TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #09-215

DIGEST

Amends 405 IAC 1-14.6-2, 405 IAC 1-14.6-4, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, 405 IAC 1-14.6-18, 405 IAC 1-14.6-21 and 405 IAC 1-14.6-23 through 405 IAC 1-14.6-25 to change the reimbursement methodology for nursing facilities and applicable definitions; add definitions of "allowed profit add-on payment" and "tentative profit add-on payment" and amend other definitions; change certain rate applicability dates, minimum occupancy rates, case mix index, the reimbursement to facilities that have more than eight ventilator-dependent residents, reimbursement for facilities that meet certain quality of care measures, special care unit reimbursement, and identify providers that are eligible for such special care unit reimbursement; change certain add-on applicability dates, allowable per day cost elements, the calculation of the administrative component, create allowed direct care component profit add-on in children's nursing facilities, define a new allowed direct and indirect care component profit add-on calculations, and a new allowed capital component profit add-on; change the end and effective dates of certain allowable compensation methodologies; change the end date of the collection of the quality assessment fee; and change the end date of the closure and conversion fund. Effective 30 days after filing with the Publisher.

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

405 IAC 1-14.6-2; 405 IAC 1-14.6-4; 405 IAC 1-14.6-7; 405 IAC 1-14.6-9; 405 IAC 1-14.6-18; 405 IAC 1-14.6-21; 405 IAC 1-14.6-23; 405 IAC 1-14.6-24; 405 IAC 1-14.6-25

SECTION 1. 405 IAC 1-14.6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions

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

~~(a) As used in this rule,~~ **(b)** "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
  (A) allowable and patient-related; and
  (B) appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) Travel.
(7) Telephone.
(8) License dues and subscriptions.
(9) Office supplies.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified mental retardation professional (QMRP).

~~(b) As used in this rule,~~ **(c)** "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual

financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is determined based on the facility's nursing home report card score based on the latest published data as of the end of each state fiscal year.

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

~~(d) As used in this rule,~~ **(f)** "Average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

~~(e) As used in this rule,~~ **(g)** "Average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

~~(f) As used in this rule,~~ **(h)** "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

~~(g) As used in this rule,~~ **(i)** "Capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

~~(h) As used in this rule,~~ **(j)** "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups under the resource utilization group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

~~(i) As used in this rule,~~ **(k)** "Children's nursing facility" means a nursing facility that, **as of January 1, 2009,** has:

(1) ~~twenty-five~~ **fifteen** percent ~~(25%)~~ **(15%)** or more of its residents who are under the chronological age of twenty-one (21) years; and

(2) received written approval from the office to be designated as a children's nursing facility.

~~(j) As used in this rule,~~ **(l)** "Cost center" means a cost category delineated by cost reporting forms prescribed

by the office.

~~(k) As used in this rule,~~ **(m)** "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

~~(l) As used in this rule,~~ **(n)** "Desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

~~(m) As used in this rule,~~ **(o)** "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.

~~(n) As used in this rule,~~ **(p)** "Fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

~~(o) As used in this rule,~~ **(q)** "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 and resident assessment data and its supporting documentation by auditors.

~~(p) As used in this rule,~~ **(r)** "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

~~(q) As used in this rule,~~ **(s)** "Forms prescribed by the office" means either of the following:

(1) Cost reporting forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

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

~~(s) As used in this rule,~~ **(u)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(t) As used in this rule,~~ **(v)** "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

~~(u) As used in this rule,~~ **(w)** "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Dietary services and supplies.

(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.

~~(v) As used in this rule,~~ **(x)** "Medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

~~(w) As used in this rule,~~ **(y)** "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 ~~(1/30/98)~~ **(9/2000)** is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare and Medicaid Services (CMS). ~~formerly the Health Care Financing Administration.~~

~~(x) As used in this rule,~~ **(z)** "Normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

~~(y) As used in this rule,~~ **(aa)** "Nursing home report card score" means a numerical score developed and published by the Indiana state department of health (ISDH) that quantifies each facility's key survey results.

~~(z) As used in this rule,~~ **(bb)** "Office" means the office of Medicaid policy and planning.

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

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

~~(cc) As used in this rule,~~ **(ee)** "Reasonable allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

~~(dd) As used in this rule,~~ **(ff)** "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

~~(ee) As used in this rule,~~ **(gg)** "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI **for all residents** and facility-average CMI for Medicaid residents.

(hh) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's nursing home report card score.

~~(ff) As used in this rule,~~ **(ii)** "Therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

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

~~(hh) As used in this rule,~~ **(kk)** "Unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system:

(1) are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15; and

(2) result in the assessment being classified into a different RUG-III category.

~~(ii) As used in this rule,~~ **(ll)** "Untimely MDS resident assessment" means either of the following:

(1) A significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly.

(2) A full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6 following the conclusion of all:

(A) physical therapy;

(B) speech therapy; and

(C) occupational therapy.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 2. 405 IAC 1-14.6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth ~~(5th)~~ calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option:

(1) may be exercised only one (1) time by a provider; and

(2) must coincide with the fiscal year end for Medicare cost reporting purposes.

If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written ~~and electronic cost report (ECR) file~~ copy of their Medicare cost report that covers their most recently completed historical reporting period. ~~Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.~~

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth ~~(5th)~~ calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written ~~and electronic ECR file~~ copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, **and** related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(10) **A** copy of the working trial balance that was used in the preparation of their submitted ~~Medicare~~ **Medicaid** cost report.

(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report.

(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(d) **An** extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.

(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh ~~(7th)~~ month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the:

(A) Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary; and ~~the~~

(B) provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary;

then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. **An** extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:

(1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and ~~the~~

(2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or **a** transfer to **a** hospital.
(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or **a** transfer to **a** hospital.
(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, ~~such~~ **the assessment or** assessments shall be assigned the ~~case mix index~~ **CMI** associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, ~~such~~ **the assessment or** assessments shall be assigned the ~~case mix index~~ **CMI** associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has untimely MDS resident assessments, then ~~such~~ **the assessment or** assessments shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).

(k) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:
(1) The office or its contractor:
(A) shall audit a sample of MDS resident assessments; and
(B) will determine the percent of assessments in the sample that are unsupported.
(2) If the percent of assessments in the sample that are unsupported is greater than the threshold percent as shown in column (B) of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below:
(A) the office or its contractor shall conclude the field portion of the MDS audit; and
(B) no corrective remedy shall be applied.
(3) For nursing facilities with MDS audits performed on all residents, the office or its contractor will determine the percent of assessments audited that are unsupported.
(4) If the percent of assessments of all residents that are unsupported is greater than the threshold percent as shown in column (B) of the table below, a corrective remedy shall apply, which shall be calculated as follows:
(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below.
(B) In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs.
(C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.
(5) If the percent of assessments of all residents that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below:
(A) the office or its contractor shall conclude the MDS audit; and
(B) no corrective remedy shall apply.
(6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table in this subdivision, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

Effective Date	Threshold Percent	Administrative Component Corrective Remedy Percent
(A)	(B)	(C)
October 1, 2002	40%	5%
January 1, 2004	30%	10%
April 1, 2005	20%	15%

(l) Based on findings from the MDS audit, beginning on the effective date of this rule, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the

MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(m) ~~Beginning on the effective date of this rule,~~ Upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 3. 405 IAC 1-14.6-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

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

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, ~~2007,~~ **2011,** the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report used to establish a Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on **the following minimum occupancy levels:**

(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.

(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the ~~eighty-five percent (85%)~~ **applicable** minimum occupancy requirement **described in subsection (d),** if both of the following conditions can be established to the satisfaction of the office:

(1) The provider demonstrates that its current resident census has:

(A) increased to ~~eighty-five percent (85%)~~ **the applicable minimum occupancy level described in subsection (d),** or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period; and

(B) remained at such level for not fewer than ninety (90) days.

(2) The provider demonstrates that its resident census has:

(A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and

(B) remained at such level for not fewer than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) **Except as provided for in subsection (h),** the CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66

Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) In place of the CMIs contained in subsection (g), beginning on the effective date of this rule amendment and continuing thereafter, the CMIs contained in this subsection shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one (1) of the following RUG-III groups:

(A) PB2.

(B) PB1.

(C) PA2.

(D) PA1.

(2) The resident has a cognitive performance score (CPS) of:

(A) zero (0) – Intact;

(B) one (1) – Borderline Intact; or

(C) two (2) – Mild Impairment.

(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence control.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before the effective date of this rule amendment.

		CMIs effective for the period following the effective date of this rule amendment		
RUG-III Group	**RUG-III Code**	**The first calendar quarter through the fourth calendar quarter**	**The fifth calendar quarter through the eighth calendar quarter**	**The ninth calendar quarter and thereafter**
Reduced Physical Functions	**PB2**	**0.48**	**0.41**	**0.30**
Reduced Physical Functions	**PB1**	**0.44**	**0.38**	**0.28**
Reduced Physical Functions	**PA2**	**0.38**	**0.32**	**0.24**
Reduced Physical Functions	**PA1**	**0.33**	**0.28**	**0.21**

~~(h)~~ **(i)** The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports:

(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and

(B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

~~(i)~~ **(j)** The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of ~~eight dollars and seventy-nine cents ($8.79)~~ **eleven dollars and fifty cents ($11.50)** per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

~~(j)~~ **(k)** Beginning July 1, 2003, through June 30, ~~2007,~~ **2011,** the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. ~~as of July 4, 2003. Medicaid reimbursement increases shall be determined according to the following:~~

~~Nursing Home Report Card Score as of July 4, 2003~~	~~Per Medicaid Patient Day Rate Add-On~~
~~0 – 50~~	~~$3.00~~
~~51 – 105~~	~~$2.50~~
~~106 – 200~~	~~$2.00~~
~~201 and higher~~	~~$1.50~~

For purposes of determining the nursing home report card score rate add-on effective with this rule amendment and each July 1 thereafter, the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of each state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	**$5.75**
83 – 265	**$5.75 – ((Nursing Home Report Card Score – 82) × $0.03125)**
266 and above	**$0**

Facilities that did not have a nursing home report card score published as of ~~July 4, 2003,~~ **the most recently completed state fiscal year** may receive a per patient day rate add-on equal to two dollars ($2).

~~(k)~~ **(l)** Beginning effective July 1, 2003, through June 30, ~~2007,~~ **2011,** the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, and operate a special care unit (SCU) for such residents as demonstrated by resident assessment data. ~~as of June 30, 2003.~~ The additional Medicaid reimbursement shall equal ~~ten dollars and eighty cents ($10.80)~~ **twelve dollars ($12)** per Medicaid resident day in their SCU. Only facilities with a SCU for Alzheimer's disease or dementia as demonstrated by resident assessment data as of ~~June 30, 2003,~~ **March 31 of each year** shall be eligible to receive the additional reimbursement. **The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.**

~~(l)~~ **(m)** Nursing facilities that satisfy each of the four (4) conditions listed in this subsection shall qualify for a capital component rate add-on:

(1) Twenty-five percent (25%) or more of its residents as of December 31, 2006, were under the chronological age of twenty-one (21) years of age.

(2) According to the last health facility survey conducted by Indiana state department of health on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i).

(3) The facility bedrooms accommodate no more than four (4) residents.

(4) The facility bedrooms measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.

~~(m)~~ **(n)** The capital component rate add-on referenced in subsection ~~(l)~~ **(m)** shall be calculated by dividing the qualifying facility's debt service associated with financing acquired exclusively to fund any capital costs incurred by the provider to come into compliance with 42 CFR 483.70(d)(1)(i), divided by total patient days from the facility's latest completed annual financial report. For purposes of this provision, debt service shall mean the total annual interest and principal payments required to be paid on any such financing arrangement or arrangements. The capital component rate add-on shall be determined upon qualification for the add-on shall be determined following the provider's demonstration to the office of qualification for this provision, and shall become effective on the date the provider successfully completes the health facility survey of any new beds as conducted by the state department of health. The capital component rate add-on shall not be updated annually. Refinancing shall be recognized only when the interest rate is less than the original financing. The capital component rate add-on shall continue to apply until the associated financing has been fully paid.

~~(n)~~ **(o)** The capital component rate add-on described under subsection ~~(m)~~ **(n)** shall be exempt from the capital component overall rate ceiling as determined under section 9(c)(4) of this rule.

~~(o)~~ **(p)** The capital component rate add-on described under subsection ~~(m)~~ **(n)** shall be exempt from the maximum allowable increase as determined under section 23 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted

filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 3, 2009, 1:44 p.m.: 20090429-IR-405080602FRA)

SECTION 4. 405 IAC 1-14.6-9 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

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

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment **as defined below.** The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The indirect care ~~administrative,~~ and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable **Medicaid** per patient day direct therapy costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(4) The administrative component shall be equal to one hundred percent (100%) of the average allowable cost of the median patient day.

(b) The profit add-on payment will be calculated as follows:

(1) For nursing facilities designated by the office as children's nursing facilities, the **allowed** direct care component profit add-on is equal to the profit add-on percentage contained in Table 1, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 1; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 1
Children's Nursing Facilities

	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	30%	52%	110%	105%

(2) For nursing facilities that are not designated by the office as children's nursing facilities, the **tentative** direct care component profit add-on **payment** is equal to the profit add-on percentage contained in Table 2, times the difference (if greater than zero (0)) between:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 2; minus

(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 2
Non-Children's Nursing Facilities

	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 3 – Allowed Direct Care Profit Add-On Percentage

Nursing Home Report Card Score	Effective Dates	
	First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date	Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter
0 – 82	100%	100%
83 – 357	100% - ((Nursing Home Report Card Score – 82) × 0.36232%)	N/A
358 and greater	0%	N/A
83 – 279	N/A	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	N/A	0%

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.

(3) The **tentative** indirect care component profit add-on **payment** is equal to the profit add-on percentage contained in Table ~~3.~~ **4,** times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table ~~3,~~ **4;** minus

(B) a provider's allowable per patient day cost.

Table ~~3~~ **4**

	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	60%	52%	105%	100%

~~(4) The administrative component profit add-on is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:~~

~~(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus~~

~~(B) a provider's allowable per patient day cost.~~

~~Table 4~~

~~Administrative Component Profit Ceiling Percentage~~

~~Effective Date~~	~~July 1, 2003, through June 30, 2007~~	~~July 1, 2007, and after~~
~~Percentage~~	~~105%~~	~~100%~~

(C) The allowed indirect care component profit add-on payment is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in Table 5, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 5 – Allowed Indirect Care Profit Add-On Percentage		
Nursing Home Report Card Score	Effective Dates	
	First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date	Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter
0 – 82	100%	100%
83 – 357	100% - ((Nursing Home Report Card Score – 82) × 0.36232%)	N/A
358 and greater	0%	N/A
83 – 279	N/A	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	N/A	0%

~~(5)~~ **(4)** The **tentative** capital component profit add-on **payment** is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table ~~5;~~ **6;** minus

(B) a provider's allowable per patient day cost.

Table ~~5~~ **6**
Capital Component Profit Ceiling Percentage

Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	100%	80%

(C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in Table 7, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 7 – Allowed Capital Profit Add-On Percentage		
Nursing Home Report Card Score	**Effective Dates**	
	First Full Calendar Quarter through Fourth Full Calendar Quarter Following Rule Effective Date	**Fifth Full Calendar Quarter Following Rule Effective Date and Thereafter**
0 – 82	**100%**	**100%**
83 – 357	**100% - ((Nursing Home Report Card Score – 82) x 0.36232%)**	**N/A**
358 and greater	**0%**	**N/A**
83 – 279	**N/A**	**100% - ((Nursing Home Report Card Score - 82) × 0.50505%)**
280 and greater	**N/A**	**0%**

~~(6)~~ **(5)** The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ceiling defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in Table ~~6.~~ **8.**

Table ~~6~~ **8**
Direct Care Component Overall Rate Ceiling Percentage

Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	120%	110%

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in Table ~~7.~~ **9.**

Table ~~7~~ **9**
Indirect Care Component Overall Rate Ceiling Percentage

Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	115%	100%

~~(3) The average allowable cost of the median patient day for administrative costs times the overall rate ceiling percentage in Table 8.~~

~~Table 8~~
~~Administrative Component Overall Rate Ceiling Percentage~~

~~Effective Date~~	~~July 1, 2003, through June 30, 2007~~	~~July 1, 2007, and after~~
~~Percentage~~	~~105%~~	~~100%~~

~~(4)~~ **(3)** The average allowable cost of the median patient day for capital-related costs times the overall rate ceiling percentage in Table ~~9.~~ **10.**

Table ~~9~~ **10**
Capital Component Overall Rate Ceiling Percentage

Effective Date	July 1, 2003, through June 30, ~~2007~~ **2011**	July 1, ~~2007,~~ **2011,** and after
Percentage	100%	80%

~~(5)~~ **(4)** For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:
(1) shall be published as a provider bulletin; and
(2) may be updated by the office as needed.
Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 5. 405 IAC 1-14.6-18 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-18 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees

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. 18. (a) Compensation for:
(1) owner, related party, management, general line personnel, and consultants who perform management functions; or
(2) any individual or entity rendering services above the department head level;
shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. Beginning effective July 1, 2003, through June 30, ~~2007,~~ **2011,** compensation subject to this limitation includes wages, salaries, and fees for owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning effective July 1, ~~2007,~~ **2011,** and thereafter, wages, salaries, and fees paid for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.

(b) Beginning effective July 1, 2003, through June 30, ~~2007,~~ **2011,** the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in subjection (a). The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.

(c) Beginning effective July 1, ~~2007,~~ **2011,** the maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:
(1) under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or
(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.
If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

(d) The owner, related party, and management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation

Beds	Allowance
10	$21,542
20	$28,741
30	$35,915

40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 and over	$129,298 + $262/bed over 200

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-18; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2982; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 6. 405 IAC 1-14.6-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-21 Allocation of expenses

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. 21. (a) Except as provided in subsection (b), the detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) The following relationships shall be followed:
(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) ~~Nothing in this rule is intended to alter the appropriate classification of costs on the annual financial report from the appropriate classification of costs under 405 IAC 1-14.1.~~ No allocation of costs between annual financial report line items shall be permitted.
(4) Any changes in the allocation or classification of costs must be approved by the office prior to the changes being implemented. Proposed changes in allocation or classification methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-21; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 7. 405 IAC 1-14.6-23 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-23 Limitation to Medicaid rate increases for nursing facilities

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. 23. Notwithstanding all other provisions of this rule, for the period October 1, 2007, through June 30, 2011, nursing facility rates that have been calculated under this rule shall be limited to a maximum allowable increase as follows:

(1) For annual rate reviews effective October 1, 2007, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's latest annual Medicaid rate with an effective date prior to March 31, 2007.

(2) For annual rate reviews effective July 1, 2008, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of October 1, 2007.

(3) For annual rate reviews effective July 1, 2009, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2008.

(4) For annual rate reviews effective July 1, 2010, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2009.

(5) The therapy rate component shall be excluded for purposes of calculating the maximum allowable increase ~~pursuant to~~ **under** subdivisions (1) through (4). ~~of this section.~~

(6) Beginning on the first full calendar quarter following the effective date of this rule amendment, the direct care component shall be excluded for purposes of calculating the maximum allowable increase under subdivisions (1) through (4).

~~(6)~~ **(7)** A provider's annual Medicaid rate may be in effect for longer or shorter than twelve (12) months. In such cases, the maximum allowable increase percent shall be proportionately increased or decreased to cover the actual time frame their previous annual rate was in effect, using a twelve (12) month period as the basis.

~~(7) Subsequent to each annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index as described in section 6(d) of this rule. These rate adjustments are not limited to the maximum allowable increase.~~

(8) Should a provider's quality assessment rate change subsequent to the effective date of their annual Medicaid rate, the office shall restate the provider's Medicaid quality assessment rate add-on and the maximum allowable increase using the new quality assessment rate, applying all provisions of this rule. A provider's Medicaid rate restated under this provision shall be used to calculate their subsequent maximum allowable increase as determined in subdivisions (1) through (4). ~~of this section.~~

(9) The additional reimbursement authorized by section 7(i) of this rule shall be excluded for purposes of calculating the maximum allowable increase ~~pursuant to~~ **under** subdivisions (1) through (4) ~~of this section~~ when the nursing facility's prior annual Medicaid rate does not include this additional reimbursement.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-23; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Oct 4, 2007, 2:05 p.m.: 20071031-IR-405070150FRA)

SECTION 8. 405 IAC 1-14.6-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-24 Nursing facility quality assessment

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15-21-3; IC 16-21; IC 16-28; IC 23-2-4

Sec. 24. (a) Effective August 1, 2003 through June 30, ~~2007,~~ **2011,** the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility **based on the most recently completed annual financial report or quality assessment data collection form,** as follows:

(1) If the total annual nursing facility census days are fewer than seventy thousand (70,000), ten dollars ($10) per non-Medicare day.

(2) If the total annual nursing facility census days are equal to or greater than seventy thousand (70,000), two dollars and fifty cents ($2.50) per non-Medicare day.

(3) If the nursing facility is nonstate government owned or operated, two dollars and fifty cents ($2.50) per non-Medicare day.

(b) The following nursing facilities shall be exempt from the quality assessment described in subsection (a):

(1) A continuing care retirement community registered with the securities commissioner of the office of the secretary of state under IC 23-2-4.

(2) A hospital-based nursing facility licensed under IC 16-21.

(3) The Indiana Veterans' Home.

(c) For nursing facilities certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed annual financial report.

(d) For nursing facilities that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the ~~department of state revenue shall collect the quality assessment under 45 IAC 20.~~ **facility shall remit the quality assessment to the state of Indiana within ten (10) days after the due date. If a nursing facility fails to pay the quality assessment under this subsection within ten (10) days after the date the payment is due, the nursing facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).**

(e) The office or its contractor shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall be as follows:

(1) In writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

(B) The rationale for the facility's position.

(3) Signed by the authorized representative of the facility and must be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.

Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the facility of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the facility's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

(f) The assessment shall be calculated on an annual basis with equal monthly amounts due on or before the tenth day of each calendar month.

(g) A facility may file a request to pay the quality assessment on an installment plan. The request shall be as follows:

(1) In writing setting forth the facility's rationale for the request.

(2) Submitted to the office or its designee.

An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage set out in IC 12-15-21-3(6)(A).

(h) A facility that fails to pay the quality assessment due under this section within ten (10) days after the date the payment is due shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(i) The office may withhold Medicaid payments to a facility that fails to pay an assessment within thirty (30) days after the due date. The amount withheld may not exceed the amount of the assessment and any interest due under subsection (h).

(j) Not later than one hundred twenty (120) days after payment of the quality assessment was due, the office shall report each facility that has failed to pay the quality assessment by the due date to the state department of health to initiate license revocation proceedings.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-24; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 9. 405 IAC 1-14.6-25 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-25 Additional reimbursement for closing or converting nursing facilities

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. 25. (a) Beginning **on the first full calendar quarter following the** effective ~~July 1, 2003,~~ **date of this rule amendment** and continuing through June 30, ~~2007,~~ **2011,** nursing facility operators that were licensed and certified to participate in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) ~~as of July 1, 2003,~~ **on the effective date of this rule amendment** may be eligible to receive additional Medicaid reimbursement if they:

(1) close their nursing facility; or
(2) convert their nursing facility to alternative uses.

(b) The amount of additional reimbursement available under this section shall be determined by the office taking into consideration the following factors:

(1) The location of the nursing facility.
(2) The number of beds proposed to be closed or converted.
(3) The current and historical census of the facility.
(4) The financial condition of the nursing facility operator.
(5) The proposed time frame for closing or converting the facility.
(6) The availability of other facilities and services to meet the needs of residents.

(c) In order to receive additional reimbursement available under this section, the nursing facility provider shall submit a proposal to the office or its designee that fully describes the operator's proposed plan to close or convert the nursing facility. The office or its designee shall specify procedures and time frames that facilities shall follow in preparing and submitting proposals.

(d) The office shall review all proposals submitted under subsection (c) and shall notify the proposing nursing facility provider in writing of its response to their proposal. Based on its review of any proposal, the office may, in its sole discretion, do any of the following:

(1) Accept and approve the proposal for additional reimbursement as submitted.
(2) Request additional information it deems necessary to complete its review.
(3) Request modifications of the proposal as submitted.
(4) Accept and approve the proposal for additional reimbursement as revised.
(5) Reject and disapprove the proposal for additional reimbursement with or without requesting additional information or modifications from the proposing nursing facility provider.

(e) In the event the office accepts and approves a proposal for additional reimbursement, the office and nursing facility provider shall negotiate in good faith to execute a written agreement that specifies all terms and conditions that shall govern the proposing nursing facility provider's efforts to close or convert the nursing facility. The agreement between the office and the nursing facility provider shall be finalized and executed by all appropriate parties before any additional reimbursement available under this section shall be paid.

(f) The office shall pay any additional reimbursement available under this section into an escrow account, which will be established for the sole purpose to retain and disburse these funds. The funds shall be disbursed to the provider following the provider's successful completion of all conditions specified in the agreement referenced in subsection (e).

(g) The additional reimbursement available under this section shall

~~(1)~~ consist of an enhanced capital reimbursement rate add-on. ~~and~~

~~(2) be used to fund debt service termination and related closing costs as delineated in the agreement referenced in subsection (e).~~

The enhanced capital reimbursement rate add-on shall be computed by dividing the total amount determined in subsection (b) by the facility's actual occupancy from the most recently completed desk reviewed annual financial

report and shall be reimbursed for a period not to exceed twelve (12) months.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-25; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2984; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 10. All provisions of this rule amendment shall be implemented effective on the first day of the first calendar quarter following the effective date of this rule amendment.

Notice of Public Hearing

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