

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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ATTACHMENT 4.19-D

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Of Section 1902(a)(13)(A) of the Social Security Act

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- NURSING FACILITIES AND
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

OMB No.: 0938-1136
CMS Form: CMS-10364

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

Reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Effective July 1, 2011, reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

No payment shall be made for services for Other Provider Preventable Conditions (OPPCs). OPPC is one category of Provider Preventable Conditions (PPC), as identified by the Centers for Medicare & Medicaid Services, and applies broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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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. REIMBURSEMENT FOR TRIBAL 638 FACILITIES:

Effective August 18, 2023, the Human Services Department will reimburse Tribal 638 Nursing Facilities at the Office of Management and Budget (OMB) outpatient rate as published and specified in the Federal Register. This rate will be updated annually based on rates published each year in the Federal Register by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321 (a) and 322 (b) of the Public Health Service Act (42 U.S.C. 248 and 249 (b)), Public Law 83-568 (42 U.S.C. 2001 (a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

III. 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.

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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.

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.

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.

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.

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.

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.

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.

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:

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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.

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.

Facility -- The actual physical structure in which services are provided.

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.

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.

Replaced Facility -- The facility replaced by a replacement facility as defined above.

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).

Imputed Occupancy -- The level of occupancy attributed for the purpose of calculating the reimbursement rate.

Owner -- The entity holding legal title to the facility.

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III. 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,

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unless an extension is granted prior to the due date, will result in termination of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

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

1. Audits will be performed in accordance with 42 CFR 447.202.

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.

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

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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 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;
 - 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.

a. Operating Costs include such things as:

- (1) Regular room.
- (2) Dietary and nursing services.
- (3) Medical and surgical supplies (including syringes, catheters, ileostomy, and colostomy supplies).
- (4) Use of equipment and facilities.
- (5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.
- (6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.
- (7) 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, OTC ointments, and tongue depressors.
- (8) 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.
- (9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.
- (10) Laundry services including basic personal laundry.

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(11) 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 on-going basis:

- a) The long term care facility 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
- b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in section 310.0805 (B).

(12) Managerial, administrative, professional, and other services related to the providers operation and rendered in connection with patient care.

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

(1) 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.

- a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.
- b) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.
- c) Fair market value is the price for which an asset would have been purchased on the date of acquisition in

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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.

d) 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.

e) 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.

(2) 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.

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

c. 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.

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- 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.

IV. 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 1, Year 2, and Year 3. Because rebasing is done every three years, operating year 4 will again become Year 1, etc.

Cost 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. Rebasing of costs in excess of 110% 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 Year1 (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 report. The rate period January 1, 1996, through June 30, 1996, will be considered Year 1. The rate period July 1, 1996, through June 30, 1997, will be considered Year 2, and the rate period July 1, 1997, through June 30, 1998, will be considered year 3. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section.

Effective for dates of service on or after July 1, 2015, each private nursing facility's existing "Low Level of Care" rate is increased 4%.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (NHI).

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 1. For the out of cycle rebasing occurring for rates effective January 1, 1996,

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through June 30, 1996, the mid-year point for indexing for operating Year 1 will be 3/31.

The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the NHI for the previous year plus 2 percentage points. For each rate period thereafter, the inflation factor will be the change in the NHI for the previous year.

C. Incentives to Reduce Increase in Costs

As an incentive to reduce the increases in the costs of operation, the Department will share with the provider

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in accordance with the formula described below 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 1

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

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 NHI as described in B above

I = Allowable incentive per diem

FC = Allowable facility costs per diem

Years 2 and 3

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

Where

PR = Prospective per diem rate

OP = Allowable operating costs per diem

I = Allowable incentive per diem

NHI = The change in the NHI 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.

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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

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:

1. The applicable facility cost ceiling.
2. The operating cost ceiling.

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:

1. The lower of allowable facility costs or the applicable facility cost ceiling
2. The lower of allowable operating costs or the operating cost ceiling

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

G. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs determined by using the Medicare principles of reimbursement, or the facility cost ceiling.
2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

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H. Changes of provider by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling, as defined by this plan.
2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, 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.
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

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:

1. The median operating cost for its category.
2. The lower of allowable facility costs or the applicable facility cost ceiling.

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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, which ever 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.

V. 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

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facility cost ceiling of \$11.50 will be trended forward in Year 2 beginning July 1, 1985, by NHI minus 1 percentage points and then annually by the NHI.

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 which are 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

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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 section IV, B, 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

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- 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.

VI. 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.

VII. 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.

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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.

VIII. 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.

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 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.

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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

IX. 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.

X. 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.

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- 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.

XI. 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.

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- 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.

XII. SEVERABILITY

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

COMPARISON IN CERTIFICATION REQUIREMENTS

<u>Requirement</u>	<u>Cost Effect</u>	<u>Comments</u>
1. Nurse aide continuing education/in-service	\$0.11	
2. Supplies	\$0.04	for continuing education and in-service
3. RN-8hr.*	\$0.39	
4. 24 hour nursing*	\$0.18	
5. Physician Involvement*	\$0.06	
6. Social services and elimination of ICP/SNP distinction*	\$0.64	
7. Wage adjustment for trained aides	\$0.90	
8. Overtime staff costs due to aide training	\$0.23	
9. PASAAR screen	\$0.01	
10. Pharmacy & dietary consulting	\$0.15	
11. Resident rights	\$0.01	
12. Interest bearing accounts/surety bonds	\$0.10	
13. Increased aide staffing for restraints and individualized needs	\$1.11	

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SUPERSEDES: TN- *94-06*

14. Increased social services/activities staff for individual resident needs \$0.72

15. Resident assessment \$0.31

TOTAL COST PER PATIENT DAY \$4.96

* Increases do not apply to existing SNFs as these requirements already built into SNF cost report.

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EXHIBIT D
ESTIMATION OF COSTS COSTA '00 L'0
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CATEGORY

NURSE AIDE CONTINUING
EDUCATION/INSERVICE

SUPERSEDES: TN - *94-06*

9.11 ASSUME A STANDARD OF 24 HOURS OF IN-SERVICE TRAINING PER AIDE
THIS CATEGORY HAS TWO COMPONENTS: 1) THE COST OF MAINTAINING
STAFFING LEVEL WHILE THE AIDES ARE RECEIVING IN-SERVICE TRAINING AND THE
COST OF THE IN-SERVICE INSTRUCTOR. THE FIRST COMPONENT IS CALCULATED
AS FOLLOWS: ADDITIONAL COSTS OF PROVIDING IN-SERVICE TRAINING TO AIDES
NOT AT THE 24 HOUR LEVEL DIVIDED BY THE NUMBER OF PATIENT DAYS
IN THOSE FACILITIES $1077151.25/87096 = .0071$ THE COST FOR THE IN-SERVICE
INSTRUCTOR IS BASED ON THE SALARY LEVEL OF AN RN AND ON THE
NUMBER OF HOURS NEEDED TO ACHIEVE THE STANDARD DIVIDED BY THE NUMBER OF
PATIENT DAYS IN THE AFFECTED FACILITIES $102016.31/87096 = .0023$

SUPPLIES

9.04 THIS COST IS BASED ON THE PROVISION OF INSTRUCTOR MANUALS AT AN AVERAGE COST OF
\$22.13, VIDEO AT AN AVERAGE COST OF \$22.13 PER FACILITY AND STUDENT
STUDENT MANUALS AT AN AVERAGE COST OF \$4.22.25 PER FACILITY. MISCELLANEOUS COSTS SUCH AS
PAPER, PENS, ETC. ARE ALSO INCLUDED. A TURNOVER RATE IS CALCULATED FOR EACH
FACILITY USING TOTAL 0-24 HOURS CURRENT AIDE LEVEL. $101073/1375735$
THE DIVISOR IS EQUAL TO RELEVANT PATIENT DAYS.

8 HRS PER DAY SN COVERAGE

9.09 THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS
THE COST OF OBTAINING THE REQUIRED COVERAGE.
 $6536386/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

24 HOUR NURSING COVERAGE

9.10 THIS IS ADJUSTMENT TO ASSURE LICENSED NURSE COVERAGE AROUND THE CLOCK.
 $6249590/1375735$

PHYSICIAN INVOLVEMENT

9.06 THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS
THE COST OF OBTAINING THE REQUIRED SERVICE.
 $997507/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

SOCIAL SERVICES &
ICF/SNF DISTINCTION

9.04 ADDITIONAL COSTS NECESSARY TO MEET NF STANDARDS, TO ADDRESS NEW QUALIFICATIONS
FOR SOCIAL WORKERS, ACTIVITIES DIRECTORS, MEDICAL RECORDS
TECHNICIANS AND THE ADDITION OF A DENTAL ADVISOR.
 $882068/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

NURSE ADJUSTMENT FOR
TRAINED AIDES

9.90 THIS REPRESENT A DIFFERENTIAL BETWEEN NEW UNTRAINED NURSES AND
TRAINED AIDES. $61241839/1375735$

OVERTIME STAFF COSTS DUE TO
AIDE TRAINING

9.23 THIS REPRESENTS THE COSTS ON ENSURING ADEQUATE STAFFING WHILE AIDES
ARE IN TRAINING. $9316963/1375735$

PASAPR SCREENING

9.01 THIS COVERS THE COST OF NEW AND ON-GOING LEVEL 1 SCREENS.
 $94127.21/1375735$

RESIDENT ASSESSMENT AND CARE
PLANNING/SERVICE

9.31 CALCULATED BASED ON FOUR ASSESSMENTS PER BED USING AN AVERAGE
FACILITY SIZE OF 85 BEDS; AVERAGE OF 2.75 AS PER ASSESSMENT;
AT A RATE OF \$14.00 PER HOUR OF ASSESSMENT.

PHARMACY & DIETARY
CONSULTANT

0.15 BASED ON 4 HOURS PER MONTH PER CONSULTANT AT \$50
PER HOUR PER 80 RESIDENTS.
2/11/92/32120

RESIDENT RIGHTS
REQUIREMENTS

0.01 BASED ON \$1.00 PER ADMISSION PACKET AT 15%
TURNOVER RATE OF AVERAGE OF 80 RESIDENTS PER YEAR. INCLUDES
COST OF FORMS, TAPE, TRANSLATION, ETC.
0132/32120

INTEREST BEARING ACCOUNTS
SURETY BONDS

0.10 BASED ON THE NUMBER OF RESIDENTS REQUIRING THAT SERVICE.
THIS ASSUMES 80 PERCENT OF THE RESIDENTS IN AN 80 BED
FACILITY WILL NEED THE SERVICE; THE COST FOR THE ACCOUNTS IS
ONE HOUR AT A COST OF \$11 PER HOUR FOR 80 RESIDENTS; AND AN
ADDITION OF \$500 PER FACILITY FOR THE SURETY BONDS.

ACTIVITIES/SOCIAL SERVICES
INCREASED STAFF FOR INDIVIDUALIZED
SERVICES

0.72 ADDITIONAL STAFF TO ADDRESS RESIDENT NEEDS. BASED ON
30 HOURS OF SOCIAL SERVICES AND 10 HOURS OF
ACTIVITIES WITH ASSOCIATED TOTAL COSTS OF \$17,500 AND \$5,000 RESPECTIVELY
PER 80 RESIDENTS.

INCREASED AIDE STAFFING FOR
INDIVIDUALIZED SERVICES

01.11 BASED ON 2 FTE AIDES WITH BENEFITS PER DAY. ASSUME AIDE COST OF
\$6.12 PER HOUR WITH BENEFITS AT 16 HOURS PER DAY PER 80 RESIDENTS.

TOTAL OBRA '87 LTC COST
PER PATIENT DAY

34.96

NOTE:

ESTIMATES FOR THE FIRST NINE ITEMS IN THIS DOCUMENT WERE DERIVED FROM
FACILITY SPECIFIC INFORMATION COLLECTED VIA A COMPUTERIZED TOOL DEVELOPED
BY THE NEW MEXICO HEALTH CARE ASSOCIATION, PETERSON HALL
& DOWN & BOC SEIDMAN. THE REMAINING ITEMS WERE DEVELOPED BY THE
BY A REASSESSMENT COMMITTEE OF THE NMHCA.
THE NMHCA THEN PRESENTED A PACKAGE TO THE MEDICAL ASSISTANCE DIVISION
THE DIVISION REVIEWED THE SUBMISSION THEN RECOMMENDED ADDITIONAL CHANGES.
THESE FINAL FIGURES REPRESENT THE FINAL NEGOTIATIONS WITH THE
EXECUTIVE DIRECTOR AND PRESIDENT OF THE ASSOCIATION.

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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.

I. GENERAL REIMBURSEMENT POLICY

The Human Services Department will reimbursement ICF/MR facilities the lower of the following, effective for services rendered on or after September 1, 1990:

- A. Billed charges;
- B. The prospective per diem rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. 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, precesses, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

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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. If amounts are received from the Federal Government to finance hospital activities or service operations that are covered by the Medicaid program, then these amounts must be treated as applicable credits.

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.

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.

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.

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.

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.

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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.

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 recipient charges to total charges on a departmental basis.
2. ratio of recipient 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.

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.

Facility --The actual physical structure in which services are provided.

Owner --The entity holding legal title to the facility.

III. DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS

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 ICF/MR providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing

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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 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, unless an extension is granted prior to the due date, will result in suspension of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

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 of ownership.

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D. Retention of Records

1. Each ICF/MR 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 N.M. 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 report.

E. Audits

Audits will be performed in accordance with 42 CFR 447.202.

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.

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

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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 60 days following the discovery.
- 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;
 - 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.
 - a. Operating costs include such things as:
 - (1) Regular room
 - (2) Dietary and nursing services
 - (3) Medical and surgical supplies (including but not limited to

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syringes, catheters, ileostomy, and colostomy supplies).

- (4) Use of equipment and facilities
- (5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.
- (6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.
- (7) 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, OTC ointments, and tongue depressors.
- (8) 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.
- (9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.
- (10) Laundry services other than for personal clothing.
- (11) 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 on-going basis:

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- a) 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
 - b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in that section.
- (12) All services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.
- (13) Managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.
- b. Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.
- (1) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.
- a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.
 - b) Historical cost is the actual

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cost incurred in acquiring and preparing an asset for use.

- c) 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.
 - d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15) will apply.
 - e) 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.
- (2) 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.
 - (3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

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c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with the 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.

d. Depreciation, interest, lease cost, or other costs are subject to limitations stated in the HIM-15.

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 States's cost reports.

3. Return on equity capital.

4. Other cost and expense items identified as unallowable in HIM-15.

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5. Interest paid on overpayments as per Medical Assistance Manual Section 307.
6. Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

IV. 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 ceiling:

A. Base Year

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.

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 1, Year 2, and Year 3. Since rebasing is done every three years, operating year 4 will again become Year 1, etc.

Costs incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which ends in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing 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.

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- B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (MBI)- Without Capital and Medical Fees.

Each provider's operating costs will be indexed to a mid-year point of February 28 for operating Year 1.

The inflation factor will be the percentage change in the most current available actual or forecast MBI for the previous calendar year.

- C. Incentive to Reduce Increases in Cost

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:

$$A = [1/2 (B-C)] \leq \$1.00$$

Where:

A = Allowable Incentive per diem

B = A&G/R&B 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)

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E. Case-Mix Adjustment

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 will be used to adjust the reimbursement levels in the Direct Patient Care cost center. The key objective of the case-mix adjustment 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:

Level I	1.077
Level II	0.953
Level III	0.768

Using these level specific relative values, a provider specific base year case-mix index (CMI) will be derived. 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:

$$[(A \times 1.077) + (B \times .953) + (C \times .768)] / N = \text{CMI}$$

WHERE: A = Number of Level I residents
B = Number of Level II residents
C = Number of Level III residents
N = Total number of provider's residents

F. Calculation of the Prospective Per Diem Rate

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.

The provider's Direct Patient Care (DPC) allowable cost per diem will be divided by the provider's case-mix index 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

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classification to determine the DPC component of the rate. To this, will be added the allowable cost per diem A & G and R & B amount (as constrained by the ceiling described in Section V.,B.) and the allowable facility cost per diem. The formula for the rates will be as follows:

The formula for Year 1 is:

$$(A1 \times RV) + C1 + D + E = PR \text{ (Year 1)}$$

The formula for Year 2 is:

$$[(A1 \times RV) + C1] \times (1 + MBI)] + D + E = PR \text{ (Year 2)}$$

The formula for Year 3 is:

$$[(A2 \times RV) + C2] \times (1 + MBI)] + D + E = PR \text{ (Year 3)}$$

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

"1" = The numerical subscript means the date of the data used in the formula. For example, "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

Each provider will have three prospective rates, one for each of the three levels of care(I, II, and III.)

G. Effective dates of prospective rates

Rates will be effective September 1 of each year for each facility. In addition, the case mix index for

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each facility will be reviewed at the mid point of each year. At that time, the rate will be readjusted to reflect the current case mix index.

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 (as described in Section V.B.) per diem plus;
3. Facility cost per diem as determined by using the Medicare principles of reimbursement.

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 cost report must be submitted no later than 90 days after the completion of the six month period or the fiscal year end, whichever comes later. 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 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.

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J. Changes of ownership by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate 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 and exiting facility

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

V. 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 (using the index described in Section IV.B.) to 12/31 of the base year. The ceiling will then be indexed (using the index described in Section IV.B.) 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

No ceiling will be imposed on this cost center, except in relation to leases.

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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).

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 Section IV, B 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 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.

VI. 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. Therefor, the provider may request such an adjustment for the following reasons:

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- 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.

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.

VII. RESERVE BED DAYS

Reserve bed days will be paid using the provider's Level III rate.

VIII. 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

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- 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. 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.

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- 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.

IX. 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.

X. SEVERABILITY

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