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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #02-16

DIGEST

Amends 405 IAC 1-12 to revise the reimbursement methodology that the Medicaid program utilizes to reimburse nonstate-owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) such that rebasing of Medicaid payment rates will occur every other year, rather than annually. Makes other technical changes to remove outdated language and references to repealed provisions and to conform with federal and state statutes and regulations. Effective 30 days after filing with the secretary of state.

405 IAC 1-12-1
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405 IAC 1-12-26

SECTION 1. 405 IAC 1-12-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-1 Policy; scope
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-3

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified intermediate care facilities for the mentally retarded (ICF/MR), with the exception of those facilities operated by the state, and community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by ~~405 IAC 1-4.~~ **405 IAC 1-17.** All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. ~~which must be incurred by efficiently and economically operated facilities.~~ The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate

Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process.

(e) Providers must pay interest on all overpayments. The interest charge shall not exceed the percentage set out in ~~IC 24-4.6-1-101.~~ **IC 12-15-13-3(f)(1).** The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 2. 405 IAC 1-12-2, PROPOSED TO BE AMENDED AT 25 IR 1690, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-2 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

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate, which, at a minimum, reimburses for all nursing or resident care, room and board, supplies, and all ancillary services within a single, comprehensive amount.

(c) "Allowable cost determination" means a computation performed by the office or its contractor to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

~~(c)~~ **(d)** "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

~~(d)~~ **(e)** "Annual or historical 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, which shall constitute a comprehensive basis of accounting.

(f) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three-hundred sixty-six (366) days.

~~(e)~~ **(g)** "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be computed on a statewide basis for like levels of care, with the exception noted in this subsection, and shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1. If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half ~~(8½)~~ **(8½)** or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs

residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental increased by one hundred fifty-nine percent (159%).

~~(f)~~ **(h)** "Change of provider status" means a bona fide sale, ~~or capital~~ lease, **or termination of an existing lease** that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. ~~The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.~~

~~(g)~~ **(i)** "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

~~(h)~~ **(j)** "CRF/DD" means a community residential facility for the developmentally disabled.

~~(i)~~ **(k)** "DDARS" means the Indiana division of disability, aging, and rehabilitative services.

~~(j)~~ **(l)** "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

~~(k)~~ **(m)** "Desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

~~(l)~~ **(n)** "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

~~(m)~~ **(o)** "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 by auditors.

~~(n)~~ **(p)** "Forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

~~(o)~~ **(q)** "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

~~(p)~~ **(r)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(q)~~ **(s)** "ICF/MR" means an intermediate care facility for the mentally retarded.

~~(r)~~ **(t)** "Like levels of care" means:
(1) care within the same level of licensure provided in a CRF/DD; or
(2) care provided in a nonstate-operated ICF/MR.

(u) "Nonrebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a nonrebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. Nonrebasing years shall be:
(1) October 1, 2003 through September 30, 2004;
(2) October 1, 2005 through September 30, 2006;
(3) October 1, 2007 through September 30, 2008;
(4) October 1, 2009 through September 30, 2010; and
(5) every second year thereafter.

~~(s)~~ **(v)** "Office" means the Indiana office of Medicaid policy and planning.

~~(t)~~ **(w)** "Ordinary patient or resident related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

~~(u)~~ **(x)** "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

~~(v)~~ **(y)** "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

~~(w)~~ **(z)** "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.

(aa) "Rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. Rebasing years shall be:

(1) October 1, 2002 through September 30, 2003;
(2) October 1, 2004 through September 30, 2005;
(3) October 1, 2006 through September 30, 2007;
(4) October 1, 2008 through September 30, 2009; and
(5) every second year thereafter.

~~(x)~~ **(bb)** "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.

~~(y)~~ **(cc)** "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

~~(z)~~ **(dd)** "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

~~(aa)~~ **(ee)** "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 3. 405 IAC 1-12-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and on the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.
(8) Certification by the provider that the data are true, accurate, related to patient or resident care, and that expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office or its representatives circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office or its representatives prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office or its representatives shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office or its representatives.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:
(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, **and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.**
(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-4; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; filed Aug 14, 1998, 4:27 p.m.: 22 IR 64; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 4. 405 IAC 1-12-5, PROPOSED TO BE AMENDED AT 25 IR 1691, SECTION 2, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:
(1) the prior provider's then current rate, **including any changes due to a field audit,** if applicable; or
(2) the fiftieth percentile rates as computed in this subsection.
Initial interim rates shall be effective upon the later of the certification date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/MR providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the

fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental increased by one hundred fifty-nine percent (159%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(d) The provider's historical financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following at a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and ordinary charge.
(8) Certification by the provider that:
  (A) the data are true, accurate, and related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

~~(e) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve month period as the basis for the computation.~~

~~(f) The base rate established from the nine (9) months of historical data shall be the rate used for determining subsequent limitations on annual rate adjustments.~~

~~(g)~~ **(e)** Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

~~(h)~~ **(f)** If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until

the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. **The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.**

~~(i)~~ **(g)** Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

~~(j) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted in November 1976 by the American Institute of certified Public Accountants.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 5. 405 IAC 1-12-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-6 Active providers; rate review; annual request
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) ~~As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review.~~ The rate effective date **of the annual rate review established during rebasing years and nonrebasing years** shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) ~~A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its rate effective year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.~~ **The annual rate review that shall become effective during a rebasing year shall be established using the annual financial report as the basis of the review.**

(c) ~~To request the additional review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data, of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the office.~~ **The annual rate review that shall become effective during a nonrebasing year shall be established by applying an inflation adjustment to the previous year's annual or base Medicaid rate. 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 or base 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) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional rate review.~~

~~(e) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this~~

~~rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the maximum allowable annual rate increase limitation, adjusted by the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using the actual occupancy level for existing beds, plus, where appropriate, those added census days needed to project the census in the additional beds in the following manner:~~

~~(1) For large ICFs/MR, the greater of:~~

~~(A) ninety-five percent (95%) of total beds available; or~~

~~(B) the occupancy the provider could reasonably anticipate for the additional beds.~~

~~(2) For CRFs/DD, the greater of:~~

~~(A) ninety percent (90%) of total beds available; or~~

~~(B) the occupancy the provider could reasonably anticipate for the additional beds.~~

~~In no event shall the occupancy used to calculate the capital return factor be less than ninety-five percent (95%) of total beds available for large ICFs/MR and ninety percent (90%) for CRFs/DD. Rate reviews completed under this section will not constitute the provider's additional rate review in one (1) reporting year. This review shall be completed in the same manner as the annual rate review, using all limitations in effect at the time the annual review or base rate review took place, whichever is later.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-6; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 6. 405 IAC 1-12-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

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. 7. (a) Rate setting **during rebasing years** shall be ~~prospective,~~ based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs **during rebasing years**, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. 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 increased for inflation using the ~~Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF)~~ **CMS Nursing Home without Capital Market Basket** index as published by ~~DRI/McGraw-Hill.~~ **DRI/WEFA.** The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day **as applicable during rebasing years,** each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. 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 increased for inflation using the ~~Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF)~~ **CMS Nursing Home without Capital Market Basket** index as published by ~~DRI/McGraw-Hill.~~ **DRI/WEFA.** The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

Median 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

(c) For ICFs/MR and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ICFs/MR and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule.
(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 7. 405 IAC 1-12-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis
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. 8. (a) Advertising is not an allowable cost under this rule, except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient or resident utilization.

(b) Each facility and **distinct** home office **location** shall be allowed:
(1) one (1) patient or resident care-related automobile; and
(2) one (1) vehicle that can be utilized for facility maintenance or patient or resident support or for both uses;
to be included in the vehicle basis for purposes of cost reimbursement under this rule. Vehicle basis means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office **location or locations** are responsible for maintaining records to substantiate operational and personal use for all allowable vehicles. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-8; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 8. 405 IAC 1-12-9, PROPOSED TO BE AMENDED AT 25 IR 1693, SECTION 3, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office
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. 9. **During rebasing years and for base rate reviews,** the Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate **established during rebasing years and for base rate reviews** is subject to ~~several limitations. Rates will be established at the lowest of~~ the **following** four (4) limitations: ~~listed as follows:~~
(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the DDARS.
(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.
(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.
(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I
Profit Add-On

The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.

Level of Care	(A) Percent	(B) Ceiling	(C) Cap
Sheltered living	40%	105%	10%
Intensive training	40%	120%	10%
Child rearing	40%	130%	12%
Nonstate-operated ICF/MR	40%	125%	12%
Developmental training	40%	110%	10%
Child rearing with a specialized program	40%	120%	12%
Small behavior management residences for children	40%	120%	12%
Basic developmental	40%	110%	10%
Small extensive medical needs residences for adults	40%	110%	10%

TABLE II
Overall Rate Limit

Level of Care	(A) Percent
Sheltered living	115%
Intensive training	120%
Child rearing	130%
Developmental training	120%
Child rearing with a specialized program	120%
Small behavior management residences for children	120%
Basic developmental	120%
Small extensive medical needs residences for adults	120%
Nonstate-operated ICF/MR	107%

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-9; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2320; filed Aug 15, 1997, 8:47 a.m.: 21 IR 79; filed Oct 31, 1997, 8:45 a.m.: 21 IR 951; filed Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 9. 405 IAC 1-12-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-12 Allowable costs; capital return factor

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. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are

owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient or resident care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate **during rebasing years** is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient or resident care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-12; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 10. 405 IAC 1-12-13 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

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. 13. (a) The use fee limitation is based on the following:
(1) The assumption that facilities and equipment are prudently acquired and financed.
(2) Providers will obtain independent financing in accordance with a sound financial plan.
(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years. **If facility payments toward the principal loan amount are less than the amount derived from a standard loan amortization during the reporting period, the computation of the use fee shall be limited to the principal and interest amounts actually paid during the reporting period, unless the financing arrangement specifically requires that amortized payments to be made to a sinking fund, or its equivalent, for future principal payments and the provider can demonstrate that payments from the sinking fund are actually made.**

(c) The use fee component of the capital return factor shall be limited by the lesser of:
(1) the original loan balance at the time of acquisition;
(2) eighty percent (80%) of historical cost of the facilities and equipment; or
(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the

amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall be recognized only when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall be recognized only if the provider can demonstrate that such loans were reasonable and necessary in providing patient or resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient or resident care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:
(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.
(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).
(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.
(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-13; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; filed Sep 1, 2000, 2:10 p.m.: 24 IR 16; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 11. 405 IAC 1-12-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-14 Allowable costs; capital return factor; computation of return on equity component
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. 14. (a) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment or actual equity in allowable facilities and equipment up to sixty percent (60%) of allowable historical cost of facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical costs of facilities and equipment, or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations of section 15(b) of this rule.
(Office of the Secretary of Family and Social Services; 405 IAC 1-12-14; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2323; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 12. 405 IAC 1-12-15 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis
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. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400

3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

The schedule shall be updated semiannually effective on March 1 and September 1 by the office and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date;

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) the rate of return on equity is the greater of the United States Treasury bond, ~~thirty (30)~~ **ten (10)** year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-15; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2324; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 13. 405 IAC 1-12-16 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

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) The basis used in computing the capital return factor shall be the historical cost of all assets used to deliver patient or resident related services, provided the following:

(1) They are in use.

(2) They are identifiable to patient or resident care.

(3) They are available for physical inspection.

(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost **and any associated property financing or capital lease** shall not be included in computing the capital return factor.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor shall include only items currently used in providing services customarily provided to patients or residents.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-16; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 14. 405 IAC 1-12-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

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. 17. (a) If a facility is sold or leased within eight (8) years of the seller's or lessor's acquisition date and this transaction is recognized as a change of provider status, the buyer's or lessee's property basis in facilities and equipment shall be the seller's or lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's or lessor's historical cost basis, for each month the seller or lessor has owned or leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.

(2) Inception date of the initial agreement between lessee and lessor.
(3) Imputed or stated interest rate.
(4) Duration of payments.
(5) Renewal options.
Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized only if the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:
(1) There is no spousal relationship between parties.
(2) The following persons are considered family members:
(A) Natural parents, child, and sibling.
(B) Adopted child and adoptive parent.
(C) Stepparent, stepchild, stepsister, and stepbrother.
(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, and daughter-in-law.
(E) Grandparent and grandchild.
(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.
(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.
(5) The seller ~~is~~ **and all parties with an ownership interest in the previous provider are** not associated with the facility in any way after the sale other than as a passive creditor.
(6) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.
(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.
(8) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.
(9) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(g) In order to establish an historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines issued in November 1976 by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members, for purposes of determining the basis, cost, and valuation of

the buyer's capital return factor component of the Medicaid rate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-17; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 15. 405 IAC 1-12-19 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient or resident care-related functions and that compensation amounts are reasonable and allowable under this section and sections 20 through 22 of this rule.

(b) The provider shall report using the forms or in a format prescribed by the office all patient and resident related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when such services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. Hours for laundry services in CRF/DD or ICF/MR facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility. Hours associated with the provision of day services and other ancillary services, **except as specified in subsection (d),** shall be excluded from the staffing limitation.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-19; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 16. 405 IAC 1-12-24, AS AMENDED AT 25 IR 381, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-24 Assessment methodology

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount not to exceed ten percent (10%) of ~~the gross residential services~~ **total annual facility** revenue. ~~of the facility for the facility's annual reporting period year for annual rate reviews. CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount not to exceed ten percent (10%) of the annualized gross residential services.~~ **In determining total annual** revenue ~~of the facility for the facility's preceding nine (9) months for determining the base rate as set out in section 5(d) of this rule.~~ **when the financial report period is other than three hundred, sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period.** The assessment percentage **applied to total annual revenue** shall ~~be determined annually by the office or its contractor in such a manner that the amount assessed shall, in the aggregate,~~ not exceed **the greater of** six percent (6%) ~~of total facility revenues.~~ **or such percentage determined to be eligible for federal financial participation under federal law.**

(b) The assessment on provider ~~gross residential services~~ **total annual** revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. ~~Gross residential services~~ **Total annual** revenue is defined as revenue from the provider's previous reporting period as set out in section 4(a) of this rule or previous base rate reporting period set out in section ~~5(d)~~ **5(c)** of this rule. ~~and excludes allowable day services costs for the period.~~ Providers will submit data to calculate the amount of provider assessment with their annual **and** base ~~and~~ rate reviews as set out in sections 4(a) and ~~5(d)~~ **5(c)** of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 17. 405 IAC 1-12-26 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-26 Administrative reconsideration; appeal
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5; IC 12-13-7-3

Sec. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate ~~determination,~~ **and allowable cost determinations** after ~~such rate~~ **they have** 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 (c).

(b) If the provider disagrees with a rate **or allowable cost** redetermination resulting from an audit adjustment or a reportable condition affecting a rate, the provider must request an administrative reconsideration from the Medicaid 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 the 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 determinations as** 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 or reportable condition. 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 (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC*

1-12-26; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on June 28, 2002 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Auditorium, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to the Medicaid reimbursement methodology for Medicaid-enrolled nonstate owned community residential facilities for the developmentally disabled (CRFs/DD) and intermediate care facilities for the mentally retarded (ICFs/MR).

Further, in accordance with the public notice requirements of 42 CFR 447.205 and Section 1902(a)(13)(A) of the Social Security Act, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP) publishes this notice of proposed revisions to the Medicaid reimbursement formula for CRFs/DD and ICFs/MR by providing for rebasing of Medicaid rates established under 405 IAC 1-12 every two years.

This change is necessary to help ensure that Medicaid reimbursement for costs incurred by facilities that are not economically and efficiently operated are minimized, and the OMPP can implement cost containment initiatives to assist in covering the increasing costs of the Indiana Medicaid program.

It is estimated that the first nonrebasing year fiscal impact for this change will be approximately $3.3 million (state and federal dollars) reduction in expenditures.

Prior to October 1, 2003, there will be no change to the methodology for establishing rates for nonstate owned ICFs/MR and CRFs/DD under these proposed amendments. Beginning October 1, 2003, Medicaid rates for nonstate owned ICFs/MR and CRFs/DD will be established by increasing the prior year's Medicaid rate by a factor equal to one plus an inflation adjustment derived from the CMS Nursing Home without Capital Market Basket Index, as described in 405 IAC 1-12-6 of the proposed rule. Copies of the proposed rates are not available at this time and will not be available until 2003. Written comments may be directed to IFSSA, Attention: Karen S. Filler, 402 West Washington Street, Room W382, P.O. Box 7083, Indianapolis, Indiana 46207-7083.

Correspondence should be identified in the following manner: "COMMENTS RE: LSA DOCUMENT #02-16, PROPOSED CHANGES TO THE CRFs/DD AND ICFs/MR REIMBURSEMENT SYSTEM." Written comments received will be made available for public display at the address below of the Office of Medicaid Policy and Planning.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection. Also, copies of these rules and this public notice are now on file and open for public inspection by contacting the Director of the local County Division of Family and Children office, except in Marion County where public inspection may be made at 402 West Washington Street, Room W382, Indianapolis, Indiana.

John Hamilton
Secretary
Office of the Secretary of Family and Social Services