**TITLE 8 SOCIAL SERVICES**
**CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES**
**PART 3 COST RELATED REIMBURSEMENT OF ICF/IID FACILITIES**

**8.313.3.1 ISSUING AGENCY:** Health care authority (HCA), medical assistance division.
[8.313.3.1 NMAC - Rp 8.313.3.1 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.2 SCOPE:** This rule applies to the general public.
[8.313.3.2 NMAC - Rp 8.313.3.2 NMAC, 7/1/2024]

**8.313.3.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.313.3.3 NMAC - Rp 8.313.3.3 NMAC, 7/1/2024]

**8.313.3.4 DURATION:** Permanent.
[8.313.3.4 NMAC - Rp 8.313.3.4 NMAC, 7/1/2024]

**8.313.3.5 EFFECTIVE DATE:** July 1, 2024, unless a later date is cited at the end of a section.
[8.313.3.5 NMAC - Rp 8.313.3.5 NMAC, 7/1/2024]

**8.313.3.6 OBJECTIVE:** The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.313.3.6 NMAC - Rp 8.313.3.6 NMAC, 7/1/2024]

**8.313.3.7 DEFINITIONS:**

**A. Terms beginning with the letter "A":**

**(1) "Accrual basis of accounting"** means 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.

**(2)** "**Allocable costs"** means 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.

**(3)** "**Applicable credits"** means 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.

**B. Terms beginning with the letter "B": [RESERVED]**

**C. Terms beginning with the letter "C":**

**(1) "Cash basis of accounting"** means 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.

**(2)** "**Charges"** means 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 HCA shall be the usual and customary rate charged to all patients.

**(3)** "**Cost center"** means 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.

**(4)** "**Cost finding"** means 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.

**D. Terms beginning with the letter "D": [RESERVED]**

**E. Terms beginning with the letter "E": [RESERVED]**

**F. Terms beginning with the letter "F": "Facility"** means the actual physical structure in which services are provided.

**G. Terms beginning with the letter "G":**

**(1) "General service cost centers"** means 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.

**(2)** "**Governmental institution"** means a provider of services owned and operated by a federal, state or local governmental agency.

**H. Terms beginning with the letter "H": [RESERVED]**

**I. Terms beginning with the letter "I":** "**Inpatient cost centers**" means cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

**J. Terms beginning with the letter "J": [RESERVED]**

**K. Terms beginning with the letter "K": [RESERVED]**

**L. Terms beginning with the letter "L": [RESERVED]**

**M. Terms beginning with the letter "M": [RESERVED]**

**N. Terms beginning with the letter "N": [RESERVED]**

**O. Terms beginning with the letter "O": "Owner"** means the entity holding legal title to the facility.

**P. Terms beginning with the letter "P": "Provider"** means 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.

**Q. Terms beginning with the letter "Q": [RESERVED]**

**R. Terms beginning with the letter "R": [RESERVED]**

**S. Terms beginning with the letter "S": "Special service cost centers"** is 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.

**T. Terms beginning with the letter "T": [RESERVED]**

**U. Terms beginning with the letter "U": [RESERVED]**

**V. Terms beginning with the letter "V": [RESERVED]**

**W. Terms beginning with the letter "W": [RESERVED]**

**X. Terms beginning with the letter "X": [RESERVED]**

**Y. Terms beginning with the letter "Y": [RESERVED]**

**Z. Terms beginning with the letter "Z": [RESERVED]**

[8.313.3.7 NMAC - Rp 8.313.3.7 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.8 MISSION STATEMENT:** We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.313.3.8 NMAC - Rp 8.313.3.8 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.9 COST RELATED REIMBURSEMENT OF ICF/IID FACILITIES:** The New Mexico title XIX program makes reimbursement for appropriately licensed and certified intermediate care facilities for individuals with intellectual disabilities as outlined in this material.
[8.313.3.9 NMAC - Rp 8.313.3.9 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.10 GENERAL REIMBURSEMENT POLICY:** The HCA will reimburse ICF/IID facilities the lower of the following, effective September 1, 1990:

**A.** billed charges;

**B.** the prospective rate as constrained by the ceilings established by the HCA as described in this plan.

[8.313.3.10 NMAC - Rp 8.313.3.10 NMAC, 7/1/2024; A, 9/1/2026]

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

**A. Adequate cost data:**

**(1)** Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

**(2)** The cost finding method to be used by ICF/IID providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

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

**C.** Cost reporting:

**(1)** At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. title XIX cost reporting form. This cost report must be submitted on an annual basis to the medical assistance division (MAD) or its designee within the time frames specified by medicare. ICF/IIDs will not be granted an extension to the cost report filing time frames. Failure to file a cost report within the specified time frames will result in suspension of title XIX payments.

**(2)** In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The HCA will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the HCA. The provider must notify the HCA 60 days prior to any change of ownership.

**D.** Retention of records:

**(1)** Each ICF/IID provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

**(2)** The state agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

**E.** Audits: Audits will be performed in accordance with 42 CFR 447.202.

**(1)** Desk audit: Each cost report submitted will be subject to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

**(2)** Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

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

**G.** Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in the medicare provider reimbursement manual (PRM 15-1) that are not modified by these regulations.

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

**(a)** 42 CFR 442;

**(b)** Sections 1861(j) and 1902(a)(28) of the Social Security Act;

**(c)** standards included in 42 CFR 431.610;

**(d)** cost incurred to meet requirements for licensing under state law which are necessary to provide ICF/IID service.

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

**(a)** regular room;

**(b)** dietary and nursing services;

**(c)** medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies);

**(d)** use of equipment and facilities;

**(e)** general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

**(f)** items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

**(g)** items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors;

**(h)** items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment;

**(i)** special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

**(j)** laundry services other than for personal clothing;

**(k)** oxygen for emergency use--the HCA 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:

**(i)** the provider may purchase the oxygen and include it as a reimbursable cost in its cost report; this is the same as the method of reimbursement for oxygen administration equipment; or

**(ii)** the HCA will make payment directly to the medical equipment provider in accordance with procedures outlined in 8.324.5 NMAC, *Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics* and subject to the limitations on rental payments contained in 8.324.5 NMAC.

**(l)** all services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.;

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

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

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

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

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

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

**(iv)** In determining the historical cost of assets where an on-going facility is

purchased, the provisions of medicare provider reimbursement manual PRM 15-1 will apply.

**(v)** Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association useful lives guide.

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

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

**H.** Non-allowable costs:

**(1)** Bad debts, charity, and courtesy allowances: Bad debts on non-title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

**(2)** Purchases from related organizations: Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the states' cost reports.

**(3)** Return on equity capital.

**(4)** Other cost and expense items identified as unallowable in PRM 15-1.

**(5)** Interest paid on overpayments as per 8.302.2 NMAC, *Billing for Medicaid Services*.

**(6)** Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

[8.313.3.11 NMAC - Rp 8.313.3.11 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES:** Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

**A.** Base year:

**(1)** For implementation year one (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

**(2)** Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two, and year three. Since re-basing is done every three years, operating year four will again become year one.

**(3)** Costs 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 re-base the prospective per diem rate. Re-basing costs in excess of one hundred and ten percent of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

**B.** Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate. Pursuant to budget availability and at the HCA’s discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

**(1)** MBI will or will not be authorized for determining rates for the year; and

**(2)** the percentage increase if the MBI is authorized;

**(3)** if utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI);

**(4)** each provider's operating costs will be indexed to a mid-year point of February 28 for operating year 1;

**(5)** if utilized, the inflation factor will be the actual MBI for the previous calendar year.

**C.** Incentive to reduce increases in cost:

**(1)** As an incentive to reduce the increases in the administrative and general (A&G) and room and board (R&B) cost center, the HCA will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

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

**(2)** 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)

**E.** Case-mix adjustment:

**(1)** In assuring the prospective reimbursement system addresses the needs of residents of ICF/IID facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the direct patient care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the HCA utilizes level of care criteria which classify ICF/IID 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

**(2)** Using these level specific relative values, a provider specific base year CMI will be calculated. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

[(A x 1.077)+(B x .953)+(C x .768)]/N = CMI

**(3)** 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:

**(1)** A prospective per diem rate for each of the three levels of ICF/IID classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

**(2)** The provider's direct patient care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

**(3)** The formula for year one is: (A1 x RV) + C1 + D + E = PR (year 1)

**(4)** The formula for year two is: [(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (year 2)

**(5)** The formula for year three is: [(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (year 3)

**(6)** Where:

A = allowable DPC per diem adjusted to a value of 1.00
B = the relative value of the level of classification.
C = allowable A&G and R&B per diem
D = allowable incentive per diem
E = allowable facility cost per diem
MBI = market basket index
PR = prospective rate
RV = the relative value for the level
"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.

**G.** Effective dates of prospective rates: Rates will be effective September 1 of each year for each facility.

**H.** Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990. For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

**(1)** the state wide average patient care cost per diem for each level plus;

**(2)** the A&G and R&B ceiling per diem plus;

**(3)** facility cost per diem as determined by using the medicare principles of reimbursement;

**(4)** after six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report; this will be audited to determine the actual allowable and reasonable cost for the provider; a final prospective rate will be established at that time, and retroactive settlement will take place.

**I.** Changes of provider by sale of an existing facility: When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

**(1)** the patient care cost per diem for each level, established for the previous owner plus;

**(2)** the A&G and R&B per diem established for the previous owner; plus

**(3)** allowable facility costs determined by using the medicare principles of reimbursement.

**J.** Changes of ownership by lease of an existing facility: When a change of ownership occurs, the provider's prospective per diem rate 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 existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[8.313.3.12 NMAC - Rp 8.313.3.12 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.13 ESTABLISHMENT OF CEILINGS:** Ceilings on the four major cost centers will be established as follow:

**A.** Direct patient care: No ceiling will be imposed on this cost center.

**B.** A&G and R&B: The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at one hundred ten percent of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year one and set. For years two and three, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

**C.** Facility cost:

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

**(2)** Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the 12 months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH).

**(3)** The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective, and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.

**(4)** Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the HCA the name of the appraiser, a copy of their certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the HCA.

[8.313.3.13 NMAC - Rp 8.313.3.13 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.14 ADJUSTMENTS TO BASE YEAR COSTS:** Since rebasing of the prospective per diem rate will take place every three years, the HCA recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

**A.** Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)

**B.** Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

**C.** Additional costs of approved expansion, remodeling or purchase of equipment.

**D.** Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1,000 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 HCA will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

**(1)** beginning with the month the cost was actually incurred if prior approval was obtained, or

**(2)** no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

[8.313.3.14 NMAC - Rp 8.313.3.14 NMAC, 7/1/2024]

**8.313.3.15 RESERVE BED DAYS:** Reserve bed days will be paid using the provider's level III rate.

[8.313.3.15 NMAC - Rp 8.313.3.15 NMAC, 7/1/2024]

**8.313.3.16 CAREGIVERS CRIMINAL HISTORY SCREENING**: The MAD will reimburse providers for the medicaid portion of the billed amount that providers paid to the New Mexico health care authority. The following is the billing format.

**A.** Each ICF/IID will pay HCA via electronic payment using the authorized entity authorized by HCA.

**B.** A copy of the electronic receipt ICF/IID sent to the community based provider will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD's designee).

**C.** Medicaid will only be responsible for the medicaid portion of the billed amount.

**D.** There will be a one-time charge to medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider's cost report.

[8.313.3.16 NMAC - Rp 8.313.3.16 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.17 RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS**

**A.** A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: Director, Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504

**B.** The filing of a request for reconsideration will not affect 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 HCA, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

**E.** MAD 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 MAD no later than 30 days after the date of the transmittal letter.

**F.** MAD 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 MAD 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 MAD director to the secretary, or their designee, within five days after the closing date for final submittals.

**H.** The secretary, or their designee, may secure all information and call on all expertise they believe necessary to decide the issues.

**I.** The secretary, or their designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and changes to the original determination will be implemented pursuant

to that decision.
[8.313.3.17 NMAC - Rp 8.313.3.17 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.18 PUBLIC DISCLOSURE OF COST REPORTS**

**A.** Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

**B.** The request must identify the provider and the specific report(s) requested.

**C.** The cost for copying will be charged to the requestor.

[8.313.3.18 NMAC - Rp 8.313.3.18 NMAC, 7/1/2024]

**8.313.3.19 SEVERABILITY:** If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.
[8.313.3.19 NMAC - Rp 8.313.3.19 NMAC, 7/1/2024]

**HISTORY OF 8.313.3 NMAC:** The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
SP-004.2400 Section 4, General Program Administration Standards for Skilled Nursing And Intermediate Care Facilities, 3/5/1981.

**History of Repealed Material:** 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, filed 10/18/2000 Repealed effective 7/1/2024.

**Other:** 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, filed 10/18/2000 Replaced by 8.313.3 NMAC, Cost Related Reimbursement of ICF-MR Facilities, effective 7/1/2024.