TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #09-192(F)

DIGEST

Amends 405 IAC 1-17-1 to revise Medicaid reimbursement methodology for Medicaid-enrolled state-owned intermediate care facilities and state-owned nursing facilities to include state-owned psychiatric hospitals. Amends 405 IAC 1-17-2 to include state-owned psychiatric hospitals as those that fall under like levels of care. Effective 30 days after filing with the Publisher.

405 IAC 1-17-1; 405 IAC 1-17-2

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, **and state-owned psychiatric hospitals.** 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 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 intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data 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; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA)

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.

(b) "All-inclusive rate" means a per diem rate which, 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.

(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.

(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.

(e) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(f) "Desk review" means a review and application of this rule to a provider submitted annual financial report including accompanying notes and supplemental information.

(g) "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) "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

(i) "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) "Generally accepted accounting principles" means those accounting principles as established by the Governmental Accounting Standards Board (GASB).

(k) "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) "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, **or psychiatric hospital level of care provided in a state-owned psychiatric hospital.**

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

(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.

(o) "Patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(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.

(q) "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).

(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; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA)

LSA Document #09-192(F)
Notice of Intent: 20090318-IR-405090192NIA
Proposed Rule: 20100203-IR-405090192PRA
Hearing Held: March 11, 2010
Approved by Attorney General: June 21, 2010
Approved by Governor: June 28, 2010
Filed with Publisher: June 28, 2010, 2:21 p.m.
Documents Incorporated by Reference: None Received by Publisher
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Posted: 07/28/2010 by Legislative Services Agency
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