TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #06-158

DIGEST

Amends 405 IAC 1-17-1, 405 IAC 1-17-2, 405 IAC 1-17-3, 405 IAC 1-17-9, and 405 IAC 1-17-10 to revise Medicaid reimbursement methodology for Medicaid-enrolled state-owned intermediate care facilities for the mentally retarded (ICFs/MR) to include Medicaid-enrolled state-owned nursing facility. Amends 405 IAC 5-31-1 and adds 405 IAC 5-31-4.5 and 405 IAC 5-31-9 to set forth services covered by Medicaid in the per diem rate paid to a state-owned nursing facility. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 1-17-1; 405 IAC 1-17-2; 405 IAC 1-17-3; 405 IAC 1-17-9; 405 IAC 1-17-10; 405 IAC 1-17-17; 405 IAC 5-31-1; 405 IAC 5-31-4.5; 405 IAC 5-31-9

SECTION 1. 405 IAC 1-17-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-3; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified state-owned intermediate care facilities for the mentally retarded (ICF/MR) **and state-owned nursing facilities.** 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:

(1) recognize level and quality of care;

(2) establish effective accountability over Medicaid expenditures;

(3) provide for a regular review mechanism for rate changes;

(4) compensate providers for reasonable, allowable costs incurred by a prudent businessperson; and

(5) allow incentives to encourage efficient and economic operations.

The system of payment outlined in this rule is a retrospective system using interim rates predicated on a reasonable, cost-related basis, in conjunction with a final settlement process. Cost limitations are contained in this rule ~~which~~ **that** establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to ~~discounting,~~ intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data ~~which~~ **that** caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must:

(1) complete the appropriate Medicaid billing adjustment form; and

(2) reimburse the office for the amount of the overpayment.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-1; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 93)

SECTION 2. 405 IAC 1-17-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. **(a) The definitions in this section apply throughout this rule.**

~~(a) As used in this rule,~~ **(b)** "All-inclusive rate" means a per diem rate ~~which,~~ **that,** at a minimum, reimburses for all:
(1) nursing care;
(2) room and board;
(3) supplies; and
(4) ancillary therapy services;
within a single, comprehensive amount.

~~(b) As used in this rule,~~ **(c)** "Annual, historical, or budget financial report" refers to a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this rule, which shall constitute a comprehensive basis of accounting.

~~(c) As used in this rule,~~ **(d)** "Budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

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

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

(f) ~~As used in this rule,~~ "Desk ~~audit"~~ **review"** means a review **and application** of ~~a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.~~ **these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.**

(g) ~~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 by auditors.

(h) ~~As used in this rule,~~ "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms ~~which~~ **that** have received prior written approval by the office.

(i) ~~As used in this rule,~~ "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) ~~As used in this rule,~~ "Generally accepted accounting principles" means those accounting principles as established by the ~~American Institute of Certified Public Accountants.~~ **Governmental Accounting Standards Board (GASB).**

(k) ~~As used in this rule,~~ "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) ~~As used in this rule,~~ "Like levels of care" means **ICF/MR level of** care provided in a state-owned ICF/MR **and nursing facility level of care provided in a state-owned nursing facility.**

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

~~(m) As used in this rule,~~ **(n)** "Ordinary patient related costs" means costs of services and supplies that are necessary in **the** delivery of patient care by similar providers within the state.

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

~~(o) As used in this rule,~~ **(p)** "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.

~~(p) As used in this rule,~~ **(q)** "Unit of service" means all patient care ~~at the appropriate skill level~~ included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-2; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 94)

SECTION 3. 405 IAC 1-17-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

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. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles **as prescribed by the Governmental Accounting Standards Board pronouncements** shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. ~~The cash basis of~~ **State** accounting **records are maintained on a cash basis, which** shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
(2) document ~~such~~ **the** adjustments in a finalized exception report; and
(3) incorporate ~~such~~ **the** adjustments in prospective rate calculations under section 1(d) of this rule.

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for ~~such~~ **the** enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information:

(1) none of the commingled costs shall be recognized as Medicaid allowable costs; and
(2) the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-3; filed Sep 1, 1998, 3:25 p.m.: 22 IR 84; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 94)

SECTION 4. 405 IAC 1-17-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-9 Criteria limiting rate adjustment granted by office

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. ~~All state-owned intermediate care facilities for the mentally retarded (ICFs/MR)~~ **Providers reimbursed under this rule** will be reimbursed with a retrospective payment system. The annual financial reports filed by the ~~state-owned ICFs/MR~~ **providers** will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the annual financial report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the interim per diem rates based on the projected budget and paid during the report period will be multiplied by the paid client days to arrive at the annual settlement.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-9; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 98)

SECTION 5. 405 IAC 1-17-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-10 Computation of rate; allowable costs; review of cost reasonableness

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. 10. (a) The rate for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

(c) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. ~~in the same geographic area.~~ The office may request satisfactory documentation from providers whose costs do not appear to be reasonable.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-10; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 6. 405 IAC 1-17-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-17-17 State-owned facilities per diem rate

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. 17. **(a)** The per diem rate for ~~intermediate care facilities for the mentally retarded~~ **providers reimbursed under this rule:**

(1) is an all-inclusive rate; ~~The per diem rate~~ **and**
(2) includes all services provided to recipients by the facility.

(b) Resources from health insurance plans available to the resident shall apply first to defraying the costs of medical services before Medicaid. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services, Veteran's Administration, and other health insurances. Services reimbursed through other sources shall be segregated and not claimed on the facility's cost report.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-17; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 7. 405 IAC 5-31-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-31-1 Reimbursement

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. 1. Medicaid reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with 405 IAC 1-14.6 **or 405 IAC 1-17** when rendered to a Medicaid recipient whose level of care has been approved by the office **or its designee.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

SECTION 8. 405 IAC 5-31-4.5 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-31-4.5 Per diem services, state nursing facility

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. 4.5. (a) Those services and products furnished by a state nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with 405 IAC 1-17. The per diem rate for state nursing facilities includes the following services:

(1) Room and board:
(A) room accommodations;
(B) all dietary services; and
(C) laundry services.
(2) Nursing care.
(3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients, is included in the nursing facility per diem.
(4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:
(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs;
(G) traction equipment; and
(H) oxygen and equipment and supplies for its delivery;

are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require recipients to purchase or rent such equipment with their personal funds. DME purchased with

Medicaid funds becomes the property of the office of Medicaid policy and planning. The county office of family resources must be notified when the recipient no longer needs the equipment.
(5) Medically necessary and reasonable therapy services, which include:
(A) physical;
(B) occupational;
(C) respiratory; and
(D) speech pathology;
services.
(6) Dental services.
(7) Optometric services.
(8) Transportation services, except for emergency medical transportation services.
(9) Pharmaceutical products.
(10) The cost of both legend and nonlegend water products in all forms and for all uses.

(b) The services set out in subsection (a) provided to a Medicaid resident residing in a state nursing facility are reimbursed through the per diem rate except as follows:
(1) Hospital services rendered due to an acute illness or injury may be billed to Medicaid directly by the hospital. Individual exceptions to other medical care that must be rendered by practitioners outside the facility require prior authorization from the office.
(2) Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the office. Dental services prior authorized by the office must be billed to the Medicaid program directly by the outside dental provider. Admission of a recipient to a hospital for the purpose of performing dental services requires prior authorization by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-4.5)

SECTION 9. 405 IAC 5-31-9 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-31-9 Prior authorization for services rendered outside the state nursing facility

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 9. (a) Medical care rendered by practitioners outside the state nursing facility requires prior authorization.

(b) Prior authorization will not be given for medical services included in the per diem rate.

(c) Written evidence of physician involvement and personal patient evaluation in the progress notes and attached to the prior authorization form is required to document the medical necessity of the service.

(d) Prior authorization will include consideration of the following:
(1) Review of the properly completed Medicaid prior review and authorization request form substantiating both of the following:
(A) Medical necessity of the service.
(B) Explanation of why the service cannot be rendered at the facility.
(2) Review of criteria for the specific medical service requested as set forth in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-9)

Notice of Public Hearing

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