State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
COST RELATED REIMBURSEMENT OF NURSING FACILITIES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Medical Assistance Division is proposing changes to the current Cost Related Reimbursement of Nursing Facilities rules to be effective 12/30/10 to change the cost report filing timelines to follow the Medicare guidelines of 150 days, to change the report form used to the Medicare Cost Report, to make any changes to reimbursement through rebasing or adjustments to base year costs pursuant to budget availability. These changes are due to state-wide budget constraints.

VI. REGULATIONS
These proposed regulation changes will be contained in 8.312.3 NMAC of the Medical Assistance Program Manual. This register and the proposed changes are available on the Medical Assistance Division web site at http://www/hsd/state/nm/us/mad/registers/2010. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

If implemented as proposed, the following changes to will have the following affect: Rates to the nursing home providers will not be rebased nor will adjustments to base year costs be approved unless the current budget allows for such changes.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective December 30, 2010.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m. on Tuesday, November 16, 2010, in the ASD conference room of the Plaza San Miguel, 729 St. Michael's Drive, Santa Fe.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on November 16, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

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

8.312.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq. [~~(Repl. Pamp. 1991)~~].
[1/1/95; 8.312.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7-1-02; A, 12-30-10]

8.312.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[1/1/95, 2/1/95; 8.312.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 7-1-02; A, 12-30-10]

8.312.3.6 OBJECTIVE: The objective of [~~these regulations~~] this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[1/1/95, 2/1/95; 8.312.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7-1-02; A, 12-30-10]

8.312.3.8 MISSION STATEMENT: [T~~he mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.312.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7-1-02; A, 12-30-10]

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

A. billed charges;

B. the prospective rate as constrained by the ceilings (Section 8.312.3.16 NMAC) established by the department as described in this plan.

[2/1/95; 8.312.3.10 NMAC - Rn, 8 NMAC 4 MAD.731-D.I, 7-1-02; A, 12-30-10]

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.~~] Providers will submit the medicare cost report form. This itemized list must be submitted within [~~90~~] 150 days after the close of the provider's cost reporting year. Failure to file a report within the [~~90~~] 150-day limit[~~,~~

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

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

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

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

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

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

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

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

(a) 42 CFR 442;

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

(c) standards included in 42 CFR 431.610; and

(d) cost incurred to meet requirements for licensing under state law which are necessary for providing NF service.

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

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including syringes, catheters; ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

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

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

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

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

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

(j) laundry services including basic personal laundry;

(k) The department will make payment directly to the medical equipment provider in accordance with procedures outlined in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*, and subject to the limitations on rental payments contained in that section; and

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

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

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

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

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

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

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

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

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

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

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

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

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

H. **Non-allowable costs:**

(1) bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs;

(2) purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere; providers shall identify such related organizations and costs in the state's cost reports;

(3) return on equity capital;

(4) other cost and expense items identified as unallowable in HIM-15;

(5) interest paid on overpayments as per 8.302.2 NMAC, *Billing for Medicaid Services*; and

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

[2/1/95; 8.312.3.11 NMAC - Rn, 8 NMAC 4 MAD.731-D.III, 7-1-02; A, 12-01-04; A, 12-30-10]

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

A. **Base year:** Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year [~~1, year 2, and year 3~~] one, year two and year three. Because rebasing is done every three years, operating year [~~4~~] four will again become year [~~1~~] one, etc. Cost incurred, reported, audited [~~and/or~~] or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year [~~1~~] one will be used to re-base the prospective per diem rate. Rebasing of costs in excess of 110[~~%~~] percent of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs. For implementation year [~~1~~] one (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984. Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost reports. The rate period January 1, 1996, through June 30, 1996, will be considered year [~~1~~] one. The rate period July 1, 1996, through June 30, 1997, will be considered year [~~2~~] two, and the rate period July 1, 1997, through June 30, 1998, will be considered year [~~3~~] three. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section. Pursuant to budget availability, any changes to reimbursement, including the decision to rebase rates will be at the department's discretion.

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

(1) Pursuant to budget availability and at the department's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every July informing each provider that a:

(a) MBI will or will not be authorized; and

(b) the percentage increase if the MBI is authorized.

(2) If utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI) or a percentage up to the MBI.

(3) Each provider's operating costs will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating year [~~1~~] one, if applicable. For out-of-cycle rebasing occurring for rates effective January 1, 1996, through June 30, 1996, the mid-year point for indexing in operating year 1 will be 3/31.

(4) The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the (MBI) for the previous year plus [~~2~~] two percentage points.

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

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

where

M = current operating cost ceiling per diem

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

I = allowable incentive per diem

D. **Calculation of the prospective per diem rate:** The following formulas are used to determine the prospective per diem rate:

YEAR [~~1~~] ONE

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

where

PR = prospective per diem rate

BYOC = allowable base year operating costs as described in A above, and indexed as described in B above.

NHI = the change in the MBI as described in B above

I = allowable incentive per diem

FC = allowable facility costs per diem

YEARS [~~2 and 3~~] TWO and THREE

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

where

PR = prospective per diem rate

OP= allowable operating costs per diem

I = allowable incentive per diem

NHI = the change in the MBI as described in B above.

FC = allowable facility costs per diem

E. **Effective dates of prospective rates:** Rates are effective July 1 of each year for each facility.

F. **Calculation of rates for existing providers** that do not have 1983 actuals, and for newly constructed facilities entering the program after July 1, 1984.

(1) For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per diem rate will become the sum of:

(a) the applicable facility cost ceiling; and

(b) the operating cost ceiling.

(2) After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per diem rate will then become the sum of:

(a) the lower of allowable facility costs or the applicable facility cost ceiling; and

(b) the lower of allowable operating costs or the operating cost ceiling.

(3) Such providers will not be eligible for incentive payments until the next operating year [~~1~~] one, after rebasing.

G. **Changes of provider by sale of an existing facility:**

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

(a) the lower of allowable facility costs determined by using the medicare principles of reimbursement, or the facility cost ceiling; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year [~~1~~] one, after rebasing.

H. **Changes of provider by lease of an existing facility:**

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

(a) the lower of allowable facility costs or the facility cost ceiling, as defined by this plan; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year [~~1~~] one, after rebasing.

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

J. **Replacement of an existing facility:** When an existing facility is replaced, the provider's prospective rate will become the sum of:

(1) the lower of allowable facility costs or the facility cost ceiling as defined by this plan; and

(2) the operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. **Replaced facility re-entering the medicaid program:**

(1) When a facility is replaced by a replacement facility and the replaced facility re-enters the medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(2) Such providers will not be eligible for incentive payments until the next operating year [~~1~~] one, after rebasing.

L. **Closed facility re-entering the medicaid program:**

(1) When a facility has been closed and re-enters the medicaid program under new ownership, it shall be considered a change of ownership and either G or H, whichever is applicable, will apply.

(2) When a facility has been closed and re-enters the medicaid program under the same ownership within 12 months of closure, the provider's prospective rate will be the same as prior to the closing.

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

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(4) Providers of such facilities will not be eligible for incentive payments until the next operating year [~~1~~] one, after rebasing.

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

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

A. **Operating costs:** The ceiling for operating costs will be established at 110[~~%~~] percent 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~~] one. The facility cost ceiling will be [~~eleven dollars and fifty cents ($11.50)~~] $11.50.

(2) Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category.

(3) Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the [~~twelve~~] 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). The basis of the total investment will be subject to the limitations described in [~~1 and 2~~] (1) and (2) above. The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.312.3.12 NMAC of these regulations. Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the department.

(4) For newly constructed facilities, reconstruction of a facility to become a long-term care facility, and replacement facilities entering the medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.

(5) When an existing facility is sold, facility costs per day will be limited to the lower of:
- (a) allowable facility costs determined by using the medicare principles of reimbursement; or
- (b) the facility cost ceiling.

(6) When an existing facility is leased, the facility costs per day will be limited to the lower of:
- (a) actual allowable facility costs; or

(b) for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling; or

(c) for facilities owned or operated by the lessor less than 10 years, 110[~~%~~] percent of the median of facility costs for all providers in the same category.

(7) When a replaced facility re-enters the medicaid program either under the same ownership as existed prior to the replacement or under different ownership, facility costs per day will be limited to the lower of:

(a) actual allowable facility costs; or

(b) the median of facility costs for all other existing facilities in the same category.

[2/1/95; 8.312.3.13 NMAC - Rn, 8 NMAC 4 MAD.731-D.V & A, 7-1-02; A, 12-30-10]

8.312.3.15 ADJUSTMENTS TO BASE YEAR COSTS:

A. Since rebasing of the prospective per diem rate will take place every three years, the department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

(1) additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, social security taxation of 501 (c)(3) corporations, minimum wage change, property tax increases, etc.);

(2) additional costs incurred as a result of uninsurable losses from catastrophic occurrences; and

(3) additional costs of approved expansion, remodeling or purchase of equipment;

B. Such additional costs must reach a minimum of $10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

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

(2) no later than 30 days from the date of the approval if retroactive approval was obtained.

C. At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the department determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

D. Pursuant to budget availability, the decision to approve any adjustments to base year costs will be at the department's discretion.

[2/1/95, 12/30/95; 8.312.3.15 NMAC - Rn, 8 NMAC 4 MAD.731-D.VII, 7-1-02; A, 12-30-10]