**Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled**

405 IAC 1-12-1 Policy; scope

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nonstate-operated intermediate care facilities for the mentally retarded (ICF/MR), nonstate operated ICFs/MR licensed as comprehensive rehabilitative management needs facilities (CRMNF), and nonstate-operated community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 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

(i) "Change of provider status" means a bona fide sale, 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.

(j) "CRMNF" means a Comprehensive Rehabilitative Management Needs Facility" as defined at 460 IAC 9-1-2.

(k) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

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

(m) "DDRS" means the Indiana division of disability and rehabilitative services.

(n) "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.

(o) "Desk review" means a review and application of these regulations to a provider submitted financial report, including accompanying notes and supplemental information.

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

(q) "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

(r) "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.

(s) "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

(t) "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.

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

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

(w) "Like levels of care" means care:
(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ICF/MR; or
(3) provided in a nonstate-operated ICF/MR licensed as a CRMNF.

(x) "Non-rebasing 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 non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:

October 1, 2011, through September 30, 2012
October 1, 2013, through September 30, 2014
October 1, 2015, through September 30, 2016
October 1, 2017, through September 30, 2018

And every second year thereafter.

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

(z) "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.

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

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

(cc) "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.

(dd) "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. The following years shall be rebasing years:

October 1, 2012, through September 30, 2013
October 1, 2014, through September 30, 2015
October 1, 2016, through September 30, 2017
October 1, 2018, through September 30, 2019

And every second year thereafter.

(ee) "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.

(ff) "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.

(gg) "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).

(hh) "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, for all providers, except for providers of extensive support needs residences for adults.

(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 statement signed by the provider that:
(A) the data are true, accurate, related to patient or resident care, and
(B) expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed 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.

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day.

(d) Any ICF/MR that is licensed as a CRMNF will be paid at a rate of six hundred thirty-nine dollars and eighteen cents ($639.18) per resident day. This per diem rate is available only upon certification as a Medicaid ICF/MR and licensure by the division of disability and rehabilitative services. ICFs/MR that are licensed as CRMNFs will not receive a base rate nor be subject to the base rate reporting requirements at 405 IAC 1-12-5.

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

Sec. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20.5 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;

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

(3) extensive support 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 |
| Small extensive medical needs residences for adults | 12.0 |
| Extensive support needs residences for adults | 24.0 |

(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 that 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 DDRS, based upon the DDRS assessment of the program needs of the residents. The DDRS 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 DDRS, then the DDRS 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:

(A) conduct a complete and independent review of a request for increased staffing; and

(B) 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 that would permit staffing above the limitation of four and one-half

405 IAC 1-12-24 Assessment methodology

Sec. 24. (a) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:

(1) For an annual rate review, from the provider's previous annual financial reporting period as set out in 405 IAC 1-12-4(a);

(2) For a base rate review, from the provider's previous base financial reporting period set out in 405 IAC 1-12-5(c); or

(3) For an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in 405 IAC 1-12-5(a). The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the annualized bed days available to determine the new provider's annualized assessment.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 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.

(b) For ICFs/MR licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews, from the provider's previous annual financial reporting period as set out in 405 IAC 1-12-4(a).

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405 IAC 1-12-25 Reimbursement for day services

Sec. 25. For ICF/MR and CRF/DD facilities the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.