State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
COST-RELATED REIMBURSEMENT OF ICF/MR FACILITIES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
Due to statewide budget constraints, the Human Services Department/Medical Assistance Division (HSD/MAD) is proposing to make changes to the cost-related reimbursement of ICF/MRs through rebasing pursuant to budget availability. The total financial impact on providers will be 3.5 million dollars.

VI. REGULATIONS
These proposed regulation changes will be contained in 8.313.3 NMAC, *Cost-Related Reimbursement of ICF/MR Facilities*, of the Medical Assistance Program Manual. This register and the attached proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2011. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective October 1, 2011.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m. on Thursday, August 18, 2011 in the South Park Conference Room, 2055 S. Pacheco, Ste 500-590, Santa Fe, NM.

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:

Sidonie Squier, 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 August 18, 2011. 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. PUBLICATION

Publication of these regulations approved by:

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SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

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

Explanatory paragraph: This is an amendment to 8.313.3 NMAC, Sections 8 and 12 which will be effective October 1, 2011. The Medical Assistance Division is amending the Mission Statement (Section 8) and Paragraph (2) of Subsection A of 8.313.3.12 NMAC, *establishment of prospective per diem rates*, to include the potential for changes to the cost-related reimbursement of ICF/MRs through rebasing pursuant to budget availability.

8.313.3.8 MISSION STATEMENT: [~~The 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; 8.313.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11-1-00; A. 10-1-2011]

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 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.

(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 1, Year 2, and Year 3. Since re-basing is done every three years, operating year 4 will again become Year 1. Pursuant to budget availability, any changes to reimbursement, including the decision to rebase rates will be at the department's discretion.

(3) Costs 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. Re-basing 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.

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 Department'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 Department will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

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

(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-MR 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 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

(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:

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

(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-MR 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 1 is: $(A1 \times RV) + C1 + D + E = PR$ (Year 1)
(4) The formula for Year 2 is: $[(A1 \times RV) + C1) \times (1 + MBI)] + D + E = PR$ (Year 2)
(5) The formula for Year 3 is: $[(A2 \times RV) + C2) \times (1 + MBI)] + D + E = PR$ (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.

[2-1-95; 8.313.3.12 NMAC – Rn, 8 NMAC 4.MAD.732.D.IV & A, 11-1-00; A, 9-1-02; A, 10-1-2011]