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

**Proposed Rule**
LSA Document #05-112

DIGEST

Amends 405 IAC 1-14.6-2 to add a definition for "nursing home report card score". Amends 405 IAC 1-14.6-5 to describe the method for calculating the nursing facility quality assessment and Medicaid rate add-on for new providers. Amends 405 IAC 1-14.6-7 to increase Medicaid reimbursement based on the nursing home report card score and to increase reimbursement to certain nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia. Amends 405 IAC 1-14.6-9 to change the profit add-on calculation. Amends 405 IAC 1-14.6-18 to change the limitation applied to owner, related party, and management compensation. Adds 405 IAC 1-14.6-24 to establish a nursing facility quality assessment as required by P.L.186-2005. Adds 405 IAC 1-14.6-25 to allow a nursing facility to apply for additional Medicaid reimbursement if the facility is closed or converted to another use. *NOTE: SECTION 6 of this document is jointly promulgated with the Department of State Revenue. See LSA Document #05-359, printed at 29 IR 1596.* Effective 30 days after filing with the Secretary of State.

**405 IAC 1-14.6-2**
**405 IAC 1-14.6-5**
**405 IAC 1-14.6-7**
**405 IAC 1-14.6-9**
**405 IAC 1-14.6-18**
**405 IAC 1-14.6-24**
**405 IAC 1-14.6-25**

SECTION 1. 405 IAC 1-14.6-2 IS AMENDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-2 Definitions**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

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

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

(b) As used in this rule, "allowable per patient day cost" means a ratio between allowable variable cost and patient days using each

provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

**(1)** the minimum occupancy requirements as contained in this rule; or

**(2)** each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

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

(d) As used in this rule, "average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

**(1)** the minimum occupancy requirements as contained in this rule; or

**(2)** each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

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

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

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

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

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

(1) Medicaid residents.

(2) All residents.

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

~~(j)~~ **(i)** As used in this rule, "children's nursing facility" means a nursing facility that has:

**(1)** twenty-five percent (25%) or more of its residents who are under the chronological age of twenty-one (21) years; and ~~has~~

**(2)** received written approval from the office to be designated as a children's nursing facility.

**(j) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.**

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

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

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

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen. ~~and~~
(8) Medical records costs.

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

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

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

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

(q) As used in this rule, "forms prescribed by the office" means **either of the following:**

**(1)** Cost reporting forms provided by the office. ~~or~~

**(2)** Substitute forms that have received prior written approval by the office.

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

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

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

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

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

**(v) As used in this rule, "medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.**

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

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

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

**(y) As used in this rule, "nursing home report card score" means a numerical score developed and published by the Indiana state department of health (ISDH) that quantifies each facility's key survey results.**

~~(y)~~ **(z)** As used in this rule, "office" means the office of Medicaid policy and planning.

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

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

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

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

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

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

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

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

~~(hh)~~ **(ii)** As used in this rule, "untimely MDS resident assessment" means **either of the following:**
**(1)** A significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly. ~~or~~

**(2)** A full or quarterly MDS assessment that is not completed as required by ~~405 IAC 1-15-6(a)~~ **405 IAC 1-15-6** following the conclusion of all:

**(A)** physical therapy;

**(B)** speech therapy; and

**(C)** occupational therapy.

*(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869)*

SECTION 2. 405 IAC 1-14.6-5 IS AMENDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates**

**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 an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. ~~Prior to~~ **Before** the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's ~~case mix index~~ **CMI** for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's ~~case mix index~~ **CMI** for Medicaid residents. Initial interim rates shall be effective on the:

**(1)** certification date; or ~~the~~

**(2)** date that a service is established;

whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(b) ~~Prior to~~ **Before** the first annual rate review, the rate will be adjusted effective on each calendar quarter ~~pursuant to~~ **under** section 6(d) of this rule to account for changes in the provider's ~~case mix index~~ **CMI** for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

**(c) In conjunction with establishing an initial interim rate, a new operation shall submit a nursing facility quality assessment data collection form that contains projected patient census data from the first day of operation through the provider's first fiscal year end with a minimum of six (6) months of actual historical data. Following completion of the provider's first fiscal year end with a minimum of six (6) months of actual historical data, the provider shall submit a nursing facility quality assessment data collection form reporting actual patient census data covering the period from the first day of operation until the provider's first fiscal year end with a minimum of six (6) months of actual historical data. This form shall be submitted to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. Failure to submit a nursing facility quality assurance data collection form shall result in the actions specified at section 4(e) of this rule.**

~~(c)~~ **(d)** In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor.

**(e) For a new operation, the interim quality assessment and Medicaid rate add-on shall be based on projected patient days. A retroactive settlement of the quality assessment and Medicaid rate add-on will be determined, based on actual patient days, for the time period from the first day of operation until the first annual rate effective date associated with the provider's first fiscal year end with a minimum of six (6) months of actual historical data.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-5; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2242; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2467)*

SECTION 3. 405 IAC 1-14.6-7 IS AMENDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15-13-6**

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

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

(b) Notwithstanding subsection (a), beginning ~~on the effective date of this rule through September 30, 2005,~~ **August 1, 2006,** the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). ~~Prior to September 30, 2005, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly.~~ Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

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

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

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

(1) The provider demonstrates that its current resident census has:
**(A)** increased to eighty-five percent (85%) or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period; and ~~the provider's census has~~
**(B)** remained at such level for ~~no less~~ **not fewer** than ninety (90) days. ~~and~~

(2) The provider demonstrates that its resident census has:
**(A)** increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and ~~has~~
**(B)** remained at such level for ~~no less~~ **not fewer** than ninety (90) days.

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

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

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

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

(1) Two (2) preliminary CMI reports. These preliminary CMI reports:

**(A)** serve as confirmation of the MDS assessments transmitted by the nursing facility; and

**(B)** provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

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

(i) The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to ~~such~~ **the** facilities at a rate of eight dollars and seventy-

nine cents ($8.79) per Medicaid resident day. ~~Such~~ **The** additional reimbursement shall:

**(1)** be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and ~~shall~~

**(2)** remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

**(j) Beginning July 1, 2003, through July 31, 2006, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score as of July 4, 2003. Medicaid reimbursement increases shall be determined according to the following:**

| Nursing Home Report Card Score as of July 4, 2003 | Per Medicaid Patient Day Rate Add-On |
|---|---|
| 0 – 50 | $3.00 |
| 51 – 105 | $2.50 |
| 106 – 200 | $2.00 |
| 201 and higher | $1.50 |

**Facilities that did not have a nursing home report card score published as of July 4, 2003, may receive a per patient day rate add-on equal to two dollars ($2).**

**(k) Beginning effective July 1, 2003, through July 31, 2006, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, and operate a special care unit (SCU) for such residents as demonstrated by resident assessment data as of June 30, 2003. The additional Medicaid reimbursement shall equal ten dollars and eighty cents ($10.80) per Medicaid resident day in their SCU. Only facilities with a SCU for Alzheimer's disease or dementia as demonstrated by resident assessment data as of June 30, 2003, shall be eligible to receive the additional reimbursement.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873)*

SECTION 4. 405 IAC 1-14.6-9 IS AMENDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15-13-6**

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

(1) The indirect care, administrative, and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable per patient day direct therapy costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average ~~case mix index~~ **CMI** for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

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

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

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average ~~case mix index~~ **CMI** for Medicaid residents times ~~one hundred five percent (105%);~~ **the profit ceiling percentage contained in Table 1;** minus

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

**Table 1**
**Children's Nursing Facilities**

| | Direct Care Profit Add-on Percentage | | Direct Care Profit Ceiling Percentage | |
|---|---|---|---|---|
| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
| **Percentage** | **30%** | **52%** | **110%** | **105%** |

(2) ~~Beginning on the effective date of this rule through June 30, 2006,~~ For nursing facilities that are not designated by the office as children's nursing facilities, the direct care component profit add-on is equal to ~~zero (0). Beginning July 1, 2006,~~ the ~~direct care component~~ profit add-on ~~is equal to fifty-two percent (52%) of~~ **percentage contained in Table 2, times** the difference (if greater than zero (0)) ~~of.~~ **between:**

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average ~~case mix index~~ **CMI** for Medicaid residents times ~~one hundred five percent (105%);~~ **the profit ceiling percentage contained in Table 2;** minus

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

**Table 2**

**Non-Children's Nursing Facilities**

| | Direct Care Profit Add-on Percentage | | Direct Care Profit Ceiling Percentage | |
|---|---|---|---|---|
| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
| **Percentage** | **30%** | **0%** | **110%** | **105%** |

(3) The indirect care component profit add-on is equal to ~~fifty-two percent (52%) of~~ **the profit add-on percentage contained in Table 3, times** the difference (if greater than zero (0)) ~~of.~~ **between:**

(A) the average allowable cost of the median patient day times ~~one hundred percent (100%);~~ **the profit ceiling percentage contained in Table 3;** minus

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

**Table 3**

| | Indirect Care Profit Add-on Percentage | | Indirect Care Profit Ceiling Percentage | |
|---|---|---|---|---|
| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
| **Percentage** | **60%** | **52%** | **105%** | **100%** |

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

(A) the average allowable cost of the median patient day times ~~one hundred percent (100%);~~ **the profit ceiling percentage contained in Table 4;** minus

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

**Table 4**

| | Administrative Component Profit Ceiling Percentage | |
|---|---|---|
| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
| **Percentage** | **105%** | **100%** |

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

(A) the average allowable cost of the median patient day times ~~eighty percent (80%);~~ **the profit ceiling percentage contained in Table 5;** minus

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

**Table 5**

| | Capital Component Profit Ceiling Percentage | |
|---|---|---|
| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
| **Percentage** | **100%** | **80%** |

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

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ~~component limit~~ **ceiling** defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average ~~case mix index~~

**CMI** for Medicaid residents times ~~one hundred ten percent (110%).~~ **the overall rate ceiling percentage in Table 6.**

**Table 6**

**Direct Care Component Overall Rate Ceiling Percentage**

| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
|---|---|---|
| **Percentage** | **120%** | **110%** |

(2) The average allowable cost of the median patient day for indirect care costs times ~~one hundred percent (100%).~~ **the overall rate ceiling percentage in Table 7.**

**Table 7**

**Indirect Care Component Overall Rate Ceiling Percentage**

| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
|---|---|---|
| **Percentage** | **115%** | **100%** |

(3) The average allowable cost of the median patient day for administrative costs times ~~one hundred percent (100%).~~ **the overall rate ceiling percentage in Table 8.**

**Table 8**

**Administrative Component Overall Rate Ceiling Percentage**

| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
|---|---|---|
| **Percentage** | **105%** | **100%** |

(4) The average allowable cost of the median patient day for capital-related costs times ~~eighty percent (80%).~~ **the overall rate ceiling percentage in Table 9.**

**Table 9**

**Capital Component Overall Rate Ceiling Percentage**

| **Effective Date** | **July 1, 2003, through July 31, 2006** | **August 1, 2006, and after** |
|---|---|---|
| **Percentage** | **100%** | **80%** |

(5) For the therapy component, no overall rate component limit shall apply.

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

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:

**(1)** shall be published as a provider bulletin; and

**(2)** may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874)*

SECTION 5. 405 IAC 1-14.6-18 IS AMENDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-18 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees**

**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. 18. (a) Compensation for:

**(1)** owner, related party, management, general line personnel, and consultants who perform management functions; or

**(2)** any individual or entity rendering services above the department head level;

shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. ~~This~~ **Beginning effective July 1, 2003, through July 31, 2006, compensation subject to this limitation** includes wages, salaries, and fees for owner, ~~administrator, assistant administrator,~~ management, contractors, and

consultants who actually perform management functions as well as any other individual or entity performing such tasks. **Beginning effective August 1, 2006, and thereafter, wages, salaries, and fees paid for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.**

**(b) Beginning effective July 1, 2003, through July 31, 2006, the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in subjection (a). The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.**

~~(b)~~ ~~The~~ **(c) Beginning effective August 1, 2006, the** maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:

**(1)** under subsection ~~(c),~~ **(d),** as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or ~~the amount~~

**(2)** of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.

If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or ~~such~~ **the** costs shall be disallowed.

~~(c)~~ **(d)** The owner, related party, and management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation

| Beds | Allowance |
|---|---|
| 10 | $21,542 |
| 20 | $28,741 |
| 30 | $35,915 |
| 40 | $43,081 |
| 50 | $50,281 |
| 60 | $54,590 |
| 70 | $58,904 |
| 80 | $63,211 |
| 90 | $67,507 |
| 100 | $71,818 |
| 110 | $77,594 |
| 120 | $83,330 |
| 130 | $89,103 |
| 140 | $94,822 |
| 150 | $100,578 |
| 160 | $106,311 |
| 170 | $112,068 |
| 180 | $117,807 |
| 190 | $123,562 |
| 200 | $129,298 |
| 200 and over | $129,298 + $262/bed over 200 |

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-18; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

SECTION 6. 405 IAC 1-14.6-24 IS ADDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-24 Nursing facility quality assessment**

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

**Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15-21-3; IC 16-21; IC 16-28; IC 23-2-4**

**Sec. 24. (a) Effective August 1, 2003, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility as follows:**

**(1) If the total annual facility census days are fewer than seventy thousand (70,000), ten dollars ($10) per non-Medicare day.**

**(2) If the total annual facility census days are equal to or greater than seventy thousand (70,000), two dollars and fifty cents ($2.50) per non-Medicare day.**

**(3) If the nursing facility is nonstate government owned or operated, two dollars and fifty cents ($2.50) per non-Medicare day.**

**(b) The following nursing facilities shall be exempt from the quality assessment described in subsection (a):**

**(1) A continuing care retirement community registered with the securities commissioner of the office of the secretary of state under IC 23-2-4.**

**(2) A hospital-based nursing facility licensed under IC 16-21.**

**(3) The Indiana Veterans' Home.**

**(c) For nursing facilities certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed annual financial report.**

**(d) For nursing facilities that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the department of state revenue shall collect the quality assessment under 45 IAC 20.**

**(e) The office or its contractor shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall be as follows:**

**(1) In writing.**

**(2) Contain the following:**

**(A) Specific issues to be reconsidered.**

**(B) The rationale for the facility's position.**

**(3) Signed by the authorized representative of the facility and must be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.**

**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 assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the facility 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 facility's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.**

**(f) The assessment shall be calculated on an annual basis with equal monthly amounts due on or before the tenth day of each calendar month.**

**(g) A facility may file a request to pay the quality assessment on an installment plan. The request shall be as follows:**

**(1) In writing setting forth the facility's rationale for the request.**

**(2) Submitted to the office or its designee.**

**An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage set out in IC 12-15-21-3(6)(A).**

**(h) A facility that fails to pay the quality assessment due under this section within ten (10) days after the date the payment is due shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).**

**(i) The office may withhold Medicaid payments to a facility that fails to pay an assessment within thirty (30) days after the**

**due date. The amount withheld may not exceed the amount of the assessment and any interest due under subsection (h).**

**(j) Not later than one hundred twenty (120) days after payment of the quality assessment was due, the office shall report each facility that has failed to pay the quality assessment by the due date to the state department of health to initiate license revocation proceedings.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-24)*

SECTION 7. 405 IAC 1-14.6-25 IS ADDED TO READ AS FOLLOWS:

**405 IAC 1-14.6-25 Additional reimbursement for closing or converting nursing facilities**
**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. 25. (a) Beginning effective July 1, 2003, and continuing through July 31, 2006, nursing facility operators that were licensed and certified to participate in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as of July 1, 2003, may be eligible to receive additional Medicaid reimbursement if they:**
**(1) close their nursing facility; or**
**(2) convert their nursing facility to alternative uses.**

**(b) The amount of additional reimbursement available under this section shall be determined by the office taking into consideration the following factors:**
**(1) The location of the nursing facility.**
**(2) The number of beds proposed to be closed or converted.**
**(3) The current and historical census of the facility.**
**(4) The financial condition of the nursing facility operator.**
**(5) The proposed time frame for closing or converting the facility.**
**(6) The availability of other facilities and services to meet the needs of residents.**
**(7) Other factors the office deems appropriate.**

**(c) In order to receive additional reimbursement available under this section, the nursing facility provider shall submit a proposal to the office or its designee that fully describes the operator's proposed plan to close or convert the nursing facility. The office or its designee shall specify procedures and time frames that facilities shall follow in preparing and submitting proposals.**

**(d) The office shall review all proposals submitted under subsection (c) and shall notify the proposing nursing facility provider in writing of its response to their proposal. Based on its review of any proposal, the office may, in its sole discretion, do any of the following:**
**(1) Accept and approve the proposal for additional reimbursement as submitted.**
**(2) Request additional information it deems necessary to complete its review.**
**(3) Request modifications of the proposal as submitted.**
**(4) Accept and approve the proposal for additional reimbursement as revised.**
**(5) Reject and disapprove the proposal for additional reimbursement with or without requesting additional information or modifications from the proposing nursing facility provider.**

**(e) In the event the office accepts and approves a proposal for additional reimbursement, the office and nursing facility provider shall negotiate in good faith to execute a written agreement that specifies all terms and conditions that shall govern the proposing nursing facility provider's efforts to close or convert the nursing facility. The agreement between the office and the nursing facility provider shall be finalized and executed by all appropriate parties before any additional reimbursement available under this section shall be paid.**

**(f) The office shall pay any additional reimbursement available under this section into an escrow account, which will be established for the sole purpose to retain and disburse these funds. The funds shall be disbursed to the provider following the provider's successful completion of all conditions specified in the agreement referenced in subsection (e).**

**(g) The additional reimbursement available under this section shall:**
**(1) consist of an enhanced capital reimbursement rate add-on; and**

**(2) be used to fund debt service termination and related closing costs as delineated in the agreement referenced in subsection (e).**

**The enhanced capital reimbursement rate add-on shall be computed by dividing the total amount determined in subsection (b) by the facility's actual occupancy from the most recently completed desk reviewed annual financial report and shall be reimbursed for a period not to exceed twelve (12) months.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-25)*

***Notice of Public Hearing***

*Under IC 4-22-2-24, notice is hereby given that on February 23, 2006 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room A, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments and new rules concerning the assessment of a quality assessment fee on nursing facilities for the purpose of funding enhanced Medicaid nursing facility reimbursement.*

*The quality assessment fee is required by P.L.186-2005.*

*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.*

E. Mitchell Roob Jr.
Secretary
Office of the Secretary of Family and Social Services