

31-008 Payment for ICF/MR Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/MR services;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state, and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective beginning July 1, ~~2008~~. 2009

31-008.02 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as July 1, ~~2006~~ 2007) are used in determining the cost for Nebraska ICF/MRs with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

31-008.03 Allowable Costs: The following items are allowable costs under NMAP.

31-008.03A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of persons with mental retardation in ICF/MR's will be allowed.

31-008.05 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs that are not State-operated.

31-008.05A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

31-008.05B Total Inpatient Days: ~~In computing the provider's allowable cost per day for determination of the prospective rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days.~~ Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.05B1 For ICF/MRs with 16 beds or more: In computing the provider's allowable cost per day for determination of the rate, total

inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days.

31-008.05B2 For ICF/MRs with 4-15 beds:

In computing the provider's allowable cost per day for determination of the rate, total inpatient days for fixed costs are the greater of actual inpatient days or 85% of licensed beds. For computing the non-fixed costs per day the actual patient days are utilized.

31-008.05C New Construction, Reopenings, and Certification Changes: For new construction (entire facility or bed additions), facility reopenings, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering NMAP after July 31, 1982, must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months. Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: ~~An ICF/MR's prospective payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.~~ The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding). ~~The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, increased by the Inflation Factor (see 471 NAC 31-008.06C5) for the most recent report period.~~

Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05E1 ICF/MRs with 16 beds or more:

An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, increased by the Inflation Factor (see 471 NAC 31-008.06C7) for the most recent report period.

31-008.05E2 ICF/MRs with 4-15 beds:

An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

31-008.05F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with others than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions;-(Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply.); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

31-008.05G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-008.05J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are

computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

31-008.05H Interest Expense: For rate periods beginning January 1, 1985, interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for ICF/MR care. This limitation does not apply to government owned facilities.

31-008.05J Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Department of Health and Human Services, Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 31-008.07E, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department, for the purposes of rate setting, is the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added

costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

ICF/MRs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L Salaries of Administrators, Owners, and Directly Related Parties:

Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6) Administrator compensation maximums for the cost report period ending June 30, ~~2007~~ 2008 are:

Bed Size	Maximum
1 – 74	\$75,166 <u>\$78,062</u>
75 – 99	\$76,516 <u>\$79,464</u>
100 – 149	\$90,919 <u>\$94,422</u>
150 – 200	\$91,820 <u>\$95,357</u>
201 +	\$135,029 <u>\$140,231</u>

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the “State of Nebraska Salary Survey”.

31-008.05M Administration Expense: In computing the provider’s allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise Personnel Operating and Non-Personnel Operating Cost Components for the facility.

This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost components, including the administration cost category. If a facility’s actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

~~31-008.05N Facility Bed Size: To qualify for rate determination under provisions of 471 NAC 31-008, the facility must have a minimum of 15 licensed beds. Facilities with fewer than 15 licensed beds on October 1, 2000 were grandfathered into this methodology; facilities with fewer than 15 licensed beds after October 1, 2000 will be reimbursed under provisions of the Nebraska Home and Community Based Waiver Program.~~

31-008.05N Facility Bed Size Exception: For the rate period July 1, 2009 through June 30, 2010, rates for any privately-owned ICF/MR with less than 16 beds that was receiving Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/MRs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period is defined for non-State- operated ICF/MR providers for services provided from July 1, ~~2008~~ 2009 through June 30, ~~2009-2010~~. The Rate Period for State-Operated ICF/MR providers is defined as a calendar year.

31-008.06B Reporting Period: Each facility must file a cost report each year for the ~~twelve-month~~ reporting period ~~of July 1 through~~ ending June 30 ~~of each year~~.

31-008.06C Rates for Intermediate Care Facility for the Mentally Retarded (ICF/MR) Excluding State-Operated ICF/MR Providers:

31-008.06C1 ICF/MRs with 16 beds or more:

Effective July 1, ~~2008~~ 2009, subject to the allowable, unallowable, and limitation provisions of this system, the Department pays each facility a prospectively determined amount based on the facility's allowable, reasonable and adequate costs incurred and documented during the July 1, ~~2006~~ 2007 through June 30, ~~2007~~ 2008 Report Period. The per diem rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

1. The ICF/MR Personnel Operating Cost Component increased by the inflation factor;
2. The ICF/MR Non-Personnel Operating Cost Component increased by the inflation factor;
3. The ICF/MR Fixed Cost Component;
4. The ICF/MR Ancillary Cost Component increased by the inflation factor; and
5. The ICF/MR Revenue Tax Cost Component.

An ICF/MR facility's prospective rate is the sum of the five components.

31-008.06C2 ICF/MRs with 4-15 beds:

31-008.06C2a Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions

31-008.06C2b Final Rate: The Department pays each ICF/MR with 4-15 beds a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/MR Revenue Tax Cost Component. This component is not retroactively settled (see 31-008.06C8b).

The final rate is the sum of the above five components.

~~31-008.06C1~~ ICF/MR~~31-008.06C3~~ Personnel Operating Cost Component: This component ~~of the prospective rate~~ includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion ~~of the personnel operating cost component~~ consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry and housekeeping, property and plant, and administrative services.

31-008.06C3a ICF/MRs with 16 or more beds:

Both the resident care services and the support services portions of the personnel operating cost component of the prospective rate are the lower of:

1. The allowable personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by the Inflation Factor computed under provisions of 471 NAC ~~31-008.06C5~~31-008.06C7, or
2. The facility's Personnel Operating Cost Model, adjusted by the Inflation Factor computed under provisions of 471 NAC ~~31-008.06C5~~31-008.06C7.

~~31-008.06C1a~~31-008.06C3b Personnel Operating Cost Model:

The personnel operating cost model cost per day for each facility is determined based on each facility's average actual occupancy per day limited to an average occupancy of not less than 15 residents per day, level of care resident mix, staffing standards, and reasonable wage rates as adjusted for reasonable fringe benefits.

~~31-008.06C1a~~31-008.06C3b(1) Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in 471 NAC ~~31-008.06C1a(2)~~31-008.06C3b(2), are used to determine

each facility's efficient and adequate personnel cost. The 19 staff categories and respective standards are used to determine total efficient and adequate personnel cost and are not intended to be required staffing levels for each staff category. All standard hours per resident day are paid hours and, therefore, include vacation, sick leave, and holiday time.

The staff categories and standards are as follows:

Hours per Resident Day

<u>Staff Categories</u>	<u>All</u>
<u>Direct Care Staff</u>	
-Aides, attendants, houseparents, counselors, house managers	6.5160
<u>Direct Care Admin.</u>	
-QMRPs, residential service/ program coordinators, direct care supervisors	0.9105

Hours per Resident Day

<u>Active Treatment Services</u>		<u>All</u>
-Physical therapists & assistants		0.0620
-Occupational therapists & assistants		0.0830
-Psychologists		0.0940
-Speech therapists & audiologists		0.0700
-Social workers		0.1390
-Recreation therapists		0.1460
-Other professional & technical staff		0.4330
<u>Medical Services</u>		
-Health services supervisor	--see description following-	
-Registered nurses	--see description following-	
-LPN or vocational nurses		0.1975
<u>Dietary</u>		
-Dietitian, nutritionists		0.0230
-Food service staff		0.5540
<u>Laundry & Housekeeping</u>		
-Laundry & housekeeping personnel		0.3940

Property & Plant

-Maintenance personnel 0.3000

Administration

-Administrator --see description following--

-Assistant administrators --see description following--

-Other support personnel --see description following--

The standard for the Health Services Supervisor position is one full-time equivalent employee, which will result in a varying number of standard hours per resident day depending upon the number of resident days. The standard hours per resident day for registered nurses are 0.1885 reduced by the Health Services Supervisor hours per resident day. However, these standard hours may not reduce the facility below one full-time equivalent for the combined Health Services Supervisor and R.N. positions.

The standard for the Administrator position is one full-time equivalent employee. The standard for assistant administrators is based on facility size and is as follows:

<u>Number of Residents</u>	<u>Number of Assistant Administrators</u>
1 to 100	None
101 to 200	1
201 to 300	2
301 to 400	3
401 to 500	4
501 and over	5

For other support personnel, the standard hours per resident day are 0.608, reduced by the assistant administrators' hours per resident day.

31-008.06C1a31-008.06C3b(2) Standard Wage Rates: Wage rates for each personnel category will be determined annually based on the actual average wage rates of the Beatrice State Developmental Center for the current cost report period.

31-008.06C3c ICF/MRs with 4-15 beds:
Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C231-008.06C4 ICF/MR Non-Personnel Operating Cost Component: This component of the prospective rate includes all costs

other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers.

31-008.06C4a ICF/MRs with 16 beds or more:

The nonpersonnel operating cost component of the prospective rate is the lower of:

1. The allowable non-personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC ~~31-008.06C531-008.06C7~~;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/MR facilities, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC ~~31-008.06C531-008.06C7~~; or
3. 30 percent of the weighted mean for all ICF/MR facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under 471 NAC ~~31-008.06C531-008.06C7~~. The mean will be weighted by the Nebraska Medicaid ICF/MR days.

31-008.06C4b ICF/MRs with 4-15 beds:

The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C331-008.06C5 ICF/MR Fixed Cost Component: This component ~~of the prospective rate~~ includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component ~~of the prospective rate~~ is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C431-008.06C6 ICF/MR Ancillary Cost Component: ~~This component of the rate includes the ancillary cost center.~~ The ancillary cost component of the ~~prospective~~ rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C531-008.06C7 ICF/MR Inflation Factor: For the Rate Period of July 1, ~~2008~~ 2009 through June 30, ~~2009~~ 2010, the inflation factor is ~~5.8%~~ 5.0%.

31-008.06C631-008.06C8 ICF/MR Revenue Tax Cost Component:

31-008.06C8a ICF/MRs with 16 or more beds:

Under the ICF/MR Reimbursement Protection Act, for the Rate Period July 1, ~~2008~~ 2009 through June 30, ~~2009~~ 2010, the ICF/MR revenue tax per diem is computed as the ICF/MR revenue

tax based on State Fiscal Year ~~2007-08~~ 2008-09 net revenue divided by State Fiscal Year ~~2007-08~~ 2008-09 facility resident days. (See 405 NAC 1-003.)

31-008.06C8b ICF/MRs with 4-15 beds:

Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue divided by the prior report period facility resident days. (See 405 NAC 1-003.)

31-008.06C731-008.06C9 ICF/MR Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increases(s).

31-008.06F Initial Rates for New Providers:

31-008.06F1 Initial Rates for New Providers of ICF/MRs with 16 beds or more: Providers entering the NMAP as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering the NMAP as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

31-008.06F2 Initial Rates for New Providers of ICF/MRs with 4-15 beds:
New providers entering the NMAP will be required to submit a proposed budget. The initial rate will be negotiated between the provider and the Department.

New providers as a result of a change in ownership will be required to submit a proposed budget. The initial rate will be negotiated between the provider and the Department.