Document: Final Rule, **Register Page Number:** 25 IR 3121
Source: July 1, 2002, Indiana Register, Volume 25, Number 10

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #01-420(F)

DIGEST

Amends 405 IAC 1-12 to establish Medicaid reimbursement criteria for certain community residential facilities for the developmentally disabled (CRFs/DD) licensed as small extensive medical needs residence for adults. Sets a limit of 12 hours per resident day for staffing costs for a facility that is exclusively for adults with extensive medical needs. Effective 30 days after filing with the secretary of state.

405 IAC 1-12-2 **405 IAC 1-12-9**
405 IAC 1-12-5 **405 IAC 1-12-22**

SECTION 1. 405 IAC 1-12-2 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 per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(d) "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.

(e) "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) 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) "Change of provider status" means a bona fide sale or capital 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) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

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

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

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

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

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

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

(r) "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.

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

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

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

(w) “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.

(x) “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) “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) “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) “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; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121)*

SECTION 2. 405 IAC 1-12-5 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, 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 (12) 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) 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) 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.

(i) 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; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123)*

SECTION 3. 405 IAC 1-12-9 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. The Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the 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; Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124)

SECTION 4. 405 IAC 1-12-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-22 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate

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. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20 of this rule, the procedures described in this section apply to intermediate care facilities for the mentally retarded with eight (8) or fewer beds (community residential facilities for the developmentally disabled), except for intermediate care facilities for the mentally retarded licensed as:

(1) small behavior management residences for children for which the procedures described in this section apply to facilities with six (6) or fewer beds; **and**

(2) small extensive medical needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds.

(b) Costs related to staffing shall be limited to the following:

Type of License	Staff Hours Per Resident Day
Sheltered living	4.5
Intensive training	6.0
Developmental training	8.0
Child rearing	8.0
Child rearing residences with specialized programs	10.0
Basic developmental	10.0
Small behavior management residences for children	12.0

(c) Any change in staffing that exceeds the current limitations of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children will require approval on a case-by-case basis, upon application by the facility. This approval will be determined in the following manner:

(1) A new or current provider of service which seeks staffing above four and one-half (4.5) hours per resident day for adults or eight (8) hours per resident day for children must first obtain approval from the DDARS, based upon the DDARS assessment of the program needs of the residents. The DDARS will establish the maximum number of staff hours per resident day for each facility, which may be less than but may not be more than the ceiling for each type of license. If a change in type of license is required to permit the staffing limitation determined by the DDARS, then the DDARS will make its recommendation to the licensing authority and convey to the office of Medicaid policy and planning the decision of the licensing authority. The office shall conduct a complete and independent review of a request for increased staffing and shall retain final authority to determine whether a rate change will be granted as a result of a change in licensure type.

(2) If a provider of services holds a current license which would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDARS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each community residential facility for the developmentally disabled provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; filed Aug 15, 1997, 8:47 a.m.: 21 IR 81; filed Oct 31, 1997, 8:45 a.m.: 21 IR 953; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124)*

LSA Document #01-420(F)
Notice of Intent Published: 25 IR 1196
Proposed Rule Published: February 1, 2002; 25 IR 1690
Hearing Held: February 25, 2002
Approved by Attorney General: May 24, 2002
Approved by Governor: June 7, 2002
Filed with Secretary of State: June 10, 2002, 2:24 p.m.
Incorporated Documents Filed with Secretary of State: None