

Document: Final Rule, **Register Page Number:** 26 IR 3869

Source: September 1, 2003, Indiana Register, Volume 26, Number 12

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**TITLE 405 OFFICE OF THE SECRETARY OF
FAMILY AND SOCIAL SERVICES**

LSA Document #02-340(F)

DIGEST

Amends 405 IAC 1-14.6 to revise the Medicaid nursing facility case mix reimbursement methodology to increase the minimum occupancy parameter for the direct care, indirect care, and administrative rate components; eliminates the provision that disallows annual rebasing of rates; extends the date for application of the historical cost inflation reduction factor; and removes profit add-on from direct care component. Effective 30 days after filing with the secretary of state.

405 IAC 1-14.6-2	405 IAC 1-14.6-9
405 IAC 1-14.6-6	405 IAC 1-14.6-16
405 IAC 1-14.6-7	405 IAC 1-14.6-22

SECTION 1. 405 IAC 1-14.6-2, AS AMENDED AT 26 IR 707, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 16-10-1

Sec. 2. (a) As used in this rule, “administrative component” means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

- (1) Administrator and co-administrators, owners’ compensation (including directors fees) for patient-related services.
- (2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.
- (3) Office and clerical staff.
- (4) Legal and accounting fees.
- (5) Advertising.
- (6) Travel.
- (7) Telephone.
- (8) License dues and subscriptions.
- (9) Office supplies.
- (10) Working capital interest.
- (11) State gross receipts taxes.
- (12) Utilization review costs.
- (13) Liability insurance.
- (14) Management and other consultant fees.
- (15) Qualified mental retardation professional (QMRP).

(b) As used in this rule, “allowable per patient day cost” means a ratio between allowable **variable** cost and patient days **using each provider’s actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of the minimum occupancy requirements as contained in this rule, or each provider’s actual occupancy rate from the most recently completed desk reviewed annual financial report.**

(c) As used in this rule, “annual financial report” refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider’s economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

~~(d)~~ As used in this rule, “allowable cost determination” means a computation performed by the office or its contractor to determine a nursing facility’s per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

~~(e)~~ **(d)** As used in this rule, “average allowable cost of the median patient day” ~~applicable to providers with an actual occupancy rate of at least sixty-five percent (65%)~~ means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable **variable** cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider’s actual occupancy from the most recently completed **desk reviewed** annual financial report. ~~and The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of the minimum occupancy requirements as contained in this rule, or each provider’s actual occupancy rate from the most recently completed desk reviewed annual financial report. The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.~~

~~(f)~~ As used in this rule, “average allowable cost of the median patient day applicable to providers with an actual occupancy rate of less than sixty-five percent (65%)” means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of sixty-five percent (65%); or each provider’s actual occupancy rate from the most recently completed annual financial report; and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

~~(g)~~ **(e)** As used in this rule, “average historical cost of property of the median bed” means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

~~(h)~~ **(f)** As used in this rule, “calendar quarter” means a three (3) month period beginning January 1, April 1, July 1, or October 1.

~~(i)~~ **(g)** As used in this rule, “capital component” means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

- (1) The fair rental value allowance.
- (2) Property taxes.
- (3) Property insurance.

~~(j)~~ **(h)** As used in this rule, “case mix index” (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

- (1) Medicaid residents.
- (2) All residents.

~~(k)~~ **(i)** As used in this rule, “cost center” means a cost category delineated by cost reporting forms prescribed by the office.

~~(l)~~ **(j)** As used in this rule, “children’s nursing facility” means a nursing facility that has twenty-five percent (25%) or more of its residents who are under the chronological age of twenty-one (21) years and has received written approval from the office to be designated as a children’s nursing facility.

~~(m)~~ **(k)** As used in this rule, “delinquent MDS resident assessment” means an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. This determination is made on the fifteenth (~~15th~~) day of the second (~~2nd~~) month following the end of a calendar quarter.

~~(n)~~ **(l)** As used in this rule, “desk review” means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(m) As used in this rule, “direct care component” means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all:

- (1) nursing and nursing aide services;
- (2) nurse consulting services;
- (3) pharmacy consultants;
- (4) medical director services;
- (5) nurse aide training;
- (6) medical supplies;
- (7) oxygen; and
- (8) medical records costs.

(n) As used in this rule, “fair rental value allowance” means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(o) As used in this rule, “field audit” means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(p) As used in this rule, “fixed costs” means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(q) As used in this rule, “forms prescribed by the office” means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(r) As used in this rule, “general line personnel” means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(s) As used in this rule, “generally accepted accounting principles” or “GAAP” means those accounting principles as established by the American Institute of Certified Public Accountants.

(t) As used in this rule, “incomplete MDS resident assessment” means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(u) As used in this rule, “indirect care component” means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

- (1) Allowable dietary services and supplies.
- (2) Raw food.
- (3) Patient laundry services and supplies.
- (4) Patient housekeeping services and supplies.
- (5) Plant operations services and supplies.
- (6) Utilities.
- (7) Social services.
- (8) Activities supplies and services.
- (9) Recreational supplies and services.
- (10) Repairs and maintenance.

~~(w)~~ (v) As used in this rule, “minimum data set (MDS)” means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration.

~~(x)~~ (w) As used in this rule, “medical and nonmedical supplies and equipment” include those items generally required to assure adequate medical care and personal hygiene of patients.

~~(y)~~ As used in this rule, “non-rebasing year” means the year during which a nursing facility’s annual Medicaid rate is not established based on a review of its annual financial report covering its most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate components from the previous year by an inflation adjustment. The following year shall be a non-rebasing year: July 1, 2003, through June 30, 2004.

~~(z)~~ (x) As used in this rule, “normalized allowable cost” means total allowable direct patient care costs for each facility divided by that facility’s average case mix index (CMI) for all residents.

~~(aa)~~ (y) As used in this rule, “office” means the office of Medicaid policy and planning.

~~(bb)~~ (z) As used in this rule, “ordinary patient-related costs” means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

~~(cc)~~ (aa) As used in this rule, “patient/recipient care” means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

~~(dd)~~ (bb) As used in this rule, “reasonable allowable costs” means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in this rule.

~~(ee)~~ As used in this rule, “rebasing year” means the year during which a nursing facility’s Medicaid rate is based on a review of its annual financial report covering its most recently completed historical period. The following years shall be rebasing years:

July 1, 2002, through June 30, 2003

July 1, 2004, through June 30, 2005

And every year thereafter.

~~(ff)~~ (cc) As used in this rule, “related party/organization” means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

~~(gg)~~ (dd) As used in this rule, “RUG-III resident classification system” means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI and facility-average CMI for Medicaid residents.

~~(hh)~~ (ee) As used in this rule, “therapy component” means the portion of each facility’s direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

~~(ii)~~ (ff) As used in this rule, “unit of service” means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

~~(jj)~~ (gg) As used in this rule, “unsupported MDS resident assessment” means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15, and such data items result in the assessment being classified into a different RUG-III category.

~~(kk)~~ **(hh)** As used in this rule, “untimely MDS resident assessment” means a significant change MDS assessment, as defined by CMS’ Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident’s condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy. (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted, filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869*)

SECTION 2. 405 IAC 1-14.6-6, AS AMENDED AT 26 IR 712, SECTION 3, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-6 Active providers; rate review

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative, and capital components, ~~which are applicable to the facility based on their actual occupancy rate from the most recently completed historical period;~~ shall ~~only~~ be determined ~~during a rebasing~~ **once per year** for each provider for the purpose of performing the provider’s annual rate review.

(b) The ~~annual rate review that shall become effective during a rebasing year shall be established by determining the~~ normalized allowable per patient day cost for the direct care component, and the 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) The ~~annual rate review that shall become effective during a non-rebasing year shall be established by applying an inflation adjustment to the previous year’s indirect care, administrative, capital, and therapy Medicaid rate components. The direct care component of the annual rate review during a non-rebasing year shall be established by applying an inflation adjustment to the previous year’s normalized allowable cost and applying the Medicaid case mix adjustment as prescribed by this rule. The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year’s annual Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:~~

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

~~(d)~~ **(c)** The rate effective date of the annual rate review ~~during rebasing years and non-rebasing years~~ shall be the first day of the second calendar quarter following the provider’s reporting year end.

~~(e)~~ **(d)** Subsequent to the annual rate review, ~~established during rebasing years and non-rebasing years;~~ 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.

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

~~(g)~~ **(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).

(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. (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3872*)

SECTION 3. 405 IAC 1-14.6-7, AS AMENDED AT 26 IR 712, SECTION 4, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, ~~during a rebasing year~~, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning on the effective date of this rule through September 30, ~~2003~~, **2005**, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, ~~2003~~, **2005**, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, ~~for use in establishing the annual rebasing year rate review~~, the previous provider's most recently completed annual financial report **used to establish a Medicaid rate for the previous provider** shall be utilized to calculate the new provider's first annual ~~rebasement~~ **rebasement** year rate review. The inflation adjustment for the new provider's first annual ~~rebasement~~ **rebasement** year rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable **fixed** costs per patient day for direct care, indirect care, and administrative costs shall be computed based on an occupancy rate equal to the greater of ~~sixty-five~~ **eighty-five** percent (~~65%~~) (**85%**), or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the ~~month~~ **quarter** following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the ~~sixty-five~~ **eighty-five** percent (~~65%~~) (**85%**) minimum occupancy requirement, if **both** of the following conditions can be established to the satisfaction of the office:

- (1) the provider demonstrates that its current resident census has increased to ~~sixty-five~~ **eighty-five** percent (~~65%~~) (**85%**) or greater since the facility's fiscal year end of the **most recently completed and desk reviewed** cost report ~~used to establish its Medicaid rate during the most recent rebasing year utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period~~, and the provider's census has remained at such level for no less than ninety (90) days; and
- (2) the provider demonstrates that its resident census has increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the **most recently completed and desk reviewed** cost report ~~used to establish its Medicaid rate during the most recent~~

~~rebasement year~~ and has remained at such level for no less than ninety (90) days.

(f) Allowable **fixed** costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports serve as confirmation of the MDS assessments transmitted by the nursing facility and provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments. The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(i) The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to such facilities at a rate of eight dollars and seventy-nine cents (\$8.79) per Medicaid resident day. Such additional reimbursement shall be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents and shall remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents. (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873*)

SECTION 4. 405 IAC 1-14.6-9, AS AMENDED AT 26 IR 714, SECTION 5, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

- (1) The indirect care, administrative, and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).
- (2) The therapy component is equal to the provider's allowable per patient day direct therapy costs.
- (3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(b) The profit add-on payment will be calculated as follows:

- (1) For nursing facilities designated by the office as children's nursing facilities, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

- (2) Beginning on the effective date of this rule ~~and continuing for eight (8) full calendar quarters thereafter, through June 30, 2006,~~ for nursing facilities that are not designated by the office as children's nursing facilities, the direct care component profit add-on is equal to zero (0). Beginning ~~on the first day of the ninth (9th) full calendar quarter after the effective date of this rule,~~ **July 1, 2006,** the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

- (3) The indirect care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

- (4) The administrative component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

- (5) The capital component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus

(B) a provider's allowable per patient day cost.

- (6) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined

as follows:

- (1) The normalized average allowable cost of the median patient day for direct care costs ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).
- (2) The average allowable cost of the median patient day for indirect care costs ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times one hundred percent (100%).
- (3) The average allowable cost of the median patient day for administrative costs ~~applicable to the facility based on its actual occupancy rate from the most recently completed historical period;~~ times one hundred percent (100%).
- (4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).
- (5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874*)

SECTION 5. 405 IAC 1-14.6-16, AS AMENDED AT 26 IR 716, SECTION 7, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-16 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall ~~apply cost allocation principles established by the federal Medicare cost report methodology based~~ **calculate a ratio of indirect cost to direct cost based on the direct and total therapy and nonallowable ancillary costs reported** on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall ~~apply cost allocation principles established by the federal Medicare cost report methodology~~ **remove the indirect and administrative costs reimbursed by other payers** based on a statewide average ratio, **excluding hospital based facilities**, of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports. **The statewide average ratio shall be computed on a statewide basis from the most recently completed desk reviewed annual financial report and shall be maintained by the office with revisions made four (4) times per year**

effective January 1, April 1, July 1, and October 1. (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-16; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3875*)

SECTION 6. 405 IAC 1-14.6-22, AS AMENDED AT 26 IR 716, SECTION 8, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-3

Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate ~~and allowable cost determinations~~ after ~~they have~~ **such rate has** been computed. If the provider disagrees with the rate or allowable cost determinations, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate ~~or allowable cost determinations~~ as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with a rate ~~or allowable cost~~ redetermination resulting from a financial audit adjustment or reportable condition affecting a rate, ~~or allowable cost redetermination~~, the provider must request an administrative reconsideration from the Medicaid financial audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate ~~or allowable cost~~ ~~redeterminations~~ computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the MDS audit contractor shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the MDS audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. (*Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3876*)

LSA Document #02-340(F)

Notice of Intent Published: 26 IR 1115

Proposed Rule Published: March 1, 2003; 26 IR 2099

Hearing Held: March 26, 2003

Approved by Attorney General: July 17, 2003

Approved by Governor: July 23, 2003

Filed with Secretary of State: July 29, 2003, 4:00 p.m.

Incorporated Documents Filed with Secretary of State: None