THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Submission of Cost Reporting Information, Section 8.442.3
Rule Number:	MSB 13-02-14A
Division / Contact / Phone:	Long-Term Services and Supports Program Operations Unit/Jason Takaki / 6687

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 13-02-14A, Revision to the Medical Assistance Rule Concerning Submission of Cost Reporting Information, Section 8.442.3
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.442.3.A,B,D, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please revise current text at §8.442.3.A, §8.442.3.B and §8.442.3.D with the new text provided. All text that is indicated in blue is for clarification only and should not be revised. This change is effective 06/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Submission of Cost Reporting Information, Section 8.442.3
Rule Number:	MSB 13-02-14A
Division / Contact / Phone:	Long-Term Services and Supports Program Operations Unit/Jason Takaki / 6687

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Proposed change seeks to address the time frame in which the department/contract auditor has to obtain additional documentation from a provider after they have received a proposed adjustment. This allows the provider an extension of days in which to submit information.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. section 447, Subpart C (2013).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);

Initial Review	**04/12/2013**	Final Adoption	**05/10/2013**
Proposed Effective Date	**06/30/2013**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Submission of Cost Reporting Information, Section 8.442.3
Rule Number:	MSB 13-02-14A
Division / Contact / Phone:	Long-Term Services and Supports Program Operations Unit/Jason Takaki / 6687

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Providers will have direct and positive impact from proposal.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Rule has to do with change in time frame only.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There is no impact. This rule is budget neutral.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Operational level, allows more time for the provider to collect and submit relevant documentation.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   This rule is the only method through which the necessary programmatic clarifications can be made.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The purpose of this rule change can only be achieved by extending the audit timeline.

8.442.3 PROPOSED ADJUSTMENTS

8.442.3.A. Following completion of a field audit, desk review or rate calculation, the Department or its contract auditor shall notify the affected ~~nursing facility~~ provider in writing of any proposed adjustment(s) to the costs reported on the facility's MED-13 form and the basis of the proposed adjustment(s).

8.442.3.B. ~~The facility shall have 35 calendar days from the date the notification was mailed to submit additional documents or other supporting information to the Department or its contract auditor in response to the proposed adjustment(s).~~ The provider may submit additional documentation in response to proposed adjustments. ~~In response to proposed adjustments, t~~The department or its contract auditor must receive the additional documentation~~s~~ or other supporting information from the provider within 60 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

8.442.3.C The Department may grant an additional period, not to exceed 30 calendar days, for the facility to submit such documents and information, when necessary and appropriate, given the facility's particular circumstances.

8.442.3.D. The Department's contract auditor shall complete the field audit, desk review or rate calculation within 30 days of the expiration of the ~~35~~60day provider response period. The contract auditor shall also complete and deliver the resulting rate letter to the Department by the 30thday following the expiration of the ~~35~~60 day provider response period.

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 13-03-01-A, Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Reimbursement, Sections 8.440.2, 8.443.4, and 8.443.8
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440.2, 8.443.4, and 8.443.8, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please add new text provided at §8.440.2.C.4. Please replace current paragraph at §8.443.4.B with new text provided. Please add new text at §8.443.8.A.19. Please replace text at §8.443.8.F and §8.443.8.F.1 with new text provided. All text indicated in blue is for clarification only and should not be altered. This change is effective 06/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Reimbursement, Sections 8.440.2, 8.443.4, and 8.443.8
Rule Number:	MSB 13-03-01-A
Division / Contact / Phone:	Finance Office / Weston Lander / x.3467

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

House Bill 03-1292 authorized the Colorado Department of Human Services (DHS) to collect a provider fee on Class II and Class IV nursing facilities, also known as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The fee program was suspended in FY 2011-12 due to questions about whether it was compliant with federal regulations. Suspending the fee program allowed the Department of Health Care Policy and Financing (the Department) to develop a strategy to work with the Centers for Medicare and Medicaid Services (CMS) to ensure the program meets regulatory standards.

In April 2012 the Department reached an agreement with CMS to reinstate the provider fee program in a manner that complies with federal regulations. With federal approval of the fee program, the Joint Budget Committee (JBC) appropriated funds for the fee and fee reimbursement for both FY 2011-12 and FY2012-13 as part of Senate Bill 13-167. The ICF/IID provider fee program saves the state General Fund approximately $1 million annually, while maintaining reimbursement rates for the facilities.

The current rules governing ICF/IID reimbursement are ambiguous as to the inclusion of provider fees as an allowable cost. Current statute (C.R.S. 25.5-6-204) states that ICFs/IID should be reimbursed for the actual cost of services provided, which would include the cost of the provider fee. Provider fees are not explicitly defined as an allowable cost for reimbursement purposes in rule. In order to ensure that ICFs/IID are reimbursed their full cost, the Department is proposing rule changes to explicitly define provider fees as an allowable cost.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or

☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. sections 433.55 and 433.68 (2012)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-6-204 C.R.S (2012)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Reimbursement, Sections 8.440.2, 8.443.4, and 8.443.8
Rule Number:	MSB 13-03-01-A
Division / Contact / Phone:	Finance Office / Weston Lander / x.3467

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The three ICF/IIDs operating in the state will be impacted by this rule change. The rule change is proposed to clarify that provider fee costs an allowable cost for determining reimbursement rates.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The qualitative impact of the rule change will ensure that ICF/IID facilities are able to maintain reimbursement rates, which in turn ensure the financial viability of the ICF/IID facilities, and the ability to provide essential services to some of Colorado's most vulnerable populations. Quantitatively, the rule changes will allow the providers to be reimbursed about $2 million in fee costs per year. The increase in reimbursement is offset by the cost of the fees; so the net reimbursement on the facilities is unchanged.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The rule changes proposed will maintain the viability of the fee program. Without reimbursement for the fee costs, ICF/IID facilities would not be able to afford the cost of the fee. The federal matching funds generated by the fee provide approximately $1 million in General Fund savings per year.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefits of the proposed rule changes are the maintenance of ICF/IID reimbursement rates and the financial viability of a program that saves the state General Fund $1 million per fiscal year as directed by the Colorado General Assembly. If the rule changes are not made, facilities will lose the assurance of reimbursement of fee cost, which in turn would put the fee program at risk. Without the fee, ICF/IID reimbursement would be reduced and the state General Fund would lose the savings it obtains from the increased FFP.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   This rule change is the only method through which the necessary programmatic clarifications can be made.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The purpose of this rule change can only be achieved by clearly defining provider fees as an allowable cost for this class of providers.

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs funds if requested, in writing by a resident and/or the resident's family:

1. Cosmetic and grooming items and services in excess of those for which payment is allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow, rouge/blush, haircuts, beyond simple trimming, normally performed by licensed barbers or beauticians;

2. Gifts purchased on behalf of a resident;

3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility, prescribed by the resident's physician;

4. Items or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that:

    a. The resident has made an informed decision supported by a statement in the Personal Needs Funds file that he/she/family is willing to use personal funds.

    b. The balance in the Personal Needs Funds in the resident's ledger is sufficient to cover the charge.

5. Personal clothing and dry cleaning;

6. Personal comfort items, including smoking materials, notions, novelties and confections/candies;

7. Personal reading material, subscriptions;

8. Private room;

9. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;

10. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. If the resident refuses the prepared food the facility shall offer substitutes. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item pursuant to 42 C.F.R. 483.35.

11. Telephone, television/radio for personal use, if not equally available to all residents.

12. Provider fee.

13. Prescription drugs, with certain specific exemptions.

14. Ambulance and medical transport, including emergent and non-emergent.

15. Oxygen

16. Physician fees

17. Non-nursing costs, including but not limited to direct and indirect outpatient therapy, assisted living, independent living, adult day care and meals-on-wheels.

8.440.2.B. The Department's approval shall be required in order for a resident or his/her relatives to be billed for the following:

1. The physician orders that a full-time R.N. or L.P.N. is needed. The R.N. or L.P.N. is not employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room.

2. The physician orders a private room.

3. The attending physician shall indicate the medical necessity on the resident's chart for either service above and shall submit to the Department a completed copy of Form 10013 (Physician's Request for Additional Benefits).

4. Upon approval of the Form 10013, payment for such services may be received from the resident's personal needs fund, relatives or others.

8.440.2.C The following items are allowable costs for class II and class IV facilities only:

1. Eye/Hearing examinations

2. Eyeglasses and repairs

3. Hearing aids and batteries

4. Provider fees

8.443.4 INFLATION ADJUSTMENT

8.443.4.A For class I nursing facilities, the per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective Medicare reimbursement rates recommended to the United States Congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

1. The percentage change shall be rounded at least to the fifth decimal point.

2. The index used for this allowance will be the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. The latest available publication prior to July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1, and June 30.

8.443.4.B For class II and privately-owned class IV facilities ~~intermediate care facilities for the mentally retarded~~, at the beginning of each facility's new rate period, the inflation adjustment shall be applied to all costs except provider fees, interest, and costs covered by fair rental allowance.

1. The inflation adjustment shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less.

2. The annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.

3. The price indexes listing in the latest available publication prior to the July 1 limitation setting shall be used to determine inflation indexes. The inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1 and June 30.

4. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period.

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A. Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described in 8.443.7.A.1.

2. Any portion of other staff costs directly attributable to administration.

3. Advertising and public relations.

4. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

7. Purchased services: accounting fees, legal fees; computer services. A computer service refers to any costs associated with the information technology system such as repair, maintenance and upgrades.

8. Management fees and home office costs, except as described in 8.443.7.A.13.

9. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.

10. All business related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.

11. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance, which is a health care cost.

12. Facility membership fees and dues in trade groups or professional organizations.

13. Miscellaneous general and administrative costs.

14. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

15. Purchases (including depreciation and interest), rentals, repairs, betterments and improvements of equipment utilized in administrative departments, including but not limited to the following:

    Resident room furniture and decor, excluding beds and mattresses

Office furniture and decor

Dining room and common area furniture and decor

Lighting fixtures

Artwork

Computers and related software used in administrative departments

16. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.

17. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.

18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

19. Provider fees for Class II and Class IV facilities.

8.443.8.B Property costs include:

1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

3. Property taxes.

4. Property insurance.

5. Mortgage insurance.

6. Interest on loans associated with property costs covered in this section.

7. Repairs, betterments and improvements to property not covered by the fair rental allowance.

8. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

8.443.8.C Room and board includes:

1. Dietary, other than raw food, and salaries related to dietary personnel including tray help, except registered dieticians which are health care.

2. Laundry and linen.

3. Housekeeping.

4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).

5. Repairs, betterments and improvements to equipment related to room and board services.

8.443.8.D Determination of the Administrative and General Maximum Allowable Rate (Limit) for Class II and IV Facilities.

The determination of the reasonable cost of services shall be made every 12 months. The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For class II facilities, one hundred twenty percent (120%) of the median actual costs of all class II facilities.

2. For class IV facilities, one hundred twenty percent (120%) of the median actual costs of all class IV facilities.

3. Determination of the rates beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before May 2.

4. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2.

5. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

   a. Exclude part, or all, of a provider's MED-13 or

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report to May 2.

6. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

7. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

8. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8.E. Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

1. Determination of the class I rates beginning on July 1 each year shall utilize the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers.

3. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one or more licensed beds, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

4. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.

5. Actual days of care shall be counted rather than occupancy-imputed days of care.

6. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.

7. Amounts contained in cost reports used to establish this median shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

    a. The percentage change shall be rounded at least to the fifth decimal point.

    b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

9. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

10. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

11. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

12. For fiscal years commencing on and after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between administrative and general costs and the health care costs causes a nursing facility provider’s administrative and general costs to exceed the reasonable price established by the state department, the

state department may pay the nursing facility provider the higher per diem payment for administrative and general services.

13. The reasonable price will be phased in over three years in accordance with the following schedule:

July 1, 2008	50% reasonable price
.	50% cost-based rate
July 1, 2009	50% reasonable price
.	50% cost-based rate
July 1, 2010	75% reasonable price
.	25% cost-based rate
July 1, 2011	100% reasonable price

The phase in will allow a percentage of the reasonable price established in accordance with these rules (reasonable price) and a percentage of the July 1, 2008 administrative and general rate in accordance with the rules in effect prior to implementation of these rules (cost-based rate). The cost-based rate determined at July 1, 2008 will be adjusted annually at July 1st for two subsequent years. The cost-based rate shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8.443.8.F For the purpose of reimbursing class II and privately-owned class IV facilities ~~intermediate care facilities for the mentally retarded~~ a per diem rate for the cost of administrative and general services, the Department shall establish an annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs and a fair rental allowance for capital-related assets.

1. In computing per diem cost, each class II and class IV facility~~intermediate care facility for the mentally retarded~~ provider shall annually submit cost reports to the Department.

2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit per 8.443.7D) divided by the higher of actual resident days or occupancy imputed days per 8.443.3.

3. An inflation adjustment per 8.443.4B will be applied to the per diem administrative and general and health care reimbursement rates.

4. An incentive allowance for administrative and general costs may be included per 8.443.5.

5. Each facility will be paid a per diem for capital-related assets per 8.443.9.A.