASRR review of the his or her level I screen data prior to NF admission);
   (2) when readmitted to NFs from hospitals to which he/she was transferred for the purpose of receiving care; and
   (3) when transferred from one NF to another without an intervening hospital stay.

B. Purpose of the screens: The purpose of the PASRR screen is to determine whether residents have a mental illness or an intellectual disability, need the level of services furnished in a NF and need specialized services based on the mental illness or intellectual disability. A NF performs the level I screen which identifies an eligible recipient resident who has a mental illness or an intellectual disability. When an eligible recipient resident is identified, the NF refers him or her to the developmental disabilities division of DOH for a PASRR level II evaluation.

C. Level II screen determination: The PASRR level II screen determines the following:
   (1) the eligible recipient resident’s total needs are such that his or her needs can be met in an appropriate community setting;
   (2) the eligible recipient resident’s total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;
   (3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or
   (4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the eligible recipient resident’s needs, another setting, such as an intermediate care facility for the intellectually disabled can be indicated.

D. Right to an administrative hearing: Residents who believe that an erroneous determination was made with regard to the PASRR can request administrative hearings. See 8.354.2 NMAC, PASRR and Patient Status Hearings, for more information. The NF must provide notice to an eligible recipient resident of proposed transfers or changes of status. The notice must inform an eligible recipient resident of his or her right to request a hearing, the method by which a hearing can be requested and his or her right to present evidence in person or through representatives. An eligible recipient resident who requests a hearing has 90 calendar days after the date of the notice to request a hearing. Within 60 days of receipt of the request for a hearing, the hearing is conducted, decisions reached and notice furnished to the eligible recipient resident and the NF.

E. Restriction on reimbursement for medicaid residents: A NF is not reimbursed for any service furnished to an eligible recipient resident when pre-admission screens, subsequent specified reviews or significant

8.312.2 NMAC
change reviews are not performed in a timely manner. MAD pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to a NF during periods of noncompliance. MAD payment for services does not begin until a Level II screening has been performed, if applicable.

[2/1/95; 8.312.2.18 NMAC - Rn, 8 NMAC 4.MAD.731.9, 6/15/10; Repealed, 10/15/12]

**8.312.2.19 MINIMUM DATA SET:**

A. A long term care facility participating in the medicare and the MAD program is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment describes the resident's ability to perform daily life functions and any significant impairments in functional capacity. The assessment is based on a uniform minimum data set (MDS) of core elements and common definitions specified by the secretary of the federal health and human services department. A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient residents who may be interested in transitioning back to his or her community.

- (1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.
- (2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done electronically.

[2/1/95; 8.312.2.19 NMAC - Rn, 8 NMAC 4.MAD.731.10, 6/15/10; A, 10/1/12]

**8.312.2.20 MEDICAL CARE CREDITS:** If [a] an eligible recipient resident has income beyond the maintenance allowance, MAD reimburses the NF for the difference between the NF’s reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements also apply to co-payments and deductibles for medicare crossover payments.

[2/1/95; 8.312.2.20 NMAC - Rn, 8 NMAC 4.MAD.731.11, 6/15/10; Repealed, 10/15/12]

**8.312.2.21 NURSE AIDE TRAINING:** A NF must comply with nurse aide training requirements as a condition of MAD participation. See 42 CFR Section 483 Subpart D. The NF will not be approved if the NF has been out of compliance with federal requirement within the previous two calendar years.

A. **Requirements for nurse aide training:** A NF cannot employ individuals as nurse aides for more than four months unless they have completed a nurse aide training and competency evaluation program (NATCEP). The NATCEP program must have a minimum duration of 75 hours.

- (1) A nurse aide who has not performed nursing or nursing-related services for monetary compensation for a period of 24 consecutive months since completion of a NATCEP must take either a new NATCEP or a new competency evaluation program (CEP).
- (2) A NF must not use temporary nurse aides who have not completed a NATCEP or a CEP.
- (3) A NF must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. A NF must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for MAD eligible recipient residents.
- (4) A NF must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. **Other nurse aide requirements:** A NF must not employ individuals who have been convicted by the court of abuse or neglect of any NF residents or misappropriation of any NF residents' property.

C. **Nurse aide registry:** DOH maintains a registry of all nursing aides who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by the state.

[2/1/95; 8.312.2.21 NMAC - Rn, 8 NMAC 4.MAD.731.12, 6/15/10; Repealed, 10/15/12]

**8.312.2.22 PATIENT SELF DETERMINATION ACT:** All adult eligible recipient residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, General Provider Policies.

[2/1/95; 8.312.2.22 NMAC - Rn, 8 NMAC 4.MAD.731.13, 6/15/10; Repealed, 10/15/12]
8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: A MAD eligible recipient resident who believes that the NF has erroneously determined that he or she should be transferred or discharged can request an HSD administrative hearing. A NF must provide an eligible resident notice of the proposed transfer or discharge. The notice must inform the eligible recipient of his or her right to request a hearing, the method by which a hearing can be requested and his or her right to present evidence in person or through his or her representatives. See 8.352.2 NMAC, Recipient Hearings. [2/1/95; 8.312.2.23 NMAC - Rn, 8 NMAC 4.MAD.731.14, 6/15/10; Repealed, 10/15/12]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. Prior approval: Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. See Subsection A of 8.311.2.16 NMAC, emergency room services.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review. See 8.350.2 Reconsideration of Utilization Review Decisions. [2/1/95; 8.312.2.24 NMAC - Rn, 8 NMAC 4.MAD.731.15, 6/15/10; Repealed, 10/15/12]

8.312.2.25 REIMBURSEMENT: Nursing facility providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See 8.302.2 NMAC, Billing for Medicaid Services.

A. MAD reimburses a NF at the lesser of the following:

1. the NF's billed charges;
2. the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities; and
3. the NF's billed charge must be their usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. Reimbursement limitations: Payments are made only to a NF which meets the conditions for participation, specified in this section. Payments to a NF are limited to those service costs which are included as allowable costs under approved provisions of the state plan. See 8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities. All claims for payment from MAD are subject to utilization review and control.

C. Reimbursement methodology: See 8.312.3 NMAC, Cost Related Reimbursement of Nursing Facilities. [2/1/95; 6/1/98; 8.312.2.25 NMAC - Rn, 8 NMAC 4.MAD.731.16, 6/15/10; Repealed, 10/15/12]

HISTORY OF 8.312.2 NMAC:
Pre- NMAC History: The material in this part was derived from that previously filed with the State Records Center: ISD 310.0300, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 2/27/80. MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 12/1/87. MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 1/6/88. MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92.
SP-004.1903, Section 4, General Program Administration Reserve Beds, filed 6/10/81.
SP-004.1101, Section 4, General Program Administration Standards for Institutions, filed 6/26/81.

8.312.2 NMAC
NURSING FACILITIES

History of Repealed Material:
MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/92 - Repealed effective 2/1/95.
8.312.2 NMAC, Nursing Facilities, filed 5-27-2010 - Repealed effective 10-15-2012
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8.313.2 NMAC

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ISSUING AGENCY: Human Services Department, Medical Assistance Division
[2-1-95; 8.313.2.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11-1-00]

SCOPE: This rule applies to the general public.
[2-1-95; 8.313.2.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11-1-00]

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-
[2-1-95; 8.313.2.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11-1-00]

DURATION: Permanent
[2-1-95; 8.313.2.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11-1-00]

EFFECTIVE DATE: February 1, 1995.
[2-1-95; 8.313.2.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11-1-00]

OBJECTIVE: The objective of these regulations is to govern the service portion of the New
Mexico medicaid and medical assistance programs. These policies describe eligible providers, covered services,
noncovered services, utilization review, and provider reimbursement.
[2-1-95; 8.313.2.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11-1-00; A, 5-1-07]

DEFINITIONS: [RESERVED]
[8.313.2.7 NMAC - N, 11-1-00]

MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD)
is to maximize the health status of HSD/MAD program eligible individuals by furnishing payment for quality health
services at levels comparable to private health plans.
[2-1-95; 8.313.2.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11-1-00; A, 5-1-07]

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED: The New
Mexico medicaid program (medicaid) pays for medically necessary health services furnished to recipients, including
services furnished by intermediate care facilities for the mentally retarded [42 CFR 440.150]. This section
describes eligible providers, covered services, service restrictions, personal fund accounts, and general
reimbursement methodology.
[2-1-95; 8.313.2.9 NMAC - Rn, 8 NMAC 4.MAD.732, 11-1-00]

ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by
New Mexico medical assistance division (MAD), intermediate care facilities for the mentally retarded (ICF-MR)
which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible
medicaid recipients:

1. the ICF-MR must be licensed and certified by the division of health improvement, health facility
licensing and certification bureau of the New Mexico department of health (DOH) to meet the intermediate care
facility requirements. See 42 CFR 483 Subpart I;

2. the ICF-MR must comply with 8.313.2.17 NMAC, Recipient Personal Fund Accounts;

3. the ICF-MR must participate in the MAD utilization review process and must agree to operate in
accordance with all policies and procedures of that system, including the performance of discharge planning.

B. Once enrolled, providers receive instruction on how to access medicaid and other medical
assistance provider program policies, billing instructions, utilization review instructions, and other pertinent
material. It is the provider’s responsibility to access these instructions or ask for paper copies to be provided, to
understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement. 

[2-1-95; 8.313.2.10 NMAC - Rn, 8 NMAC 4.MAD.732.1, 11-1-00; A, 5-1-07]

**8.313.2.11 APPEALS PROCESS FOR DENIAL, TERMINATION OR NON-RENEWAL OF PARTICIPATION:** See Section MAD-967.5, Appeals for Denial, Termination, or Non-Renewal of Provider Participation.

[2-1-95; 8.313.2.11 NMAC - Rn, 8 NMAC 4.MAD.732.11, 11-1-00]

**8.313.2.12 SANCTIONS AND PENALTIES:** See Section MAD-967, Sanctions for Non-Compliance and Section MAD-968, Intermediate Remedies.

[2-1-95; 8.313.2.12 NMAC - Rn, 8 NMAC 4.MAD.732.12, 11-1-00]

**8.313.2.13 PROVIDER RESPONSIBILITIES:**
A. Providers who furnish services to HSD/MAD program eligible recipients must comply with all specified HSD/MAD participation requirements. See Section MAD-701, General Provider Policies.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain any and all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section MAD-701, General Provider Policies.

[2-1-95; 8.313.2.13 NMAC - Rn, 8 NMAC 4.MAD.732.2, 11-1-00; A, 5-1-07]

**8.313.2.14 REQUIRED SERVICES:** Medicaid does not reimburse ICFs-MR for furnishing services, unless they provide at least the following, see 42 CFR 483.440(a):

A. room and board;
B. continuous active treatment program, including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the following:
   1. acquisition of the behaviors necessary for the recipient to function with as much self determination and independence as possible; and
   2. prevention or deceleration of regression or loss of current functional status.
C. personal assistance services twenty-four (24) hours a day, seven (7) days a week; personal assistance services are those services, other than professional nursing services, which may be needed by an individual because of age, infirmity, physical or mental limitations, and/or dependence in accomplishing the activities of daily living.

[2-1-95; 8.313.2.14 NMAC - Rn, 8 NMAC 4.MAD.732.3 & A, 11-1-00]

**8.313.2.15 COVERED SERVICES:** Medicaid covers the costs of ICF-MR services identified as allowable. See Section MAD-732-D, Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded, Section III.G. Pharmacy services furnished in the ICF-MR are reimbursed separately and are subject to specific requirements. See Section MAD-753, Pharmacy Services.

[2-1-95; 8.313.2.15 NMAC - Rn, 8 NMAC 4.MAD.732.4 & A, 11-1-00]

**8.313.2.16 NONCOVERED SERVICES:**
A. Medicaid does not cover the costs of ICF-MR services that are not allowable. See Section MAD-732-D, Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded.

B. Medicaid does not pay for residents with a primary diagnosis of mental retardation who are receiving care in a general nursing facility setting. Coverage of these residents is included only when they are residing in an ICF-MR facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.

[2-1-95; 8.313.2.16 NMAC - Rn, 8 NMAC 4.MAD.732.5 & A, 11-1-00]

**8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:**
A. As a condition for participation in medicaid, each ICF-MR must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that his or her personal funds be cared for by the facility. See 42 CFR 483.10(c).
(1) Requests for ICFs-MR to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient's fund or a letter signed by the resident or his/her representative. The form or letter is retained in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowance established by MAD. If the resident receives any income in excess of this allowance, the excess is applied to the cost of the resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) All facilities must have procedures on the handling of medicaid residents' funds. These procedures must not allow the facility to commingle medicaid residents' funds with facility funds.

(4) Facilities should use these medicaid guidelines to develop procedures for handling resident funds.

(5) Residents have the right to manage their financial affairs and no facility can require residents to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. Fund custodians: Facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis. Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(1) reconcile balances of the individual medicaid residents' accounts with the collective bank account;
(2) periodically audit and reconcile the petty cash fund;
(3) authorize checks for the withdrawal of funds from the bank account; and
(4) facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

C. Bank account: Facilities must establish a bank account for the deposit of all medicaid residents who request the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any resident's personal funds of more than fifty dollars ($50) in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the resident's account to that account.

(2) Facilities must maintain residents' personal fund up to fifty dollars ($50) in a non-interest bearing account or a petty cash fund. Residents must have convenient access to these funds.

(3) Individual financial records must be available on the request of residents or their legal representatives.

(4) Within 30 days of the death of residents whose personal funds are deposited with the facility, the ICF-MR must convey the resident's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the resident's estate.

D. Establishment of individual accounts: Facilities must establish accounts for each medicaid resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file, or looseleaf binder.

(1) For money received, the source, amount, and date must be recorded. Residents or their authorized representatives must be given receipts for the money. The facility must retain a copy of the deposit in the resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. Any money spent either on behalf of residents or withdrawn by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid resident when the account balance is two hundred ($200) dollars less than the supplemental security income (SSI) resource limit for one person, specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the resident's other nonexempt resources reach the SSI resource limit for one person, the resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: Facilities must balance the individual accounts, the collective bank accounts and the petty cash fund at least once a month. The facility must provide medicaid residents or their authorized representatives with an accounting of the resident's funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. Petty cash fund: Facilities must maintain a cash fund to accommodate the small cash requirements of medicaid residents. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money maintained in the petty cash fund is determined by the number of residents using the service and
the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund.

(1) To establish the fund, the ICF-MR must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:
- recipients or their authorized representatives request small amounts of spending money;
- the amount disbursed is entered on an individual ledger record; and
- the resident or representative signs an account record and receives a receipt.

(3) To replenish the fund, the following procedures should be used:
- money in the cash box is counted and added to the total of all disbursements made since the last replenishment; and
- the total of the disbursements plus cash on hand equals the beginning amount;
- money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures must be established and used at least once each month:
- count money on hand; and
- total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals the petty cash total.

(5) To close the resident's account, ICFs-MR should do the following:
- enter date of and reason for closing the account;
- write a check against the collective bank account for the balance shown on the individual account record;
- get signature of the recipient or their authorized representative on the individual recipient account record, as receipt of payment;
- notify the local ISD office if closure is caused by the death of the recipient so that action can be taken to terminate assistance; and
- within 30 days of the death of a resident who had no relatives, the ICF-MR conveys the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate; see 42 CFR 483.10(c)(6).

G. Retention of records: All account records other than financial and statistical cost reports must be retained until after an audit is complete or six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of 8.313.3.12 NMAC Retention of Records.

H. Non-acceptable uses of recipients' personal funds:

(1) Facilities cannot impose charges against a resident's personal funds for any item or service for which payment is made by medicaid or for any item residents or their representatives did not request. Facilities must not require residents or representative to request any item or services as a condition of admission or continued stay.

(2) Facilities must inform residents or representative requesting non-covered items or services that there is a charge for the item and the amount of the charge.

(3) Non-acceptable uses of residents' personal funds include the following:
- payment for services or supplies covered by medicaid or medicare; see 8.313.3 NMAC, Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded;
- difference between the facility billed charge and the medicaid payment; or
- payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

I. State monitoring of residents' personal funds: Facilities must make all files and records involving residents' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The division of health improvement, health facility licensing & certification bureau of the DOH verifies that facilities have a system of accounting for residents' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The human services department (HSD) or its designee can complete a thorough audit of residents' personal fund accounts at HSD's discretion.

[2-1-95; 8.313.2.17 NMAC - Rn, 8 NMAC.MAD.732.6 & A, 11-1-00; A, 5-1-07]
8.313.2.18 LEVEL OF CARE DETERMINATION: Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See MAD-954 [8.350.3 NMAC], Abstract Submission for Level of Care Determinations.

8.313.2.19 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All HSD/MAD program services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for HSD/MAD programs. Providers must verify that individuals are eligible for HSD/MAD programs at the time services are furnished and determine if HSD/MAD program recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, Reconsideration Of Utilization Review Decisions.

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an ICF-MR for the following reasons: 1) to allow the resident to make home and community visits, e.g., vacations; 2) to adjust to a new living environment; or 3) for hospitalizations.

A. Coverage of reserve bed days: Without prior authorization, Medicaid covers 65 reserve bed days per calendar year for every resident for family visits, vacations, home visits, hospitalizations and adjustment to a new living environment. Reserve bed days used under this section require documentation in the facility or the client records for all absences from the facility. If the absence from the facility is not documented in the facility or the client records, Medicaid will recoup the reserve bed day payment. If the resident is away from the facility with facility staff supervision, the absence is not considered a reserve bed day.

B. Prior authorization: After the 65 days have been expended, Medicaid covers, with prior authorization, an additional six reserve bed days per calendar year for discharge planning.

(1) A resident's discharge plan must clearly state the objectives, including how visits to alternative placements relate to discharge plan implementation.

(2) To obtain Medicaid prior authorization, the facility must submit the following information in writing to MAD:

(a) the resident's name;
(b) social security number;
(c) requested approval dates;
(d) copy of the discharge plan;
(e) name and address of the individual who will care for the resident; and
(f) written physician order for trial placement.

(3) Documentation of the resident's absence from the facility for these six additional reserve bed days must be in the facility or the client records.

C. Documentation of reserve bed days: If residents leave the ICF-MR for any reason, documentation of the absence from the facility must be in the facility or client records. Hospitalizations must be documented in the client records at the ICF-MR.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the ICF-MR is limited to the provider's level III rate. Billing for reserve bed days is based on the facility census, which runs from midnight to midnight. Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for the additional six reserve bed days, which require prior authorization, the provider must attach a copy of the written notification of approval by MAD to the claim.

[2-1-95; 8.313.2.18 NMAC - Rn, 8 NMAC 4.MAD.732.8, 11-1-00; A, 5-1-07]

8.313.2.19 NMAC 5
8.313.2.21 REIMBURSEMENT: Intermediate care providers must submit claims for reimbursement on the long term care turn around documents (TAD) or its successor. See Section MAD-702, Billing for Medicaid Services. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses ICF-MR the lower of the following:
   (1) the provider's billed charges; or
   (2) the prospective rate as constrained by the ceilings established by MAD. See Section MAD-732-D, Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded.

B. Reimbursement limitations: Medicaid pays only those ICF-MRs which meet the conditions for participation, specified in this section. Payments to ICF-MRs for services are limited to those services which are included as allowable service costs under the approved state plan. All claims for payment submitted to MAD are subject to utilization review and control.


[2-1-95; 8.313.2.21 NMAC - Rn, 8 NMAC 4.MAD.732.10, 11-1-00]

HISTORY OF 8.313.2 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD 310.0300, Care In Skilled Nursing Facility And Intermediate Care Facility, 2-27-80.
SP-004.1401, Utilization Review Plan for Intermediate Care Facilities, 6-10-81.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 12-1-87.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 1-6-88.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility For The Mentally Retarded, 3-27-92.

History of Repealed Material: [RESERVED]
APPENDIX 5
PROVIDER POLICIES
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
NURSING FACILITIES
AND
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED
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8.312.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[1/1/95; 8.312.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 7-1-02]

8.312.3.2 SCOPE: The rule applies to the general public.
[1/1/95; 8.312.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 7-1-02]

8.312.3.3 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, Section 27-2-12 et seq.
[1/1/95; 8.312.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7-1-02; A, 12/31/10]

8.312.3.4 DURATION: Permanent.
[1/1/95; 8.312.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 7-1-02]

8.312.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[1/1/95, 2/1/95; 8.312.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7-1-02; A, 12/31/10]

8.312.3.6 OBJECTIVE: The objective of this rule 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.
[1/1/95, 2/1/95; 8.312.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7-1-02; A, 12/31/10]

8.312.3.7 DEFINITIONS:
A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.
B. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.
C. Governmental institution: A provider of services owned and operated by a federal, state or local governmental agency.
D. Allocable costs: An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.
E. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.
F. Charges: The regular rates established by the provider for services rendered to both beneficiaries and to other paying patients whether inpatient or outpatient. The rate billed to the department shall be the usual and customary rate charged to all patients.
G. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.
H. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.
I. General service cost centers: Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry,
dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

J. **Special service cost centers:** Commonly referred to as ancillary cost centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

K. **Inpatient cost centers:** Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

L. **RCC:** This is the ratio of charges to charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

1. ratio of beneficiary charges to total charges on a departmental basis.
2. ratio of beneficiary charges for ancillary services to total charges for ancillary services.
3. ratio of total patient charges by patient care center to the total charges of all patient care centers.

M. **Provider:** The entity responsible for the provision of services. The provider must have entered into a valid agreement with the Medicaid program for the provision of such services.

N. **Facility:** The actual physical structure in which services are provided.

O. **Replacement facility:** A facility which replaces a facility that was participating in Medicaid on July 1, 1984, or whose construction received Section 1122 approval by July 1, 1984, and where the basic structure of the facility to be replaced is at least twenty-five years old and has been in continuous use as a skilled nursing or intermediate care facility for at least twenty-five years or which facility has been destroyed by catastrophic occurrence and rendered unusable and irreparable, or condemned by eminent domain.

P. **Closed facility:** A facility which has been either voluntarily or involuntarily terminated from participation in the Medicaid program not to include termination for construction of a replacement facility.

Q. **Replaced facility:** The facility replaced by a replacement facility as defined above.

R. **Related organization:** Organizations related to the provider by common ownership or control as defined by the provisions of the Medicare provider reimbursement manual (HIM-15).

S. **Imputed occupancy:** The level of occupancy attributed for the purpose of calculating the reimbursement rate.

T. **Owner:** The entity holding legal title to the facility.

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**8.312.3.8 MISSION STATEMENT:** 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.

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**8.312.3.9 COST RELATED REIMBURSEMENT OF NURSING FACILITIES:** The New Mexico Title XIX program makes reimbursement for appropriately licensed and certified nursing facility (NF) services as outlined in this material.

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**8.312.3.10 GENERAL REIMBURSEMENT POLICY:** The human services department will reimburse nursing facilities (effective October 1, 1990, the skilled nursing facility/intermediate care facility SNF/ICF distinction is eliminated; see 8.312.3.16 NMAC) the lower of the following, effective July 1, 1984:

A. billed charges; and
B. the prospective rate as constrained by the ceilings (8.312.3.16 NMAC) established by the department as described in this plan.

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**8.312.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:**

A. **Adequate cost data:**

   (1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. 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) **Cost finding:** The cost finding method to be used by NF providers 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 greater amount of expense will be allocated first.

**B. Reporting year:** For the purpose of determining a prospective per diem rate related to cost for NF services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.

**C. Cost reporting:** At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 150 days after the close of the provider's cost reporting year. Failure to file a report within the 150-day limit will result in termination of Title XIX payments. In the case of a change of ownership the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the department. The provider must notify the department 60 days prior to any change in ownership.

**D. Retention of records:**

1. Each NF provider shall 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 cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

2. The state agency 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:** Audits will be performed in accordance with 42 CFR 447.202.

1. **Desk audit:** Each cost report submitted will be subjected to a comprehensive desk audit by the state 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 state agency.

2. **Field audit:** Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and 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 expenses attributable to such proper items of cost were accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. 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 in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

**F. Overpayments:** All overpayments found in audits will be accounted for on the HCFA-64 report to health and human services (HHS) no later than the second quarter following the quarter in which found.

**G. Allowable costs:** The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

1. **Cost of meeting certification standards:** These will include all items of expense that the provider must incur under:

   a. 42 CFR 442;
   b. Sections 1861(j) and 1902(a)(28) of the Social Security Act;
   c. standards included in 42 CFR 431.610; and
   d. cost incurred to meet requirements for licensing under state law which are necessary for providing NF service.

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(2) Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;
(b) dietary and nursing services;
(c) medical and surgical supplies (including syringes, catheters; ileostomy, and colostomy supplies);
(d) use of equipment and facilities;
(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;
(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;
(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, band aids, laxatives and fecal softeners, aspirin, antacids, over-the-counter (OTC) ointments, and tongue depressors;
(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable equipment;
(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;
(j) laundry services including basic personal laundry;
(k) the department will make payment directly to the medical equipment provider in accordance with procedures outlined in 8.324.5 NMAC, Durable Medical Equipment and Medical Supplies, and subject to the limitations on rental payments contained in that section; and
(l) managerial, administrative, professional, and other services related to the provider's operation and rendered in connection with patient care.

(3) Facility costs, for purpose of specific limitations included in this plan, include only depreciation, lease costs, and long-term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated useful life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the department.

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare provider reimbursement manual (HIM-15), Section 104.14 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association chart of accounts for hospitals.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

(4) Gains and losses on disposition: Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with Section 130 and 132 of HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

(5) Depreciation, interest, lease costs, or other costs are subject to the limitations stated in Section 2422 of HIM-15 regarding approval of capital expenditures in accordance with Section 1122 of the Social Security Act.

(6) Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-allowable costs:
(1) bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and
charity and courtesy allowances shall not be included in allowable costs;
(2) purchases from related organizations: cost applicable to services, facilities, and supplies furnished
to a provider by organizations related to the provider by common ownership or control shall not exceed the lower
of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere;
providers shall identify such related organizations and costs in the state's cost reports;
(3) return on equity capital;
(4) other cost and expense items identified as unallowable in HIM-15;
(5) interest paid on overpayments as per 8.302.2 NMAC, Billing for Medicaid Services; and
(6) any civil monetary penalties levied in connection to intermediate sanctions, licensure,
certification, or fraud regulations.

8.312.3.12 ESTABLISHMENT OF PROSPECTIVE PER-DIEM RATES: Prospective per diem rates
will be established as follows and will be the lower of the amount calculated using the following formulas, or the
ceiling:
A. Base year: Rebasing of the prospective per diem rate will take place every three years.
Therefore, the operating years under this plan will be known as year one, year two and year three. Because rebasing
is done every three years, operating year four will again become year one, etc. Cost incurred, reported, audited or
desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to
rebase the prospective per-diem rate. Rebasings of costs in excess of 110 percent of the previous year's audited cost
per diem times the index (as described further on in these regulations) will not be recognized for calculation of the
base year costs. For implementation year one (effective July 1, 1984) the base year is the provider's last available
audited cost report prior to January 1, 1984. Rebasing will occur out of cycle for rates effective January 1, 1996,
using the provider's FYE 1994 audited cost reports. The rate period January 1, 1996, through June 30, 1996, will be
considered year one. The rate period July 1, 1996, through June 30, 1997, will be considered year two, and the rate
period July 1, 1997, through June 30, 1998, will be considered year three. The rebasing cycle will resume for rates
effective July 1, 1998, and continue as described in the first paragraph of this section. Pursuant to budget
availability, any changes to reimbursement, including the decision to rebase rates will be at the department's
discretion.

B. Inflation factor to recognize economic conditions and trends during the time period covered by
the provider's prospective per diem rate:
(1) Pursuant to budget availability and at the department's discretion, an inflation factor may be used
to recognize economic conditions and trends. A notice will be sent out every July informing each provider that a:
   (a) MBI will or will not be authorized; and
   (b) the percentage increase if the MBI is authorized.
(2) If utilized, the index used to determine the inflation factor will be the center for medicare and
medicaid services (CMS) market basket index (MBI) or a percentage up to the MBI.
(3) Each provider's operating costs will be indexed up to a common point of 12/31 for the base year,
and then indexed to a mid-year point of 12/31 for operating year one, if applicable. For out-of-cycle rebasing
occurring for rates effective January 1, 1996, through June 30, 1996, the mid-year point for indexing in operating
year one will be 3/31.
(4) The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage
change in the (MBI) for the previous year plus two percentage points.

C. Incentives to reduce increases in costs: As an incentive to reduce the increases in the costs of
operation, the department will share with the provider in accordance with the following formula, the savings below
the operating cost ceiling in effect during the state's fiscal year.

\[ I = \frac{1}{2}(M - N) \leq 2.00 \]

where
\[ M = \text{current operating cost ceiling per diem} \]
\[ N = \text{allowable operating per diem rate based on the base year's cost report} \]
\[ I = \text{allowable incentive per diem} \]

D. Calculation of the prospective per-diem rate: The following formulas are used to determine the
prospective per diem rate:
YEAR ONE
\[ PR = BYOC \times (1 + \Delta MBI) + I + FC \]

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where
PR = prospective per diem rate
BYOC = allowable base year operating costs as described in A above, and indexed as described in B above.

NHI = the change in the MBI as described in B above
I = allowable incentive per diem
FC = allowable facility costs per diem

YEARS TWO and THREE
PR = (OP+1) x (1 + Δ MBI) + FC

where
PR = prospective per-diem rate
OP = allowable operating costs per diem
I = allowable incentive per diem
NHI = the change in the MBI as described in B above
FC = allowable facility costs per diem

E. Effective dates of prospective rates: Rates are effective July 1 of each year for each facility.
F. Calculation of rates for existing providers that do not have 1983 actuals, and for newly constructed facilities entering the program after July 1, 1984.
   (1) For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per-diem rate will become the sum of:
      (a) the applicable facility cost ceiling; and
      (b) the operating cost ceiling.
   (2) After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per-diem rate will then become the sum of:
      (a) the lower of allowable facility costs or the applicable facility cost ceiling; and
      (b) the lower of allowable operating costs or the operating cost ceiling.
   (3) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

G. Changes of provider by sale of an existing facility:
   (1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:
      (a) the lower of allowable facility costs determined by using the medicare principles of reimbursement, or the facility cost ceiling; and
      (b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.
   (2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

H. Changes of provider by lease of an existing facility:
   (1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:
      (a) the lower of allowable facility costs or the facility cost ceiling, as defined by this plan; and
      (b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.
   (2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

I. Sale/leaseback of an existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

J. Replacement of an existing facility: When an existing facility is replaced, the provider's prospective rate will become the sum of:
   (1) the lower of allowable facility costs or the facility cost ceiling as defined by this plan; and
   (2) the operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. Replaced facility re-entering the medicaid program:
(1) When a facility is replaced by a replacement facility and the replaced facility re-enters the medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:
   (a) the median operating cost for its category; and
   (b) the lower of allowable facility costs or the applicable facility cost ceiling.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

L. Closed facility re-entering the medicaid program:
   (1) When a facility has been closed and re-enters the medicaid program under new ownership, it shall be considered a change of ownership and either Subsection G or Subsection H, whichever is applicable, will apply.
   (2) When a facility has been closed and re-enters the medicaid program under the same ownership within 12 months of closure, the provider's prospective rate will be the same as prior to the closing.
   (3) When a facility has been closed and re-enters the medicaid program under the same ownership more than 12 months after closure, the provider's prospective rate will be the sum of:
      (a) the median operating cost for its category; and
      (b) the lower of allowable facility costs or the applicable facility cost ceiling.
   (4) Providers of such facilities will not be eligible for incentive payments until the next operating year one, after rebasing.

[2/1/95, 12/30/95; 8.312.3.12 NMAC - Rn, 8 NMAC 4 MAD.731-D.IV & A, 7-1-02; A, 12/31/10]

8.312.3.13 ESTABLISHMENT OF CEILINGS: The following categories are used to establish ceilings for calculating prospective per diem rates: 1) state-owned and operated NF, 2) non-state-owned and operated NF. The department determines the status of each provider for exclusion from or inclusion in any one category. Ceilings will be separately established for each category as described above, and separately established to the two areas of allowable costs, i.e. operating costs and facility costs. The operating cost ceiling will be calculated using the base year costs for year 1. For years 2 and 3, the operating cost ceiling will not be recalculated. It will be indexed forward using the appropriate inflation factor. The facility cost ceiling of $11.50 will be trended forward in year 2 beginning July 1, 1985, by MBI minus 1 percentage point and then annually by the MBI.

A. Operating Costs: The ceiling for operating costs will be established at 110% of the median of allowable costs for the base year, indexed to 12/31 of base year.

B. Facility Costs: For existing, replacement, and newly constructed facilities, including remodeling of a facility to become a long term care facility, facility costs will be limited as follows:
   (1) Any facility that is participating in medicaid by July 1, 1984, or has been granted Section 1122 approval by July 1, 1984, for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the applicable facility cost ceiling for implementation year 1. The facility cost ceiling will be eleven dollars and fifty cents ($11.50).
   (2) Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category.
   (3) Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH). The basis of the total investment will be subject to the limitations described in 1 and 2 above. The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.312.3.12 NMAC of these regulations. Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the department.

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(4) For newly constructed facilities, reconstruction of a facility to become a long term care facility, and replacement facilities entering the medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico Medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.

(5) When an existing facility is sold, facility costs per day will be limited to the lower of:
(a) allowable facility costs determined by using the Medicare principles of reimbursement or
(b) the facility cost ceiling.

(6) When an existing facility is leased, the facility costs per day will be limited to the lower of:
(a) actual allowable facility costs, or
(b) for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling, or
(c) for facilities owned or operated by the lessor less than 10 years, 110% of the median of facility costs for all providers in the same category.

(7) When a replaced facility re-enters the medicaid program either under the same ownership as existed prior to the replacement or under different ownership, facility costs per day will be limited to the lower of:
(a) actual allowable facility costs or
(b) the median of facility costs for all other existing facilities in the same category.

[2/1/95; 8.312.3.13 NMAC - Rn, 8 NMAC 4 MAD.731-D.V & A, 7-1-02]

8.312.3.14 IMPUTED OCCUPANCY: In order to ensure that the medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs will be calculated by imputing a 90% occupancy rate. This provision will apply to:
A. any new facility certified for participation in the medicaid program on or after January 1, 1988;
B. existing facilities, if the number of licensed or certified beds increases on or after January 1, 1988; in such cases, occupancy will be imputed for all beds;
C. replacement facilities, certified for participation in the medicaid program on or after January 1, 1988, if the replacement facility contains a higher number of licensed or certified beds than the facility being replaced;
D. any replaced facility which re-enters the medicaid program on or after January 1, 1988, either under the same ownership or different ownership;
E. any closed facility which re-enters the medicaid program on or after January 1, 1988;
F. facility costs will be adjusted and the resulting rate change will become effective when any of the above occurs. Providers operating such facilities shall submit appropriate information regarding facility costs so that the rate adjustment can be computed.
[2/1/95; 8.312.3.14 NMAC - Rn, 8 NMAC 4 MAD.731-D.VI, 7-1-01]

8.312.3.15 ADJUSTMENTS TO BASE YEAR COSTS:
A. Since rebasing of the prospective per diem rate will take place every three years, the department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:
(1) additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, social security taxation of 501(c)(3) corporations, minimum wage change, property tax increases, etc.);
(2) additional costs incurred as a result of uninsurable losses from catastrophic occurrences; and
(3) additional costs of approved expansion, remodeling or purchase of equipment;
B. Such additional costs must reach a minimum of $10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The department encourages the provider to submit such rebasing requests before the cost is actually incurred if possible. The department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:
(1) beginning with the month the cost was actually incurred if prior approval was obtained; or
(2) no later than 30 days from the date of the approval if retroactive approval was obtained.
C. At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the department determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

D. Pursuant to budget availability, the decision to approve any adjustments to base year costs will be at the department’s discretion.

[2/1/95, 12/30/95; 8.312.3.15 NMAC - Rn, 8 NMAC 4 MAD.731-D.VII, 7-1-02; A, 12/31/10]

8.312.3.16 IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENTS EFFECTIVE OCTOBER 1, 1990: As mandated by Section 1919 of the Social Security Act, the following changes are made effective October 1, 1990:

A. Elimination of SNF/ICF distinction: Effective October 1, 1990, the SNF and ICF distinctions will be eliminated and all participating providers will become NFs. In order to account for the change the following will be implemented:

1. two levels of NF services will exist, representing the care needs of the respective recipients: High NF; Low NF.
2. a high NF rate and a low NF rate will be established for each provider.
3. for existing SNFs, the high NF rate will be the provider’s SNF rate in effect on September 30, 1990.
4. for existing SNFs with no existing ICF rate, the low NF rate will be the provider’s SNF rate in effect on September 30, 1990, minus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.
5. for existing ICFs, the low NF rate will be the provider’s ICF rate in effect on September 30, 1990.
6. for existing ICFs with no existing SNF rate, the high NF rate will be the provider’s ICF rate in effect on September 30, 1990, plus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.

B. Cost increases related to nursing home reform: To account for cost increases necessary to comply with the nursing home reform provisions, the following amounts will be added to NF rates (see above), effective October 1, 1990: high NF $3.69; low NF $4.96.

[2/1/95; 8.312.3.16 NMAC - Rn, 8 NMAC 4 MAD.731-D.VIII, 7-1-02]

8.312.3.17 PAYMENT OF RESERVE BED DAYS: When medicaid payment is made to reserve a bed while the recipient is absent from the facility, the reserve bed day payment shall be in an amount equal to 50% of the regular payment rate.

[2/1/95; 8.312.3.17 NMAC - Rn, 8 NMAC 4 MAD.731-D.IX, 7-1-02]

8.312.3.18 RECONSIDERATION PROCEDURES FOR LONG TERM CARE DETERMINATIONS:

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change in ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: director, medical assistance division, human services department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348.

B. The filing of a request for reconsideration will not effect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division director no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent’s response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

8.312.3 NMAC
G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or his/her designee, within 5 days after the closing date for final submittals.

H. The secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

I. The secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

[2/1/95; 8.312.3.18 NMAC - Rn, 8 NMAC 4 MAD.731-D.X, 7-1-02]

8.312.3.19 PUBLIC DISCLOSURE OF COST REPORTS:
A. Providers' cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division.

Information thus disclosed 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 division that its cost report has been requested, and by whom. The provider shall have 10 days in which to comment to the requester before the cost report is released.

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

[2/1/95; 8.312.3.19 NMAC - Rn, 8 NMAC 4 MAD.731-D.XI, 7-1-02]

8.312.3.20 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[2/1/95; 8.312.3.20 NMAC - Rn, 8 NMAC 4 MAD.731-D.XII, 7-1-02]

HISTORY OF 8.312.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records – state records center and archives.

ISD 306.4000, Provider Protesting Certified Costs Reimbursement Rates, 1/7/80.

SP-004.2400, Section 4, General Program Administration Standards For Payments For Skilled Nursing And Intermediate Care Facility Services, 3/5/81.

History of Repealed Material: [RESERVED]
# INDEX

8.313.3.  COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES

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8.313.3.1 ISSUING AGENCY: Human Services Department, Medical Assistance Division
[2-1-95; 8.313.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1,11-1-00]

8.313.3.2 SCOPE: This rule applies to the general public.
[2-1-95; 8.313.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11-1-00]

8.313.3.3 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).
[2-1-95; 8.313.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11-1-00]

8.313.3.4 DURATION: Permanent
[2-1-95; 8.313.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11-1-00]

8.313.3.5 EFFECTIVE DATE: February 1, 1995.
[2-1-95; 8.313.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11-1-00]

8.313.3.6 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.
[2-1-95; 8.313.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11-1-00]

8.313.3.7 DEFINITIONS

A. Accrual Basis of Accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Cash Basis of Accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

C. Governmental Institution: A provider of services owned and operated by a federal, state or local governmental agency.

D. Allocable Costs: An item or group of items of cost chargeable to one or more objects, precesses, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

E. Applicable Credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the Federal Government to finance hospital activities or service operations should be treated as applicable credits.

F. Charges: The regular rates established by the provider for services rendered to both Medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the Department shall be the usual and customary rate charged to all patients.

G. Cost Finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

H. Cost Center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.
I. **General Service Cost Centers:** Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

J. **Special Service Cost Centers:** Commonly referred to as Ancillary Cost Center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

K. **Inpatient Cost Centers:** Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

L. **Provider:** The entity responsible for the provision of services. The provider must have entered into a valid agreement with the Medicaid program for the provision of such services.

M. **Facility:** The actual physical structure in which services are provided.

N. **Owner:** The entity holding legal title to the facility.

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8.313.3.8 **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.

8.313.3.9 **COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES:** The New Mexico Title XIX Program makes reimbursement for appropriately licensed and certified Intermediate Care Facilities for the Mentally Retarded as outlined in this material.

8.313.3.10 **GENERAL REIMBURSEMENT POLICY:** The Human Services Department will reimbursement ICF/MR facilities the lower of the following, effective September 1, 1990:

A. Billed charges;
B. The prospective rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

8.313.3.11 **DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES**

A. **Adequate Cost Data**

1. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. 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 ICF-MR providers 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 cost 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 greater amount of expense will be allocated first.

B. **Reporting Year:** For the purpose of determining a prospective per diem rate related to cost for ICF-MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each fiscal year.

C. **Cost Reporting**

1. At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. Title XIX cost reporting form. This cost
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report must be submitted on an annual basis to MAD or its designee within the time frames specified by Medicare. ICFs-MR will not be granted an extension to the cost report filing time frames. Failure to file a cost report within the specified time frames will result in suspension of Title XIX payments.

(2) In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The Department will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 60 days prior to any change of ownership.

D. Retention of Records

(1) Each ICF-MR provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the State Agency, the State Audit Agent, or the Department of Health and Human Services.

(2) The State Agency 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 report.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk Audit: Each cost report submitted will be subject to a comprehensive desk audit by the state 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 State Agency.

(2) Field Audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and 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. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. After each field audit is performed, the audit agent will submit a complete report of the audit to the State Agency. 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 in accordance with the State Plan. These audit reports will be retained by the State Agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA 64 report to HHS no later than the second quarter following the quarter in which found.

G. Allowable Costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in the Medicare Provider Reimbursement Manual (PRM 15-1) that are not modified by these regulations.

(1) Cost Of Meeting Certification Standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442
(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;
(c) Standards included in 42 CFR 431.610;
(d) Cost incurred to meet requirements for licensing under state law which are necessary to provide ICF-MR service.

(2) Costs of Routine Services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) Regular room
(b) Dietary and nursing services
(c) Medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies).  
(d) Use of equipment and facilities
(e) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.
(f) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.
(g) Items stocked at nursing stations or on the floor in gross supply and distributed or used
individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandages, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors.

(h) Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment.

(i) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.

(j) Laundry services other than for personal clothing.

(k) Oxygen for emergency use—The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or ongoing basis:

(i) The provider may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or

(ii) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 754, Medical Supplies, and subject to the limitations on rental payments contained in that section.

(l) All services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.

(m) Managerial, administrative, professional and other services related to the provider's operation and rendered in connection with patient care.

(3) Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the Department.

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual PRM 15-I will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American Hospital Association Useful Live's Guide.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

H. Non-Allowable Costs

(1) Bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

(2) Purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the States's cost reports.

(3) Return on equity capital.

(4) Other cost and expense items identifies as unallowable in PRM 15-I.

(5) Interest paid on overpayments as per MAD-702, BILLING FOR MEDICAID SERVICES.

(6) Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

[2-1-95; 8.313.3.11 NMAC – Rn, 8 NMAC 4.MAD.732.D.III & A, 11-1-00]

8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES: Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable

8.313.3 NMAC
A. **Base Year**

(1) For implementation Year 1 (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

(2) Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, and Year 3. Since re-basing is done every three years, operating year 4 will again become Year 1.

(3) Costs incurred, reported, audited and/or desk reviewed for the provider’s last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Re-basing costs in excess of 110% of the previous year’s reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

B. **Inflation factor to recognize economic conditions and trends during the time period covered by the facility’s prospective per diem rate.** Pursuant to budget availability and at the Department’s discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

(1) MBI will or will not be authorized for determining rates for the year; and

(2) The percentage increase if the MBI is authorized.

(3) If utilized, the index used to determine the inflation factor will be the Center for Medicare and Medicaid Services (CMS) Market Basket Index (MBI).

(4) Each provider’s operating costs will be indexed to a mid-year point of February 28 for operating Year 1.

C. **Incentive to Reduce Increases in Cost**

(1) As an incentive to reduce the increases in the Administrative and General (A&G) and Room and Board (R&B) cost center, the Department will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

\[ A = \left[ \frac{1}{2} (B - C) \right] \leq \$1.00 \]

Where:

- \( A \) = Allowable Incentive per diem
- \( B \) = A&G/R&B per diem ceiling per diem
- \( C \) = Allowable A&G/R&B per diem from the base year’s cost report

D. **Cost Centers for Rate Calculation:** For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

(1) Direct Patient Care (DPC)
(2) Administration and General (A&G)
(3) Room and Board (R&B)
(4) Facility costs (FC)

E. **Case-Mix Adjustment**

(1) In assuring the prospective reimbursement system addresses the needs of residents of ICF-MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the Direct Patient Care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the Department utilizes level of care criteria which classify ICF-MR residents into one of three levels, with Level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

<table>
<thead>
<tr>
<th>Level</th>
<th>Value</th>
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</thead>
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<tr>
<td>Level I</td>
<td>1.077</td>
</tr>
<tr>
<td>Level II</td>
<td>0.953</td>
</tr>
<tr>
<td>Level III</td>
<td>0.768</td>
</tr>
</tbody>
</table>

(2) Using these level specific relative values, a provider specific base year CMI will be calculated. The CMI represents the weighted average of the residents’ level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

\[ \text{CMI} = \frac{\sum (\text{Level} \times \text{Relative Value})}{\text{Total Resident Count}} \]

\[ \text{CMI} = \frac{[A \times 1.077] + [B \times 0.953] + [C \times 0.768]}{N} \text{ where } N = \text{Total Resident Count} \]
F. Calculation of the Prospective Per Diem Rate

(1) A prospective per diem rate for each of the three levels of ICF-MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

(2) The provider's Direct Patient Care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

(3) The formula for Year 1 is: \( (A_1 \times RV) + C_1 + D + E = PR \) (Year 1)

(4) The formula for Year 2 is: \( [(A_1 \times RV) + C_1] \times (1 + MBI) + D + E = PR \) (Year 2)

(5) The formula for Year 3 is: \( [(A_2 \times RV) + C_2] \times (1 + MBI) + D + E = PR \) (Year 3)

(6) Where:

\( A = \) Allowable DPC per diem adjusted to a value of 1.00
\( B = \) The relative value of the level of classification.
\( C = \) Allowable A&G and R&B per diem
\( D = \) Allowable incentive per diem
\( E = \) Allowable facility cost per diem
\( MBI = \) Market Basket Index
\( PR = \) prospective rate
\( RV = \) the relative value for the level

"A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI.

G. Effective Dates Of Prospective Rates: Rates will be effective September 1 of each year for each facility.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990. For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

(1) The state wide average patient care cost per diem for each level plus;
(2) The A&G and R&B ceiling per diem plus;
(3) Facility cost per diem as determined by using the Medicare principles of reimbursement.

(4) After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual allowable and reasonable cost for the provider. A final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes Of Provider By Sale Of An Existing Facility: When a change of ownership occurs, the provider's prospective per diem rate per diem will become the sum of:

(1) The patient care cost per diem for each level, established for the previous owner plus;
(2) The A&G and R&B per diem established for the previous owner, plus
(3) Allowable facility costs determined by using the Medicare principles of reimbursement.

J. Changes Of Ownership By Lease Of An Existing Facility: When a change of ownership occurs, the provider's prospective per diem rate per diem will become the sum of:

(1) The patient care cost per diem for each level established for the previous owner, plus
(2) The A&G and R&B per diem established for the previous owner, plus
(3) The lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/Leaseback Of An Existing Facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[2-1-95; 8.313.3.12 NMAC - Rn, 8 NMAC 4.MAD.732.D.IV & A, 11-1-00; A, 9-1-02]

8.313.3.13 ESTABLISHMENT OF CEILINGS: Ceilings on the four major cost centers will be established as follow:

A. Direct Patient Care: No ceiling will be imposed on this cost center.
B. **A&G and R&B:** The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at 110% of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year 1 and set. For years 2 and 3, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. **Facility Cost:**
   1. No ceiling will be imposed on this cost center, except in relation to leases.
   2. Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the twelve months prior to the date the facility became a provider in the New Mexico Medicaid program. The rates of interest for this fund are published in both the Federal Register and the Commerce Clearing House (CCH).
   3. The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.
   4. Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

8.313.3.14 **ADJUSTMENTS TO BASE YEAR COSTS:** Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:
   A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)
   B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.
   C. Additional costs of approved expansion, remodeling or purchase of equipment.
   D. Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The Department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1) beginning with the month the cost was actually incurred if prior approval was obtained, or 2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

8.313.3.15 **RESERVE BED DAYS:** Reserve bed days will be paid using the provider's Level III rate.

8.313.3.16 **CAREGIVERS CRIMINAL HISTORY SCREENING:** The MAD will reimburse providers for the Medicaid portion of the billed amount that providers paid to the New Mexico Department of Health (DOH). The following is the billing format:
   A. Each ICF-MR will pay DOH by check according to DOH regulations.
   B. A copy of the check(s) that the ICF-MR sent to DOH will be submitted to Medicaid for payment on a quarterly basis on a Medicaid Reimbursement Voucher (available at MAD or at MAD's designee).
   C. Medicaid will only be responsible for the Medicaid portion of the billed amount.

8.313.3 NMAC
D. There will be a one-time charge to Medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider's cost report.

8.313.3.17 RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to: Director, Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504.

B. The filing of a Request for Reconsideration will not effect the imposition of the determination.

C. A Request for Reconsideration, to be timely, must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the determination notice to the provider.

D. The written Request for Reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based.

E. Any point not raised in the original filed request may not be raised later.

F. The Medical Assistance Division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the transmittal letter.

G. The Medical Assistance Division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the Medical Assistance Division no later than 15 days after the date of the transmittal letter.

H. The Request for Reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the Medical Assistance Division Director to the Secretary, or his/her designee, within 5 days after the closing date for final submittals.

I. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

J. The Secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The Secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The Secretary's decision will be final and changes to the original determination will be implemented pursuant to that decision.

8.313.3.18 PUBLIC DISCLOSURE OF COST REPORTS

A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the Medical Assistance Division. Information thus disclosed 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 cost for copying will be charged to the requestor.

8.313.3.19 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

HISTORY OF 8.313.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

SP-004.2400 Section 4, General Program Administration Standards for Skilled Nursing And Intermediate Care Facilities, 3-5-81.

History of Repealed Material: [RESERVED]
## PROVIDER POLICIES

**MAD:97-12**

**SPECIALTY SERVICES**

**EFF: 8/1/97**

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768 HOME HEALTH SERVICES

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services [42 CFR, Section 484 and 42 CFR, Section 440.70]. This section describes eligible providers, covered services, service limitations, and the general reimbursement methodology. [2-1-95]

768.1 Eligible Providers

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by the New Mexico Medical Assistance Division (MAD), home health agencies that meet the following conditions are eligible to be reimbursed for furnishing services:

1. Meet the conditions of participation. See 42 CFR, Section 484 Subpart B;

2. Are licensed and certified by the Licensing and Certification Bureau of the New Mexico Department of Health to meet all standards for participation in a federal program established under Title XVIII (Medicare) of the Social Security Act. Any provider participating only in Medicaid must be licensed and certified to comply with the standards for Medicare participation; and

3. Are public agencies, private for-profit agencies, or private non-profit agencies primarily engaged in furnishing skilled nursing services and at least one other therapeutic service.

Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2-1-95, 9-15-97]
768.2 Provider Responsibilities

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES.

Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers shall have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient’s needs in the home care setting, which include, but are not limited to:

1. An evaluation visit in the recipient’s residence to consider the physical facilities available, capabilities and attitudes of the recipient, family members or significant others, the availability of care givers, if any, to help in the care of the patient, and the appropriateness of home health care for meeting the recipient’s needs in a safe environment.

2. The recipient’s need to receive medical care at home.

3. Orders from the recipient’s physician.

4. Documentation in the medical record of (1), (2) and (3).

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES.

[2-1-95, 9-15-97]

768.3 Eligible Recipients

Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused
by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home.

Recipients may be considered eligible to receive care at home if they meet one or more of the following criteria:

1. Recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual;
2. Recipients who because of severe physical or mental illness or injury must comply with doctor’s orders and avoid all stressful physical activity;
3. Recipients who cannot leave their residences because of danger caused by a mental condition;
4. Recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection.
5. Recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

Recipients are not eligible to receive care at home just because they (1) cannot drive, (2) have multiple medical problems or (3) live in an isolated area.

**768.31 Infrequent Periods Away from Residence** Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

**768.32 Determination of Medical Need to Receive Care At Home** MAD or its designee reviews information submitted by the provider and
determines whether recipients are considered eligible for home health service. Coverage is granted when the home health agency can demonstrate that care at home is appropriate to the medical needs of the recipient, the needed service is not otherwise available, and not receiving care would result in lack of access to health care services, institutionalization of the recipient and greater costs to the Medicaid program.

768.33 Documentation of Medical Need to Receive Care At Home
The home health agency is responsible for documenting on the written plan of care evidence of the recipient’s medical need for home health care.

[2-1-95, 9-15-97]

768.4 Covered Services

Medicaid covers those home health services which are skilled, intermittent, and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by his/her family, guardian or significant other. Services must be ordered by the recipient’s attending physician and included in the plan of care established by the recipient’s attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician.

The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification.

The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care.

Covered services include the following:
1. Skilled nursing services;
2. Home health aide services;
3. Physical and occupational therapy services; and
4. Speech therapy services.

768.41 Skilled Nursing Services Medicaid covers skilled, intermittent and medically necessary skilled nursing services if the following conditions are met:

(A) Services must be ordered by the attending physician and included in the plan of care established by the recipient’s attending physician in consultation with the home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician.

(B) Skills of a registered nurse or licensed practical nurse must be required for direct care or supervision of home health aides.

(C) Services must be furnished by or under the supervision of a registered nurse licensed in New Mexico who is responsible for the initial evaluation, care planning and coordination of services.

(D) Services must be reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

1. Consistent with the recipient’s particular medical needs as determined by the recipient’s attending physician.
2. Consistent with accepted standards of medical and nursing practice.
3. Consistent with provision of care in the safest, least restrictive setting for meeting the recipient’s needs.
4. Consistent with the New Mexico MAD approved Medical Necessity Criteria for Home Health.
Skilled nursing care includes, but is not limited to, the following:

1. Observation and evaluation of recipient’s health needs

2. Teaching the recipient, family members or significant other caretaker to provide care such as, but not limited to:
   a. Giving an injection;
   b. Irrigating a catheter;
   c. Providing wound care, including applying dressings to wounds, positioning, and recognizing signs of infection and other complications;
   d. Using medications properly and safely, and understanding potential side effects;
   e. Using special equipment and adaptive devices; and
   f. Home safety.

3. Insertion and sterile irrigation of catheters;

4. Administering injections;

5. Administering intravenous antibiotics and enteral and intravenous total parenteral nutrition;

6. Treating decubitus ulcers and other skin disorders; and

7. Providing other health teaching according to recipient’s needs.
768.42 Therapy Services  Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists, or speech language pathologists.

(A) Services must be ordered by the recipient’s attending physician and included in the plan of care established by the attending physician in consultation with the home health agency staff.

(B) All therapy services must conform with practice standards and licensing requirements as defined by state law.

(C) Services can be furnished by a public, private for-profit or private non-profit home health agency directly or under arrangement.

768.43 Home Health Aide Services  Medicaid covers home health aide services if the following conditions are met:

1. Home health aides must complete training and/or a competency evaluation program that meets certain requirements. See 42 CFR, Section 484.36;

2. Services must be ordered by the attending physician and included in the plan of care established by the recipient’s attending physician in consultation with the home health agency staff;

3. Written instructions for patient care are prepared by a registered nurse or therapist;

4. Assignment to a particular recipient is made by a registered nurse;

5. Duties of the home health aide include:
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a. Performance of simple procedures as an extension of nursing and therapy services;
b. Personal care;
c. Walking and exercises;
d. Household services essential to health care at home;
e. Help with medications that are normally self-administered;
f. Reporting changes in the recipient’s condition; and
g. Completing appropriate records.

6. Registered nurses or other appropriate professional staff members must make a supervisory visit to the recipient’s residence at least every two (2) weeks to observe and decide whether goals are being met. The recipient’s record must contain documentation that, at least every two (2) weeks or more often if necessary, there has been communication between the home health aide and the supervisory nurse or other appropriate professional staff member regarding the recipient’s condition; and

7. Services must be furnished directly through the home health agency staff or by contractual arrangement.

768.44 Durable Medical Equipment and Medical Supplies: Medicaid covers medically necessary durable medical equipment and medical supplies which are specified in the plan of care. See Section MAD-754, DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.

Reimbursement is made to the home health agency and is limited to medical
supplies necessary during the course of the plan of care. The following durable medical equipment and medical supplies are covered as specified:

1. Medicaid does not cover stock or routine items, such as Band-Aids, cotton balls, thermometers, lotion, personal care items, tape, and alcohol.

2. Non-routine supplies, such as catheters, ostomy supplies, feeding tubes, intravenous supplies, dressing supplies, ointments, solutions, chux diapers, and home testing kits must be ordered as part of the plan of care.

Utilization review, including retrospective review, can be made by MAD or its designee to assess the medical necessity for durable medical equipment and medical supplies and program compliance. If MAD determines that the equipment and supplies that were billed were not medically necessary or a covered service for the care of that recipient, the MAD payments are recouped.

768.45 Maternal/child services  Medicaid covers perinatal and pediatric home health services if the following conditions are met:

1. The service is prescribed by the recipient’s attending physician and is included in the plan of care established by the recipient’s physician in consultation with home health agency staff.

2. If the recipient has a medical need to receive care at home, in the sense that care in the home is more appropriate to the needs of the recipient, safe, cost-effective and will prevent or delay institutionalization.

3. The services are reasonable and medically necessary to treat a high risk pregnancy, at-risk infant, illness, injury and to prevent infection. To be considered reasonable and medically necessary, the services furnished shall be:
a. Consistent with the recipient’s particular medical needs as determined by the recipient’s attending physician;

b. Consistent with accepted standards of medical and nursing practice;

c. Consistent with the New Mexico MAD approved Medical Necessity Criteria for Home Health.

[2-1-95, 9-15-97]

768.5 Noncovered Services

Home health services are subject to the limitations and coverage restrictions of other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES. Medicaid does not cover the following home health agency services:

1. Services beyond the initial evaluation which are furnished without prior approval;

2. Home health services which are not skilled, intermittent and medically necessary;

3. Services furnished to recipients who do not meet the eligibility criteria for home health services;

4. Services furnished to recipients in places other than their place of residence;

5. Services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service;

Physical, occupational, and speech therapy can be furnished to residents of nursing facilities who require a low level of service.
6. Skilled nursing services which are not supervised by registered nurses; and

7. Services not included in written plans of care established by physicians in consultation with the home health agency staff.

[2-1-95, 9-15-97]

768.6 Prior Approval and Utilization Review

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

768.61 Prior Approval All home health services beyond initial visits for evaluation purposes, require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

768.62 Eligibility Determination Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

768.63 Reconsideration Providers who disagree with prior approval can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

768.64 Effect of Hospitalization If a recipient is hospitalized during the certification period and a significant change in condition or course of treatment occurs, the home health agency must treat the recipient as a new patient and
submit a new prior approval request and new plan of care.

If there is no significant change in the recipient’s condition or course of treatment, an agency can resume care under the existing plan of care.

[2-1-95, 9-15-97]

768.7 Treatment Plan Reserved [2-1-95; R, 9-15-97]

768.8 Reimbursement

Home health agencies assume responsibility for any and all claims submitted on behalf of the provider and under the provider’s number. Home health agencies must submit claims for reimbursement on the UB-92 claim form or its successor. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement is made based on the Title XVIII (Medicare) cost-finding procedures and reimbursement methodology. Charges are paid at an interim rate basis established under the Medicaid guidelines by the Medicare audit agent, subject to retroactive settlement when the cost report is final.

Cost reports on appropriate forms must be submitted to the audit agent within ninety (90) days of the close of the provider’s fiscal accounting period. Failure to provide timely cost reports results in suspension of payments.

[2-1-95, 9-15-97]

768.9 Reimbursement Limitations

The following limitations apply to reimbursement made to home health agencies:

1. Allowable costs are determined according to Medicare and Title XIX (Medicaid) reimbursement regulations;

2. The established percentage relationship of the agency’s cost to charges per unity of services includes all services;
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3. Out-of-state providers are reimbursed at seventy percent (70%) of billed charges. Out-of-state home health services are approved only in very unusual circumstances, since home health services are furnished in the recipient’s residence and that residence must be in New Mexico; and

4. Claims for approved home health services must include the types of visits, dates of visits, and number of visits.

[2-1-95]

768.10 Plan of Care

The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five (5) working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

1. All principle diagnoses, surgical procedures, and other pertinent diagnoses;

2. Medications and dosages;

3. Types of services, equipment and non-routine supplies required;

4. Frequency of visits;

5. Safety measures to protect against injury;

6. Nutritional/fluid balance requirements;

7. Allergies;

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8. Functional limitations, activities permitted, and documentation of homebound status;

9. Mental status;

10. Prognosis;

11. Goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient’s condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and

12. Clinical findings and updates.

(A) The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed sixty-two (62) working days.

(B) The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient’s response to care provided under the previous plan of care and specifying changes in services required.

[9-15-97]
APPENDIX 7
PROVIDER POLICIES
HEALTH CARE PROFESSIONAL SERVICES
FEDERALLY QUALIFIED HEALTH CENTER SERVICES
AND
RURAL HEALTH CLINICS
INDEX

8.310.4 FEDERALLY QUALIFIED HEALTH CENTER SERVICES

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8.310.4.1 ISSUING AGENCY: New Mexico Human Services Department.

8.310.4.2 SCOPE: The rule applies to the general public.

8.310.4.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).

8.310.4.4 DURATION: Permanent

8.310.4.5 EFFECTIVE DATE: February 1, 1995

8.310.4.6 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.

8.310.4.7 DEFINITIONS: [RESERVED]

8.310.4.8 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.

8.310.4.9 FEDERALLY QUALIFIED HEALTH CENTER SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible clients. To help New Mexico clients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered outpatient services provided at federally qualified health centers (FQHC’s). This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. MAD intends to follow federal regulation applicable to medicare where and if there are any omissions in these regulations with respect to covered services.

8.310.4.10 ELIGIBLE PROVIDERS:
A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following entities are eligible to be reimbursed for furnishing medical services as FQHCs:
   (1) entities which receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;
   (2) entities which receive funding from such a grant under a contract with the recipient of such a grant indicated above which meet the requirements to receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;
   (3) entities which the secretary of the federal department of health and human services determines meet the requirements for receiving such a grant or entities which qualify through waivers authorized by the secretary of the department of health and human services; and
   (4) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organizations receiving funds under the Indian Health Care Improvement Act for the provision of primary health services.

8.310.4 NMAC
B. Individual providers employed by or under contract with FQHCs must be enrolled with New Mexico Medicaid.

C. Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

8.310.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to Medicaid clients must comply with all specified Medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to clients. See 8.302.1 NMAC, General Provider Policies.

8.310.4.12 COVERED SERVICES: All services provided by the FQHC must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to Medicaid-covered benefits. If not specified in this section, MAD adopts definitions of coverage delineated in the FQHC sections of Medicare statutes. "Other ambulatory services" offered by the FQHC are subject to the same Medicaid limitations, utilization review requirements, and coverage restrictions that exist for other providers rendering the delineated service.

A. Physician services:

(1) Physician services are professional services that are performed by a physician, including psychiatrists, employed by or under contract with the FQHC.

(2) Services and supplies incident to a physician's professional service are covered if the service or supply meets delineated requirements. Services and supplies include the professional component of radiology services, laboratory services performed by the FQHC and specimen collection for laboratory services furnished by an off-site laboratory. To meet the definition of "incident to" a professional service, the service and supplies must be:

(a) of a type commonly furnished in a physician's office; [within the meaning of the Code of Federal Regulations (CFR) page 128 Section 405.2413 (a)(1) 10-01-98 edition]

(b) of a type commonly rendered either without charge or included in the FQHC encounter rate;

(c) furnished as an incidental, although integral, part of a physician's professional service;

(d) furnished under direct, personal supervision of a physician; and

(e) in the case of a service, furnished by a member of the FQHC's health care staff who is an employee of the FQHC or under contract with the FQHC.

(3) Inpatient hospital visits are those services furnished to an individual as a "patient" of the FQHC. Therefore, FQHC services furnished off-site (including those furnished to a person who is an inpatient of a hospital or nursing facility) will be considered FQHC services only if the physician's agreement with the FQHC requires that he or she seek compensation from the FQHC. (Section 4704 c of OBRA '90, amended Section 1905 1,2.) (HCFA Letter #91-18 dated March 1991.)

B. Mid-level practitioners: Services furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner are covered as an FQHC core service if the service is:

(1) furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner who is employed by or under contract with the FQHC;

(2) furnished in accordance with FQHC policies and individual treatment plans developed by FQHC personnel for a given client;

(3) a type which the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is permitted by licensure and/or certification;

(4) furnished under the supervision of a physician, if required by New Mexico law.

(a) The physician supervision requirement is met if the conditions specified in Section 491.8 (b) of the Social Security Act and any pertinent requirements specified under New Mexico law are satisfied.

(b) To be covered, the services provided by mid-level practitioners must comply with New Mexico law.
(c) Services and supplies are covered as incident to the provision of services by a mid-level practitioner if the requirements specified in Paragraph (2) of Subsection A of 8.310.4.12 NMAC are met.

(d) The direct personal supervision requirement for mid-level practitioners is met if the mid-level practitioner is permitted to supervise under the written policies governing the FQHC and as defined under New Mexico law.

C. **Outpatient mental health services:** Diagnosis and treatment of mental illness are covered services when the service is provided by an individual licensed as a physician by the board of medical examiners or board of osteopathy and who is board-eligible or board-certified in psychiatry, a licensed clinical psychologist (Ph.D., Psy. D., or Ed. D.), a licensed independent social worker (LISW), a licensed professional clinical mental health counselor (LPCC), a licensed marriage and family therapist (LMFT), or a clinical nurse specialist certified in psychiatric nursing (CNP) who is employed by or under contract with the FQHC. An FQHC is reimbursed for services furnished by licensed master’s level social workers, licensed psychology associates and master’s level licensed counselors who are graduates of an accredited program when the services are furnished under the direction and supervision as addressed under Subsection C of 8.310.8.10 NMAC.

D. **Visiting nurse services:** Visiting nurse services are covered if the FQHC is located in an area identified by the secretary of health and human services as having a shortage of home health agencies. No additional certification is required beyond the FQHC certification. To be covered, visiting nurse services must be:

1. rendered to clients who meet criteria for home health services;
2. furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or under contract with the FQHC; and
3. furnished under a written plan of treatment that is established and signed by a supervising physician; the plan may also be established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner employed by or under contract with the FQHC; the plan must be reviewed every 60 days by the supervising physician and revised as the client’s condition warrants;
4. visiting nurse services do not include household and housekeeping services or other services that constitute custodial care.

E. **Preventive services:**

1. Preventive primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include:
   a. medical social services;
   b. nutritional assessment and referral;
   c. individual preventive health education;
   d. well-child care, including periodic screening, to include children’s eye and ear examinations;
   e. prenatal and postpartum care;
   f. immunizations for children and adults, including tetanus-diptheria booster and influenza vaccine;
   g. family planning services;
   h. physical examinations targeted to risk, to include blood pressure measurement, weight, and client history;
   i. visual acuity screening;
   j. hearing screening;
   k. cholesterol screening;
   l. stool testing for occult blood;
   m. dipstick urinalyses;
   n. risk assessment and initial counseling regarding risks;
   o. tuberculosis testing for high risk clients;
   p. preventive dental services;
   q. for women only: PAP smears; clinical breast exams; referral for mammography; and thyroid function tests.

2. Documentation of any service provided by the FQHC must be available in the client’s record.

3. Preventive primary services do not include eyeglasses, hearing aids, group or mass information programs, health education classes, or group education activities, including media productions and publications.

F. **Pharmacy services:** Pharmacy services and medical supplies are covered services and are included as an allowable cost if dispensed from an FQHC. An FQHC encounter for the provision of medical, behavioral health, and dental services includes related pharmacy services. The FQHC shall not bill a separate
encounter for the provision of pharmacy services. To dispense medications, the FQHC must be licensed as a licensed drug clinic under the Pharmacy Practice Act.

G. Dental services: See 8.310.7 NMAC, Dental Services, for benefit coverage and service limitation. Dentists and dental hygienists providing services for an FQHC must provide services within the scope of their license as defined in the New Mexico Dental Health Care Act.

H. Case management: Targeted case management services are covered services and are subject to the same requirements that apply to providers who furnish case management services. See 8.326.2 NMAC through 8.326.8 NMAC [MAD-771 - MAD-779].

[2/1/95; 1/1/00; 8.310.4.12 NMAC - Rn, 8 NMAC 4.MAD.713.3 & A, 11/1/04]

8.310.4.13 UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Approval and Utilization Review. Once enrolled, providers receive instruction and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures and services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that the individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions [MAD-953].

[2/1/95; 1/1/00; 8.310.4.13 NMAC - Rn, 8 NMAC 4.MAD.713.4, 11/1/04]

8.310.4.14 NON-COVERED SERVICES AND SERVICE LIMITATION: FQHC services are covered when provided in outpatient settings only, including a client’s place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a client’s home. FQHC services are not covered in a hospital as defined in section 1861(e)(1) of the Act.

A. Service limitations: An FQHC may be compensated for provision of other “ambulatory services” covered in the medicaid fee-for-service program (per the Balanced Budget Act of 1997). However, an FQHC must meet licensing and certification requirements for those services as specified in the applicable MAD policy manual section for the specific service.

B. Location of clinic:
   (1) Permanent unit: Objects, equipment, and supplies necessary for the provision of services furnished directly by the FQHC must be housed in a permanent structure. Each unit must have individual FQHC certification.
   (2) Mobile unit: The objects, equipment, and supplies necessary for the provision of services furnished by the FQHC must be housed in an FQHC mobile structure which has fixed, scheduled locations.

C. Other restrictions: FQHC service providers are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, General Non-covered Services [MAD-602].

[2/1/95; 1/1/00; 8.310.4.14 NMAC - Rn, 8 NMAC 4.MAD.713.5, 11/1/04]

8.310.4.15 REIMBURSEMENT: FQHCs must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, Billing for Medicaid Services [MAD-702]. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim reimbursement for services provided by an FQHC is made by MAD based on submitted claims.

A. Initial rates: The initial interim rate for new FQHC providers will be the interim rate set by medicare.

B. Cost settlement:
   (1) FQHCs must submit cost reports on an annual basis to MAD or its designee within the time frames specified by medicare. FQHCs will not be granted an extension to the cost report filing time frames.
   (2) A final cost settlement based on the audit data will be made in accordance with delineated medicaid requirements and/or applicable medicare cost reimbursement principles when medicaid requirements are
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not specified. Final cost settlements are based on the allowable cost as audited or desk reviewed costs by MAD or its designee. "Allowable costs" are costs incurred by an FQHC which are reasonable in amount, proper and necessary for the efficient delivery of services by the FQHC (MAD or its designee will follow the HCFA Pub. 15-1 in determining allowable costs). The supporting documentation for "allowable costs" must be available upon request from MAD or its designee.

(3) MAD or its designee may reopen cost reports per HCFA Pub. 15-1 Section 2931 through 2932. Providers will be notified on a case-by-case basis thirty (30) days prior to any reopening. MAD uses the productivity standards used in the medicare cost report. However, MAD does not use the costs limits imposed by medicare. If an FQHC disagrees with an audit settlement, the provider can request a reconsideration. See 8.350.4 NMAC, Reconsideration of Audit Settlement [MAD-955].

(4) HSD or its designee will complete their initial review of cost settlement materials within 150 days of the receipt of all required information.

C. What constitutes a visit: A visit is a face-to-face encounter between a center client and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, qualified clinical psychologist or qualified clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) after the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment;

(2) the client has a dental visit, or medical visit and another health visit (e.g., a face-to-face encounter between the client and a clinical psychologist, clinical social worker, or other health professional for mental health services listed in Subsection C of 8.310.4.12 NMAC [MAD 713.33].

D. Supplemental agreements: FQHCs which executed specific agreements with HSD will receive supplemental payments for services rendered to clients enrolled in managed care in the manner and amount specified under the terms of that agreement.

E. Termination or change of ownership: The human services department (HSD) reserves the right to withhold payment on all current and pending claims until HSD rights to recoup all or portions of such payments is determined from final cost reports when a change of ownership occurs. Payment will not be withheld if HSD is informed in writing the current (new) owner or the previous owner agrees to be responsible for any potential recoupment.

HISTORY OF 8.310.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/91.

History Of Repealed Material:
MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/91 - Repealed effective 2/1/95.
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8.310.3.1 ISSUING AGENCY: New Mexico Human Services Department.

8.310.3.2 SCOPE: The rule applies to the general public.

8.310.3.3 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 Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).

8.310.3.4 DURATION: Permanent

8.310.3.5 EFFECTIVE DATE: February 1, 1995

8.310.3.6 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.

8.310.3.7 DEFINITIONS: [RESERVED]

8.310.3.8 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.

8.310.3.9 RURAL HEALTH CLINIC SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help rural New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered medicaid services provided in rural health clinics [42 CFR Section 440.20]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.

8.310.3.10 ELIGIBLE PROVIDERS:
A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following providers are eligible to be reimbursed for furnishing services as rural health clinics:
   (1) clinics certified as non-hospital based rural health clinics by the health care financing administration (HCFA) following a survey and recommendation from the licensing and certification bureau of the New Mexico department of health (DOH); or
   (2) clinics which are integral parts of institutional providers, such as hospitals, skilled nursing facilities or home health agencies, that have been certified as hospital-based rural health clinics by the licensing and certification bureau of the DOH.
B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
8.310.3.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, General Provider Policies. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, General Provider Policies.

[2/1/95; 8.310.3.11 NMAC - Rn, 8 NMAC 4.MAD.712.2, 3/1/12]

8.310.3.12 COVERED SERVICES AND SERVICE LIMITATIONS: All services provided by the clinic must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid covered benefits.

A. The following are covered services:

(1) medically necessary diagnostic and therapeutic services, supplies, and treatment of medical conditions, including medically necessary family planning services; see Section MAD-762, Reproductive Health Services;

(2) laboratory and diagnostic imaging services for diagnosis and treatment; and

(3) surgical procedures, emergency room physician services, and inpatient hospital visits furnished at a different facility when performed by a physician under contract to a rural health clinic.

B. Visiting nurse services: Medicaid covers visiting nurse services through a rural health clinic if the following criteria are met [42 CFR Section 440.20(b)(4)]:

(1) the rural health clinic is located in an area in which there is a shortage of home health agencies, as determined by the secretary of the federal department of health and human services; the rural health clinic does not need separate or additional home health agency certification to furnish visiting nurse services;

(2) the services are furnished to homebound recipients;

(3) the services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the clinic;

(4) the services are furnished under a written plan of treatment that is:
   (a) established and reviewed at least every sixty (60) days by supervising physicians at the rural health clinics;
   (b) established by certified nurse practitioners, certified physician assistants, certified nurse midwives, licensed nurse midwives, or specialized nurse practitioners and reviewed at least every sixty (60) days by supervising physicians; and
   (c) signed by nurse practitioners, physician assistants, nurse midwives, specialized nurse practitioners, or supervisory physicians of the clinic;

(5) prior approval for nursing services must be obtained from the MAD utilization review contractor.

C. Primary care network restrictions: All rural health clinics are subject to the primary care network restrictions. See Section MAD-603, Primary Care Network.

[2/1/95; 8.310.3.12 NMAC - Rn, 8 NMAC 4.MAD.712.3, 3/1/12]

8.310.3.13 NON-CORE MEDICAL SERVICES: Core medical services, as defined in the Rural Health Clinic Act, performed at rural health clinics are included in the encounter rate for purposes of medicaid reimbursement. The following non-core services may be provided in rural clinics, however, reimbursement for these services is not included in the encounter rate:

A. optometric services, including vision examinations and eyeglasses dispensing;

B. hearing aid dispensing and related evaluations;

C. psychological services;

D. rural health drug services; and

(1) pharmacy services are covered by medicaid if the rural health clinic obtains a separate pharmacy provider number, a separate New Mexico medical assistance program provider participation application must be submitted for pharmacy services and be approved by MAD;

(2) pharmacy dispensing services must be billed with the separate pharmacy provider number;

(3) the rural health clinic pharmacy must be licensed by the state pharmacy board; see 8.324.4 NMAC, Pharmacy Services.

E. Rural health dental services:

8.310.3 NMAC
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(1) Certified rural health clinics may participate as rural health dental providers if they obtain a separate dental provider numbers. A separate New Mexico medical assistance program provider participation application must be submitted by a rural health center dental provider and be approved by MAD.

(2) Dental services must be billed under the separate dental provider number, not the rural health clinic provider number. See 8.310.7 NMAC, Dental Services.

[2/1/95; 8.310.3.13 NMAC - Rn, 8 NMAC 4.MAD.712.4, 3/1/12]

8.310.3.14 NONCOVERED SERVICES: Rural health clinic services are subject to the same limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, General Noncovered Services.

[2/1/95; 8.310.3.14 NMAC - Rn, 8 NMAC 4.MAD.712.5, 3/1/12]

8.310.3.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services may require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, Reconsideration of Utilization Review Decisions.

[2/1/95; 8.310.3.15 NMAC - Rn, 8 NMAC 4.MAD.712.6, 3/1/12]

8.310.3.16 REIMBURSEMENT: Rural health clinics must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, Billing for Medicaid Services. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. Reimbursement for non-hospital based rural health clinics: Interim reimbursement is made at an encounter rate established for the clinic by the medicare intermediary.

(1) An “encounter” means a face-to-face meeting between a recipient and any health professional whose services are reimbursed as a covered rural health clinic service.

(2) A final cost settlement based on the audit data is made in accordance with applicable medicare regulations following the medicare cost settlement.

(3) Multiple encounters with the same or different health professional(s) that take place on the same date at a single location are considered a single encounter.

(a) Exceptions exist for cases in which the recipient suffers illness or injury requiring additional diagnosis or treatment on the same day, after the first encounter.

(b) All medical, surgical, diagnostic imaging, supplies, and clinical laboratory services furnished during the encounter are considered reimbursed within the encounter rate.

B. Reimbursement for non-core services: Reimbursement to rural health clinics for drug services, dental services, vision services, hearing services, psychiatric or psychological services, and other non-core medical services is made according to the regulations applicable to each of these specific program areas. These services are not reimbursed on a reasonable cost basis, but instead are reimbursed as described in the applicable service sections.

C. Reimbursement for hospital based rural health clinics: Interim reimbursement to hospital, or other facility, based rural health clinics is made at the percentage determined by MAD. Adjustments and fiscal year reconciliations are made by MAD.

[2/1/95; 8.310.3.16 NMAC - Rn, 8 NMAC 4.MAD.712.7, 3/1/12]

HISTORY OF 8.310.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD Rule 310.1800, Rural Health Clinic Services, filed 2/18/80.
ISD-Rule 310.1800, Rural Health Clinic Services, filed 2/24/86.

8.310.3 NMAC
MAD Rule 310.18, Rural Health Clinic Services, filed 4/27/88.
MAD Rule 310.18, Rural Health Clinic Services, filed 4/21/92.

History of Repealed Material: [RESERVED]
STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
PROFESSIONAL SERVICES CONTRACT

The Professional Services Contract (PSC) is made and entered into by and between the State of New Mexico, Human Services Department hereinafter referred to as HSD and NAME OF CONTRACTOR, hereinafter referred to as (the “Contractor”), and is effective as of the date set forth below upon which it is executed by the Department of Finance and Administration (DFA).

IT IS MUTUALLY AGREED BETWEEN THE APARTIES:

1. **Scope of Work.**

The Contractor shall perform all services detailed in Scope of Work, Exhibit A, attached to this PSC, and incorporated in this PSC by reference.

2. **Compensation.**

   A. The total amount payable to the Contractor under this PSC, including gross receipts tax and expenses, shall not exceed (AMOUNT). This amount is a maximum and not a guarantee that the work assigned to Contractor under this PSC to be performed shall equal the amount stated herein.

   B. HSD shall pay to the Contractor in full payment for services satisfactorily performed at the rate of ____________ dollars ($____________) per hour (OR BASED UPON DELIVERABLES, MILESTONES, BUDGET, ETC.), such compensation not to exceed (AMOUNT) (as set forth in Paragraph A) excluding gross receipts tax. The New Mexico gross receipts tax levied on the amounts payable under this PSC totaling (AMOUNT) shall be paid by HSD to the Contractor. Payment is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work, and to approval by HSD. All invoices MUST BE received by HSD no later than fifteen (15) days after the termination of the Fiscal Year in which the services were delivered. Invoices received after such date WILL NOT BE PAID.

CHOICE – MULTI-YEAR – HSD shall pay to the Contractor in full payment for services satisfactorily performed pursuant to the Scope of Work at the rate of ________ dollars ($____________) in FYXX 9USE FISCAL YEAR NUMBER TO DESCRIBE YEAR; DO NOT USE FY1, FY2, ETC.). The New Mexico gross receipts tax levied on the amounts payable under this PSC in FYXX totaling (AMOUNT) shall be paid by HSD to the Contractor. The total amount payable to the Contractor under this PSC, including gross receipts tax and expenses, shall not exceed (AMOUNT) in FYXX.

(REPEAT LANGUAGE FOR EACH FISCAL YEAR COVERED BY THE PSC – USE FISCAL YEAR NUMBER TO DESCRIBE EACH YEAR; DO NOT USE FY1, FY2, ETC.).

Payment in FYXX, FYXX, FYXX, and FYXX is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work, and to approval by HSD. All invoices MUST BE received by HSD not later
than ten (10) days after the termination of the Fiscal Year in which the services were delivered. Invoices received after such date WILL NOT BE PAID.

C. Contractor must submit a detailed statement accounting for all services performed and expenses incurred. If HSD finds that the services are not acceptable, within thirty days after the date of receipt of written notice from the Contractor that payment is requested, it shall provide the Contractor a letter of exception explaining the defect or objection to the services, and outlining steps the Contract may take to provide remedial action. Upon certification by HSD that the services have been received and accepted, payments shall be tendered to the Contractor within thirty days after the date of acceptance. If payment is made by mail, the payment shall be deemed tendered on the date it is postmarked. However, HSD shall not incur late charges, interest, or penalties for failure to make payment within the time specified herein.

3. Term.

THIS PSC SHALL NOT BECOME EFFECTIVE UNTIL APPROVED BY THE DFA. This PSC shall terminate on DATE unless terminated pursuant to paragraph 4, infra, or paragraph 5. In accordance with Section 13-1-150 NMSA 1978, no contract term for a professional services contract, including extensions and renewals, shall exceed four years, except as set forth in Section 13-1-150 NMSA 1978.

4. Termination.

A. Termination. This PSC may be terminated by either of the parties hereto upon written notice delivered to the other party at least thirty (30) days prior to the intended date of termination. Except as otherwise allowed or provided under this PSC, HSD’s sole liability upon such termination shall be to pay for acceptable work performed prior to HSD’s receipt of the notice of termination, if HSD is the terminating party, or HSD’s sending of the notice of termination if HSD is the terminating party; provided, however, that a notice of termination shall not nullify or otherwise affect either party’s liability for pre-termination defaults under or breaches of this PSC. HSD shall submit an invoice for such work within thirty (3) days of receiving or sending the notice of termination. Notwithstanding the foregoing, this PSC may be terminated immediately upon written notice to HSD if HSD becomes unable to perform the services, contracted for, as determined by HSD or if, during the term of this PSC, HSD or any of its officers, employees or agents is indicted for fraud, embezzlement, or other crime due to misuse of stat funds or due to the Appropriations paragraph herein. THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE STATE’S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY HSD’S DEFAULT / BREACH OF THIS PSC.”

B. Termination Management. Immediately upon receipt by either HSD or the Contractor’s of notice of termination of this PSC, HSD shall 1) not incur any further obligations for salaries, services or any other expenditure of funds under this PSC without written approval of HSD; 2) comply with all directives issued by HSD in the notice of termination as to the performance of work, under this PSC; and 3) take such action as HSD shall direct for the protection, preservation, retention, or transfer of all property titled to HSD and records generated under this PSC. Any non-expendable personal property or equipment provided to or purchased by HSD with contract funds shall become property of HSD upon termination and shall be submitted to HSD as soon as practicable.
5. **Appropriations.**

The terms of this PSC are contingent upon sufficient appropriations and authorization being made by the Legislature of New Mexico for the performance of this PSC. If sufficient appropriations and authorization are not made by the Legislature, this PSC shall terminate immediately upon written notice being given by HSD to the Contractor. HSD’s decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If HSD proposes an amendment to the PSC to unilaterally reduce funding, the Contractor shall have the option to terminate the PSC or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

6. **Status of Contractor.**

The Contractor and its agents and employees are independent contractors performing professional services for HSD and are not employees of the State of New Mexico. The Contractor and its agent and employees shall not accrue leave, retirement, insurance, bonding, use of state vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this PSC. The Contractor acknowledges that all sums received hereunder are personally reportable by it for income tax purposes as self-employment or business income and are reportable for self-employment tax.

7. **Assignment**

The Contractor shall not assign or transfer any interest in this PSC or assign any claims for money due or to become due under this PSC without the prior written approval of HSD.

8. **Subcontracting.**

The Contractor shall not subcontract any portion of the services to be performed under this PSC without the prior written approval of HSD.

9. **Release.**

Final payment of the amounts due under this PSC shall operate as a release of HSD, its officers and employees, and the State of New Mexico from all liabilities, claims and obligations whatsoever arising from or under this PSC.

10. **Confidentiality**

Any confidential information provided to or developed by the Contractor in the performance of this PSC shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of HSD.

11. **Product of Service – Copyright.**

All materials developed or acquired by the Contractor under this PSC shall become the property of the State of New Mexico and shall be delivered to HSD no later than the termination date of this PSC. Nothing developed or produced, in whole or in part, by the Contractor under this PSC shall be the subject of an application for copyright or other claim of ownership by or on behalf of the Contractor.
12. **Conflict of Interest; Governmental Conduct Act**

The Contractor warrants that it presently has no interest and shall no acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the PSC. The Contractor certifies that the requirements of the Governmental Conduct Act, Sections 10-16-1 through 10-16-18, NMSA 1978, regarding contracting with a public officer or state employee or former state employee have been followed.

13. **Amendment.**

This PSC shall not be altered, changed or amended except by instrument in writing executed by the parties hereto.

14. **Merger**

This PSC incorporates all the PSC’s, covenants and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, PSCs and understandings have been merged into this written PSC. No prior PSC or understanding, oral or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this PSC.

15. **Penalties for violation of law.**

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities, and kickbacks.

16. **Equal Opportunity Compliance.**

The Contractor agrees to abide by all federal and state laws and rules and regulations, and executive orders of the Governor of the State of New Mexico, pertaining to equal employment opportunity. In accordance with all such laws of the State of New Mexico, the Contractor assures that no person in the United States shall, on the grounds of race, religion, color, nation origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this PSC. If Contractor is found not to be in compliance with these requirements during the life of this PSC, Contractor agrees to take appropriate steps to correct these deficiencies.

17. **Applicable Law.**

The laws of the State of New Mexico shall govern this PSC, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with Section 38-3-1 (g) NMSA 1978. By execution of this PSC, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this PSC.
18.  **Workers Compensation.**

The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this PSC may be terminated by HSD.

19.  **Records and Audit.**

The Contractor shall maintain, for five (5) years, detailed time records which indicate the date, time and nature of services rendered. These records shall be subject to inspection by HSD and the State Auditor. HSD shall have a right to audit billings both before and after payment; payment under this PSC shall not foreclose the right of HSD to recover excessive and/or illegal payments.

20.  **Indemnification**

The Contractor shall defend, indemnify and hold harmless HSD and the State of New Mexico from all actions, proceeding, claims, demands, costs, damages, attorneys’ fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this PSC, caused by the negligent act or failure to act of the Contractor, its officers, employees, servants, subcontractors or agents, or if caused by the actions of any client of the Contractor resulting in injury or damage to persons or property during the time when the Contractor or any officer, agent, employee, servant or subcontractor thereof has or is performing services pursuant to this PSC. In the event that any action, suit or proceeding related to the services performed by the Contractor or any officer, agent, employee, servant or subcontractor under this PSC is brought against the Contractor, the Contractor shall, as soon as practicable but no later than two (2) days after it receives notice thereof, notify the legal counsel of HSD and the Risk Management Division of the New Mexico General Services Department by certified mail.

21.  **New Mexico Employees Health Coverage**

A. If a Contractor has, or grow to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Contractor certifies, by signing this PSC, to:

1) Have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2008 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed one million dollars or;

2) Have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2009 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $500,000 dollars or;

3) Have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2010 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.
B. Contractor agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the state.

C. Contractor agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information: http://insurenewmexico.state.nm.us/.

D. For Indefinite Quantity, Indefinite Delivery Contracts (price PSCs without specific limitations on quantity and providing for an indeterminate number of orders to be placed against it); Contractor agrees these requirements shall apply the first day of the second month after the offeror reports combined sales (from state and, if applicable, from local public bodies if from a state price PSC) of $250,000, $500,000, or $1,000,000, depending on the dollar value threshold in effect at that time.

22. **Invalid Term or Condition.**

If any term or condition of this PSC shall be held invalid or unenforceable, the remainder of this PSC shall not be affected and shall be valid and enforceable.

23. **Enforcement of PSC.**

A party’s failure to require strict performance of any provision of this PSC shall not waive or diminish that party’s right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this PSC shall be effective unless express and in writing, and not effective waiver by a party of any of its rights shall be effective to waive any other rights.

24. **Notices.**

Any notice required to be given to either party by this PSC shall be in writing and shall be delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

- To HSD: [insert name, address and email].
- To the Contractor [insert name, address and email].

25. **Authority**

If Contractor is other than a natural person, the individual(s) signing this PSC on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter into a binding contract.

26. **Debarment and Suspension and Other Responsibility Matters**

Pursuant to CFR, Title 31, Part 19, Appendix A, the Contractor certifies, by signing this SPC, that it and its principals, to the best of its knowledge and belief:
A) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by an Federal department or Contractor

B) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

C) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or Local) with commission of any of the offenses enumerated in (1) (b) of this certification; and

D) Have not within a three-year period preceding this application / proposal had one or more public transactions (Federal, State or Local) terminated for cause or default.
In WITNESS WHEREOF, parties have executed this PSC as of the date of signature by the DFA Contracts Review Bureau, below.

By: ___________________________________________          Date: _________________________

Contractor

By: ___________________________________________          Date: _________________________

Sidonie Squier, Secretary
New Mexico Human Services Department

By: ___________________________________________          Date: _________________________

Ray Mensack, General Counsel
New Mexico Human Services Department

The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross receipts and compensating taxes.

ID Number: ____________________________________

By: ___________________________________________          Date: _________________________

New Mexico Taxation and Revenue Department

This PSC is approved by the DFA Contracts Review Bureau:

By:  ______________________________________    Date:________________________________

Contracts Review Bureau
New Mexico Department of Finance and Administration
ATTACHMENT ONE

SCOPE OF WORK

The Scope of Work for this procurement shall include, but not be limited to, the following:

1. **Performance of Audits**

   The audit agent will perform audits of the Hospitals, Home Health Agencies, Federally Qualified Health Centers, Rural Health Clinics, and Long Term Care Facilities which participates in the New Mexico Medical Program. The audits will include Desk Audits and Field Audits and complete reports of the audits submitted to the Department on a timely basis.

2. **Planning and Development**

   The objective of the planning and development task is to plan the Offeror’s activities for the duration of the contract and to develop working procedures to carry out the work required of Offerors by this RFP. This includes, but is not limited to:
   
   a. Audit objectives
   b. Audit procedures
   c. Audit instructions
   d. Audit forms
   e. Time frames for completing audits
   f. Reporting audit results to the department.

3. **Operations**

   a. Calculate DRG rates for applicable hospitals
   b. Compute initial rates for new providers
   c. Compute TEFRA target rates
   d. Compute all ceilings as described in the State Plan
   e. Rebase rates for ICF/MR providers every 3 years.
   f. Calculate new rates for Nursing Facilities
   g. Assist the Department in the development and implementation of a new reimbursement methodology for Nursing Facilities.
   h. Participate in appeals and requests for reconsideration
   i. Monitor timely submission of cost reports
   j. Maintain and distribute cost reporting forms
   k. Provide training as necessary
   l. Submit monthly status reports
   m. Refer any material irregularities or suspicion of fraud
   n. Attend regularly scheduled contract management meetings
   o. Track repayments and recoupments
p. Perform monitoring of the cost to charge ratio and calculate interim rates as needed.
q. Determine which hospitals qualify for Disproportionate Share Program (DSH) payments and calculate amounts.
r. Perform annual DSH audits to ensure that hospitals do not exceed their DSH limit as outlined in Federal Rules.
s. On an annual basis, calculate FQHC and RHC rates based on a methodology outlined in the State Plan.
t. Calculate annual reconciliation amounts for FQHC and RHC providers.
u. Compute applicable final settlements and issue notice of settlements to providers.
v. Compute quarterly Indirect Medical Education (IME) payments and Graduate Medical Education (GME) Payments.
w. Assist the Department in the transition of current programs to the new Centennial Care Program (i.e. The Sole Community Provider Fund Program).
x. Provide planning activities related to Electronic Health Records (EHR) such as pre-payment verification process for EHR eligibility, and development of a post payment audit strategy for State 1 “meaningful use” attestations and State 2 and Stage 3 attestations. Also, provide audit activities for the EHR Program.
y. Provide for audits of the MCO Contractor’s financial records at the discretion of the Department.

4. Training

Provide training for appropriate state officials and providers on an as needed basis.

5. Consultation

Provide upon request consultation and assistance relating to revision of or development of regulations, compliance with Federal requirements or other consultation as requested.

6. Confidentiality and Security

The CONTRACTOR will be responsible for the confidentiality and security of information in accordance with Federal regulations. The Federal Government (under 42CFR 431.300) and the Department require that all information pertaining to recipients be safeguarded and remain confidential.
The entering of a contract between HSD and the successful Offeror pursuant to this RFP is a “covered transaction,” as defined by 45 CFR Part 76. HSD”s contract with the successor Offeror shall contain a provision relating to debarment, suspension, and responsibility substantially in the form contained in Article 30 of Attachment F. All Offerors must provide as a part of their proposals a certification to HSD in the form provided below. Failure of Offerors to furnish a certification or provide such additional information as requested by the Procurement Manager for this RFP will render Offerors non-responsible. Furthermore, Offerors shall provide immediate written notice to the Procurement Manager for this RFP if, at any time prior to contract award, Offerors learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

Although HSD may review the veracity of the certification through the use of the federal Excluded Parties Listing System or by other means, the certification provided by Offerors in paragraph (a), below, is a material representation of fact upon which HSD will rely when making a contract award. If it is later determined that Offerors knowingly rendered an erroneous certification, in addition to other remedies available to HSD, HSD may terminate the contract resulting from this request for proposals for default.

The certification provided by Offerors in paragraph (a), below, will be considered in connection with a determination of Offeror’s responsibility. A certification that any of the items in paragraph (a), below, exists may result in rejection of Offeror’s proposal for non-responsibility and the withholding of an award under this RFP. If Offeror’s certification indicates that any of the items in paragraph (a), below, exits, Offerors shall provide with its proposal a full written explanation of the specific basis for, and circumstances connected to, the item; Offeror’s failure to provide such explanation will result in rejection of Offeror’s proposal. If Offeror’s certification indicates that any of the items in paragraph (a), below, exists, HSD, in its sole discretion, may request, that the U.S. Department of Health and Human Services grant an exception under 45 CFR §76.120 and 76.305 if HSD believes that the procurement schedule so permits and an exception is applicable and warranted under the circumstances. In no event will HSD award a contract to Offerors if the requested exception is not granted for Offerors.

(a)(1) By signing and submitting a proposal in response to this RFP, Offerors certifies, to the best of its knowledge and belief, that:

(i) Offerors and / or any of it Principals-
(A) Are, are not, presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (B) Have, have not, within a three-year period preceding the date of Offeror’s proposal, been convicted of or had a civil judgment rendered against them for; commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, tax evasion, or receiving stolen property; (C) Are, are not, presently indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with, commission of any of the offenses enumerated in paragraph (a)(1)(i)(B) of this certification. (D) Have, have not, within a three-year period preceding the date of Offeror’s proposal, had one or more public agreements or transactions (Federal, State, or local)
terminated for cause or default; and (E) Have, have not, been excluded from participation from Medicare, Medicaid, or other federal health care programs pursuant to Title XI of the Social Security Act, 42 U.S. C. § 1320a-7.

(ii) “Principal,” for the purposes of this certification, shall have the meaning set forth in 45 CFR § 76.995 and shall include an officer, director; owner, partner, principal investigator, or other person having management or supervisory responsibilities related to a covered transaction. “Principal” also includes a consultant or other person, whether or not employed by the participant or paid with Federal funds, who: is in a position to handle Federal funds; is in a position to influence or control the use of those funds; or occupies a technical or professional position capable of substantially influencing the development or outcome of an activity required to perform the covered transaction.

(iii) For the purposes of this certification, the terms used in the certification, such as covered transaction, debarred, excluded, exclusion, ineligible, ineligibility, participant, and person have the meanings set forth in the definitions and coverage rules of 45 CFR Part 76.

(iv) Nothing contained in the foregoing certification shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of Offerors is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

OFFEROR: ____________________________________________________________________________

SIGNED BY ____________________________________________________________________________

TITLE: ________________________________________________________________________________

DATE: _______________________________________________________________________________
APPENDIX 10
COST REPORT FORM

A = Price of conducting normal scope of audit work (Appendix 9, Paragraph 1A1)

B(x) = (Plus the) Hourly rate of consultation multiplied by 80 hours of consultation.

C1 = Total Price for the two year contract: $____________________

C2 = C1 plus inflator $____________________

C3 = C2 plus inflator $____________________

TOTAL COST $____________________

DEFINE THE FOLLOWING:

Inflator = __________%

Average Hourly Cost $____________________

Average Cost Per Facility $____________________

Average Desk Review $____________________

Average Field Audit Cost $____________________
APPENDIX 11
CAMPAIGN CONTRIBUTION DISCLOSURE FORM

Pursuant to the Procurement Code, Sections 13-1-28, et seq., NMSA 1978 and NMSA 1978, § 13-1-191.1 (2006), as amended by Laws of 2007, Chapter 234, any prospective contractor seeking to enter into a contract with any state agency or local public body for professional services, a design and build project delivery system, or the design and installation of measures the primary purpose of which is to conserve natural resources must file this form with that state agency or local public body. This form must be filed even if the contract qualifies as a small purchase or a sole source contract. The prospective contractor must disclose whether they, a family member or a representative of the prospective contractor has made a campaign contribution to an applicable public official of the state or a local public body during the two years prior to the date on which the contractor submits a proposal or, in the case of a sole source or small purchase contract, the two years prior to the date the contractor signs the contract, if the aggregate total of contributions given by the prospective contractor, a family member or a representative of the prospective contractor to the public official exceeds two hundred and fifty dollars ($250) over the two year period.

Furthermore, the state agency or local public body may cancel a solicitation or proposed award for a proposed contract pursuant to Section 13-1-181 NMSA 1978 or a contract that is executed may be ratified or terminated pursuant to Section 13-1-182 NMSA 1978 of the Procurement Code if: 1) a prospective contractor, a family member of the prospective contractor, or a representative of the prospective contractor gives a campaign contribution or other thing of value to an applicable public official or the applicable public official’s employees during the pendency of the procurement process or 2) a prospective contractor fails to submit a fully completed disclosure statement pursuant to the law.

The state agency or local public body that procures the services or items of tangible personal property shall indicate on the form the name or names of every applicable public official, if any, for which disclosure is required by a prospective contractor.

THIS FORM MUST BE INCLUDED IN THE REQUEST FOR PROPOSALS AND MUST BE FILED BY ANY PROSPECTIVE CONTRACTOR WHETHER OR NOT THEY, THEIR FAMILY MEMBER, OR THEIR REPRESENTATIVE HAS MADE ANY CONTRIBUTIONS SUBJECT TO DISCLOSURE.

The following definitions apply:

“Applicable public official” means a person elected to an office or a person appointed to complete a term of an elected office, who has the authority to award or influence the award of the contract for which the prospective contractor is submitting a competitive sealed proposal or who has the authority to negotiate a sole source or small purchase contract that may be awarded without submission of a sealed competitive proposal.

“Campaign Contribution” means a gift, subscription, loan, advance or deposit of money or other thing of value, including the estimated value of an in-kind contribution, that is made to or received by an applicable public official or any person authorized to raise, collect or expend contributions on that official’s behalf for the purpose of electing the official to statewide or local office. “Campaign Contribution” includes the payment of a debt incurred in an election campaign, but does not include the value of services provided without compensation or unreimbursed travel or other personal
expenses of individuals who volunteer a portion or all of their time on behalf of a candidate or political committee, nor does it include the administrative or solicitation expenses of a political committee that are paid by an organization that sponsors the committee.

“Family member” means spouse, father, mother, child, father-in-law, mother-in-law, daughter-in-law or son-in-law of (a) a prospective contractor, if the prospective contractor is a natural person; or (b) an owner of a prospective contractor.

“Pendency of the procurement process” means the time period commencing with the public notice of the request for proposals and ending with the award of the contract or the cancellation of the request for proposals.

“Prospective contractor” means a person or business that is subject to the competitive sealed proposal process set forth in the Procurement Code or is not required to submit a competitive sealed proposal because that person or business qualifies for a sole source or a small purchase contract.

“Representative of a prospective contractor” means an officer or director of a corporation, a member or manager of a limited liability corporation, a partner of a partnership or a trustee of a trust of the prospective contractor.

Name(s) of Applicable Public Official(s) if any: ______________________________________
(Completed by State Agency or Local Public Body)

DISCLOSURE OF CONTRIBUTIONS BY PROSPECTIVE CONTRACTOR:

Contribution Made By: ____________________________________________________________

Relation to Prospective Contractor: ________________________________________________

Date Contribution(s) Made: ______________________________________________________

Amount(s) of Contribution(s) ______________________________________________________

Nature of Contribution(s) ________________________________________________________

Purpose of Contribution(s) ________________________________________________________

(Attach extra pages if necessary)

__________________________________________  ______________________________
Signature                  Date

Title (position)    —OR—
NO CONTRIBUTIONS IN THE AGGREGATE TOTAL OVER TWO HUNDRED FIFTY DOLLARS ($250) WERE MADE to an applicable public official by me, a family member or representative.

______________________________  _______________________
Signature     Date

______________________________
Title (Position)

______________________________
Contractor Name
New Mexico Employees Health Coverage Form

1. For all contracts solicited and awarded on or after January 1, 2008: If the offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, offeror must agree to:

    (a) have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2008 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed one million dollars or;

    (b) have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2009 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $500,000 dollars or

    (c) have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2010 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

2. Offeror must agree to maintain a record of the number of employees who have (a) accepted health insurance; (b) decline health insurance due to other health insurance coverage already in place; or (c) decline health insurance for other reasons. These records are subject to review and audit by a representative of the state.

3. Offeror must agree to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information http://insurenewmexico.state.nm.us/.

4. For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for an indeterminate number of orders to be placed against it); these requirements shall apply the first day of the second month after the offeror reports combined sales (from state and, if applicable, from local public bodies if from a state price agreement) of $250,000, $500,000 or $1,000,000.

Signature of Offeror: ____________________________  Date________________