TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #07-643(E)

DIGEST

Temporarily amends 405 IAC 1-14.6-6 and 405 IAC 1-14.6-23 to revise Medicaid reimbursement methodology for payment to nursing facilities, change the annual rate effective date to July 1 for all providers, and impose a maximum annual rate increase per annum, before adjusting for case mix. Authority: IC 4-22-2-37.1; IC 12-8-1-12. Effective October 1, 2007.

SECTION 1. 405 IAC 1-14.6-6 IS TEMPORARILY AMENDED TO READ AS FOLLOWS: **(a) The:**
(1) normalized average allowable cost of the median patient day for the direct care component; and
(2) average allowable cost of the median patient day for the indirect, administrative, and capital components;
shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The:
(1) normalized allowable per patient day cost for the direct care component; and
(2) allowable per patient day costs for the therapy, indirect care, administrative, and capital components;
shall be established once per year for each provider based on the annual financial report.

(c) Beginning October 1, 2007, the rate effective date of the annual rate review shall be the first October 1 that falls after the first calendar quarter following the provider's reporting year-end. Beginning July 1, 2008, the rate effective date of the annual rate review shall be the first July 1 that falls after the first calendar quarter following the provider's reporting year-end. The rate effective date of the annual rate review for all providers shall be July 1 of each year thereafter.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be:
(1) updated each calendar quarter; and
(2) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d) of this SECTION.

(g) When the number of nursing facility beds licensed by the Indiana state department of health is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate-setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

SECTION 2. 405 IAC 1-14.6-23 IS TEMPORARILY AMENDED TO READ AS FOLLOWS: **Notwithstanding all other provisions of this rule, for the period October 1, 2007, through June 30, 2011, nursing facility rates that have been calculated under this rule shall be limited to a maximum allowable increase as follows:**
(1) For annual rate reviews effective October 1, 2007, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's latest annual Medicaid rate with an effective

date prior to March 31, 2007.
(2) For annual rate reviews effective July 1, 2008, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of October 1, 2007.
(3) For annual rate reviews effective July 1, 2009, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2008.
(4) For annual rate reviews effective July 1, 2010, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2009.
(5) The therapy rate component shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this SECTION.
(6) A provider's annual Medicaid rate may be in effect for longer or shorter than twelve (12) months. In such cases, the maximum allowable increase percent shall be proportionately increased or decreased to cover the actual time frame their previous annual rate was in effect using a twelve (12) month period as the basis.
(7) Subsequent to each annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index as described in subsection (d) of SECTION 1 of this rule *[SECTION 1(d) of this document]***. These rate adjustments are not limited to the maximum allowable increase.**
(8) Should a provider's quality assessment rate change subsequent to the effective date of their annual Medicaid rate, the office shall restate the provider's Medicaid quality assessment rate add-on and the maximum allowable increase using the new quality assessment rate, applying all provisions of this rule. A provider's Medicaid rate restated under this provision shall be used to calculate their subsequent maximum allowable increase as determined in subdivisions (1) through (4) of this SECTION.
(9) The additional reimbursement authorized by 405 IAC 1-14.6-7(i) shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this SECTION when the nursing facility's prior annual Medicaid rate does not include this additional reimbursement.

SECTION 3. This document expires December 18, 2007.

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