CHAPTER 249K

NURSING FACILITY CONSTRUCTION OR EXPANSION

249K.1 Purpose — intent.

The purpose of this chapter is to provide a mechanism to support the appropriate number of nursing facility beds for the state's citizens and to financially assist nursing facilities in remaining compliant with applicable regulations. It is the intent of this chapter that the administrative burden on both the state and nursing facilities be minimal.

2007 Acts, ch 219, §35, 41, 43

249K.2 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Complete replacement"* means completed construction on a new nursing facility to replace an existing licensed and certified facility. The replacement facility shall be located in the same geographical service area as the facility that is replaced and shall have the same number or fewer licensed beds than the original facility.
2. *"Department"* means the department of health and human services.
3. *"Major renovations"* means construction or facility improvements to a nursing facility in which the total amount expended exceeds seven hundred fifty thousand dollars.
4. *"Medical assistance"*, *"medical assistance program"*, or *"Medicaid program"* means the medical assistance program created pursuant to chapter 249A.
5. *"New construction"* means the construction of a new nursing facility which does not replace an existing licensed and certified facility and requires the provider to obtain a certificate of need pursuant to chapter 10A, subchapter VII.
6. *"Nondirect care component"* means the portion of the reimbursement rate under the medical assistance program attributable to administrative, environmental, property, and support care costs reported on the provider's financial and statistical report.
7. *"Nursing facility"* means a nursing facility as defined in section 135C.1.
8. *"Provider"* means a current or future owner or operator of a nursing facility that provides medical assistance program services.
9. *"Rate determination letter"* means the letter that is distributed quarterly by the Medicaid program to each nursing facility, which is based on previously submitted financial and statistical reports from each nursing facility.

2007 Acts, ch 219, §36, 41, 43; 2013 Acts, ch 138, §123, 127; 2016 Acts, ch 1073, §85, 189; 2019 Acts, ch 24, §104; 2022 Acts, ch 1131, §79; 2023 Acts, ch 19, §820; 2023 Acts, ch 119, §22

249K.3 General provisions — instant relief — nondirect care limit exception.

1. A provider that constructs a complete replacement, makes major renovations to, or newly constructs a nursing facility may be entitled to the rate relief and exceptions provided under this chapter. The total period during which a provider may participate in any relief shall not exceed two years. The total period during which a provider may participate in any nondirect care limit exception shall not exceed ten years. A provider seeking assistance under this chapter may request both instant relief and the nondirect care limit exception.
2. If the provider requests instant relief, the following provisions shall apply:

a. The provider shall submit a written request for instant relief to the Medicaid program explaining the nature, timing, and goals of the project and the time period during which the relief is requested. The written request shall clearly state if the provider is also requesting the nondirect care limit exception. The written request for instant relief shall be submitted no earlier than thirty days prior to the placement of the provider's assets in service. The written request for relief shall provide adequate details to calculate the estimated value

of relief including but not limited to the total cost of the project, the estimated annual depreciation expenses using generally accepted accounting principles, the estimated useful life based upon existing medical assistance and Medicare provisions, and a copy of the most current depreciation schedule. If interest expenses are included, a copy of the general terms of the debt service and the estimated annual amount of the interest expenses shall be submitted with the written request for relief.

b. The following shall apply to the value of relief amount:

(1) If interest expenses are disclosed, the amount of these expenses shall be added to the value of relief.

(2) The calculation of the estimated value of relief shall take into consideration the removal of existing assets and debt service.

(3) The calculation of the estimated value of relief shall be demonstrated as an amount per patient day to be added to the nondirect care component for the relevant period. The estimated annual patient days for this calculation shall be determined based upon budgeted amounts or the most recent annual total as demonstrated on the provider's Medicaid financial and statistical report. For the purposes of calculating the per diem relief, total patient days shall be the greater of the estimated annual patient days or eighty-five percent of the facility's estimated licensed capacity.

(4) The combination of the nondirect care component and the estimated value of relief shall not exceed one hundred and ten percent of the nondirect care median for the relevant period. If a nondirect care limit exception has been requested and granted, the combination of the nondirect care component and the estimated value of relief shall not exceed one hundred twenty percent of the nondirect care median for the relevant period.

c. Instant relief granted under this subsection shall begin the first day of the calendar quarter following placement of the provider's assets in service. If the required information to calculate the instant relief, as specified in paragraph "*a*", is not submitted prior to the first day of the calendar quarter following placement of the provider's assets in service, instant relief shall instead begin on the first day of the calendar quarter following receipt of the required information.

d. Instant relief granted under this subsection shall be terminated at the time of the provider's subsequent biannual rebasing when the submission of the annual cost report for the provider includes the new replacement costs and the annual property costs reflect the new assets.

e. During the period in which instant relief is granted, the Medicaid program shall recalculate the value of the instant relief based on allowable costs and patient days reported on the annual financial and statistical report. For purposes of calculating the per diem relief, total patient days shall be the greater of actual annual patient days or eighty-five percent of the facility's licensed capacity. The actual value of relief shall be added to the nondirect care component for the relevant period, not to exceed one hundred ten percent of the nondirect care median for the relevant period or not to exceed one hundred twenty percent of the nondirect care median for the relevant period if the nondirect care limit exception is requested and granted. The provider's quarterly rates for the relevant period shall be retroactively adjusted to reflect the revised nondirect care rate. All claims with dates of service from the date that instant relief is granted to the date that the instant relief is terminated shall be repriced to reflect the actual value of the instant relief per diem utilizing a mass adjustment.

3. If the provider requests the nondirect care limit exception, all of the following shall apply:

a. The nondirect care limit for the rate setting period shall be increased to one hundred and twenty percent of the median for the relevant period.

b. The exception period shall not exceed a period of two years. If the provider is requesting only the nondirect care limit exception, the request shall be submitted within sixty days of the release of the July 1 rate determination letters following each biannual rebasing cycle, and shall be effective the first day of the month following receipt of the request. If applicable, the provider shall identify any time period in which instant relief

was granted and shall indicate how many times the instant relief or nondirect care limit exception was granted previously.

2007 Acts, ch 219, §37, 41, 43; 2023 Acts, ch 19, §821
Referred to in §249K.4

249K.4 Preliminary evaluation.

1. A provider preparing cost or other feasibility projections for a request for relief or an exception pursuant to section 249K.3 may submit a request for preliminary evaluation.

2. The request shall contain all of the information required for the type of assistance sought pursuant to section 249K.3.

3. The provider shall estimate the timing of the initiation and completion of the project to allow the department to respond with estimates of both instant relief and the nondirect care limit exception.

4. The department shall respond to a request for preliminary evaluation under this section within thirty days of receipt of the request. A preliminary evaluation does not guarantee approval of instant relief or the nondirect care limit exception upon submission of a formal request. A preliminary evaluation provides only an estimate of value of the instant relief or nondirect care limit exception based only on the projections.

2007 Acts, ch 219, §38, 41, 43

249K.5 Participation criteria.

1. The Medicaid program shall administer this chapter. The department shall adopt rules, pursuant to chapter 17A, to administer this chapter.

2. A provider requesting instant relief or a nondirect care limit exception under this chapter shall meet one of the following criteria:

a. The nursing facility for which relief or an exception is requested is in violation of life safety code requirements and changes are necessary to meet regulatory compliance.

b. The nursing facility for which relief or an exception is requested is proposing development of a home and community-based services waiver program service that meets the following requirements:

(1) The service is provided on the direct site and is a nonnursing service.

(2) The service is provided in an underserved area, which may include a rural area, and the nursing facility provides documentation of this.

(3) The service meets all federal and state requirements.

(4) The service is adult day care, consumer directed attendant care, assisted living, day habilitation, home delivered meals, personal emergency response, or respite.

c. The nursing facility for which relief or an exception is requested is proposing replacement or enhancement of an HVAC, as defined in section 105.2, system for improved infection control.

3. In addition to any other factors to be considered in determining if a provider is eligible to participate under this chapter, the Medicaid program shall consider all of the following:

a. The history of the provider's regulatory compliance.

b. The historical access to nursing facility services for medical assistance program beneficiaries.

c. The provider's dedication to and participation in quality of care, considering all quality programs in which the provider has participated.

d. The provider's plans to facilitate person-directed care.

e. The provider's plans to facilitate dementia units and specialty post-acute services.

4. *a.* Any relief or exception granted under this chapter is temporary and shall be immediately terminated if all of the participation requirements under this chapter are not met.

b. If a provider's medical assistance program or Medicare certification is revoked, any existing exception or relief shall be terminated and the provider shall not be eligible to request subsequent relief or an exception under this chapter.

5. Following a change in ownership, relief or an exception previously granted shall

continue and future rate calculations shall be determined under the provisions of 441 IAC 81.6(12) relating to termination or change of ownership of a nursing facility.

2007 Acts, ch 219, §39, 41, 43; 2022 Acts, ch 1131, §80; 2023 Acts, ch 19, §822