COST RELATED REIMBURSEMENT OF NURSING FACILITIES

The New Mexico Title XIX Program make reimbursement for appropriately licensed and certified Nursing Facility (NF) services as outlined in this material.

I. GENERAL REIMBURSEMENT POLICY:

The Human Services Department will reimburse Nursing Facilities (effective October 1, 1990, the SNF/ICF distinction is eliminated; see section VIII) the lower of the following, effective July 1, 1984:

A. Billed Charges;

B. The prospective rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. NURSING FACILITY RATE DETERMINATION FOR VENTILATOR DEPENDENT RESIDENTS

1. Effective for dates of service on and after March 14, 2022, the nursing facility per diem for a ventilator dependent resident will be $305.66.

2. The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning March 14, 2022.

3. Ventilator dependent per diem rates will cover all skilled nursing care services and will be all-inclusive.

4. No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.

5. The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization (PA) through the Department's Medical Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the New Mexico Medicaid nursing home per diem rate determined for the facility.

III. DEFINITIONS

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.

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.

Governmental Institution – A provider of services owned and operated by a federal, state or local governmental agency.

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.

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

IV. 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 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90-day limit,

d. 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.

e. 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 Medical Assistance Manual Section 307.

6. Any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

V. 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:

Such providers will not be eligible for incentive payments until the next operating year 1, 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 G or H, whichever is applicable, will apply.

2. When a facility has been closed and re-enters the Medicaid program within 12 months of closure under the same ownership, 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 more than 12 months after closure, under the same ownership, the provider's prospective rate will be the sum of:

   a) the median operating cost for its category
   b) the lower of allowable facility costs or the applicable facility cost ceiling.

Providers of such facilities will not be eligible for incentive payments until the next operating year 1, after rebasing.

VI. ESTABLISHMENT OF CEILINGS

The following categories are used to establish ceilings used in 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 or inclusion in any one category.

Ceilings will be separately established for each category as described above, and separately established for 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

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 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 which are in the same category.

VII. IMPUTED OCCUPANCY

In order to insure 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:

1. Any new facility certified for participation in the Medicaid program on or after January 1, 1988.

2. 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.

3. 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.

4. Any replaced facility which re-enters the Medicaid program on or after January 1, 1988, either under the same ownership or different ownership.

5. Any closed facility which re-enters the Medicaid program on or after January 1, 1988.

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.

VIII. 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, social security taxation of 501(c)(3) corporations, 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.

   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 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 the approval if retroactive approval was obtained.

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.

IX. IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENT 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.

   High NF
   Low NF

2. A High NF rate and 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 ICFs, the Low NF rate will be the provider's ICF rate in effect on September 30, 1990.

5. 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 (i.e. the average difference) of the operating component of current SNF/ICF rates.

6. 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 (i.e. the average difference) 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

X. 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.

XI. RECONSIDERATION PROCEDURE 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.

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.

XII. 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.

XIII. SEVERABILILTY

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