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TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 3 COST RELATED REIMBURSEMENT OF NURSING FACILITIES

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.

[2/1/95; 8.312.3.7 NMAC - Rn, 8 NMAC 4 MAD.731-D.II, 7-1-02]

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.

[2/1/95; 8.312.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7-1-02; A, 12/31/10]

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.

[2/1/95; 8.312.3.9 NMAC - Rn, 8 NMAC 4 MAD.731-D, 7-1-02]

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.

[2/1/95; 8.312.3.10 NMAC - Rn, 8 NMAC 4 MAD.731-D.I, 7-1-02; A, 12/31/10]

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.

(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, bandaids, 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 providers 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.

[2/1/95; 8.312.3.11 NMAC - Rn, 8 NMAC 4 MAD.731-D.III, 7-1-02; A, 12-01-04; A, 12/31/10]

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. Rebasing 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.

$I = [1/2(M - N)] \leq \$2.00$

where

M = current operating cost ceiling per diem

N - allowable operating per diem rate based on the base year's cost report

I = 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

$PR = BYOC \times (1 + \Delta MBI) + I + FC$

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

$PR = (OP+ I) \times (1 + \Delta MBI) + FC$

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 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 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.

(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 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:

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 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.

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.

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]