
TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule

LSA Document #12-637(F)

DIGEST

Amends [405 IAC 1-12-1](#), [405 IAC 1-12-2](#), [405 IAC 1-12-4](#), [405 IAC 1-12-21](#), [405 IAC 1-12-24](#), and [405 IAC 1-12-25](#) to revise rate-setting criteria for nonstate-owned intermediate care facilities for the mentally retarded and community residential facilities for the developmentally disabled. Effective 30 days after filing with the Publisher.

[405 IAC 1-12-1](#); [405 IAC 1-12-2](#); [405 IAC 1-12-4](#); [405 IAC 1-12-21](#); [405 IAC 1-12-24](#); [405 IAC 1-12-25](#)

SECTION 1. [405 IAC 1-12-1](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-12-1](#) Policy; scope**Authority:** [IC 12-15-1-10](#); [IC 12-15-21-2](#)**Affected:** [IC 6-8.1-10-1](#); [IC 12-13-7-3](#); [IC 12-15-13-4](#)

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified **nonstate-operated** intermediate care facilities for the mentally retarded (ICF/MR), ~~with the exception of these facilities operated by the state,~~ **nonstate-operated ICFs/MR licensed as comprehensive rehabilitative management needs facilities (CRMNF)**, and **nonstate-operated** community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by [405 IAC 1-17](#). 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 recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which 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 caused a higher rate 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 complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with [IC 12-15-13-4](#)(e).

(e) Providers must pay interest on all overpayments, consistent with [IC 12-15-13-4](#). The interest charge shall not exceed the percentage set out in [IC 6-8.1-10-1](#)(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-1](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

SECTION 2. [405 IAC 1-12-2](#) IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-2 Definitions

Authority: [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.

(b) "All-inclusive rate" means a per diem rate that, at a minimum, reimburses for all nursing or resident:

- (1) care;
- (2) room and board;
- (3) supplies; and
- (4) ancillary services;

within a single, comprehensive amount.

(c) "Allowable cost determination" means a computation performed by the office or its contractor to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.

(f) "Annual or historical 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, which shall constitute a comprehensive basis of accounting.

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable resident-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 16(a) of this rule.

(h) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1 and shall be computed on a statewide basis for like levels of care, with the exceptions noted in this subsection, as follows:

- (1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
- (2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
- (3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental homes multiplied by one hundred fifty-nine percent (159%).
- (4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs

residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(i) "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

(j) "Comprehensive rehabilitative management needs facility" or "CRMNF" has the meaning set forth in 460 IAC 9-1-2(5).

~~(j)~~ **(k)** "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

~~(k)~~ **(l)** "CRF/DD" means a community residential facility for the developmentally disabled.

~~(l)~~ **(m)** "DDRS" means the Indiana division of disability and rehabilitative services.

~~(m)~~ **(n)** "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

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

~~(o)~~ **(p)** "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year-end.

~~(p)~~ **(q)** "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

~~(q)~~ **(r)** "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.

~~(r)~~ **(s)** "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.

~~(s)~~ **(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.

~~(t)~~ **(u)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

~~(u)~~ **(v)** "ICF/MR" means an intermediate care facility for ~~the mentally retarded~~. **individuals with intellectual disabilities commonly referred to as "ICF/IID".**

~~(v)~~ **(w)** "Like levels of care" means care:

- (1) within the same level of licensure provided in a CRF/DD; ~~or~~
- (2) provided in a nonstate-operated ICF/MR; **or**
- (3) provided in a nonstate-operated ICF/MR licensed as a CRMNF.**

~~(w)~~ **(x)** "Non-rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD annual

Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:

- October 1, ~~2003~~, **2011**, through September 30, ~~2004~~ **2012**
 - October 1, ~~2005~~, **2013**, through September 30, ~~2006~~ **2014**
 - October 1, ~~2007~~, **2015**, through September 30, ~~2008~~ **2016**
 - October 1, ~~2009~~, **2017**, through September 30, ~~2010~~ **2018**
- And every second year thereafter.

~~(x)~~ **(y)** "Office" means the Indiana office of Medicaid policy and planning.

~~(y)~~ **(z)** "Ordinary patient or resident-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

~~(z)~~ **(aa)** "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

~~(aa)~~ **(bb)** "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

~~(bb)~~ **(cc)** "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.

~~(cc)~~ **(dd)** "Rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

- October 1, ~~2002~~, **2012**, through September 30, ~~2003~~ **2013**
 - October 1, ~~2004~~, **2014**, through September 30, ~~2005~~ **2015**
 - October 1, ~~2006~~, **2016**, through September 30, ~~2007~~ **2017**
 - October 1, ~~2008~~, **2018**, through September 30, ~~2009~~ **2019**
- And every second year thereafter.

~~(dd)~~ **(ee)** "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.

~~(ee)~~ **(ff)** "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

~~(ff)~~ **(gg)** "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

~~(gg)~~ **(hh)** "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-2](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; filed Aug 7, 2007, 10:27 a.m.: [20070905-IR-405060157FRA](#); readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

SECTION 3. [405 IAC 1-12-4](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-12-4](#) Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: [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 ninety (90) days 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 may be exercised only one (1) time by a provider. 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.

(b) 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 or resident census data.
- (2) Statistical data.
- (3) Ownership and related party information.
- (4) Statement of all expenses and all income.
- (5) Detail of fixed assets and patient or resident 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 and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and ordinary charge.
- (8) Certification **statement signed** by the provider that:
 - (A) the data are true, accurate, related to patient or resident care; and ~~that~~
 - (B) expenses not related to patient or resident care have been clearly identified.
- (9) Certification **statement signed** 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.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office or its representatives circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office or its representatives prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office or its representatives shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office or its representatives.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

- (1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.
- (2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-4](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; filed Aug 14, 1998, 4:27 p.m.: 22 IR 64; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 720; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

SECTION 4. [405 IAC 1-12-21](#) IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for the mentally retarded; allowable costs; compensation; per diem rate

Authority: [IC 12-15-1-10](#); [IC 12-15-21-2](#)

Affected: [IC 12-13-7-3](#); [IC 12-15](#)

Sec. 21. (a) The procedures described in this section are applicable to intermediate care facilities for the mentally retarded with nine (9) or more beds only, notwithstanding the application of standards and procedures set forth in sections 1 through 20 of this rule.

(b) The per diem rate for intermediate care facilities for the mentally retarded:

(1) is an all-inclusive rate; ~~The per diem rate and~~

(2) includes all services provided to patients by the facility.

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day.

(d) Any ICFs/MR that is licensed as a CRMNF will be paid at a rate of six hundred thirty-nine dollars and eighteen cents (\$639.18) per resident day. This per diem rate is available only upon certification as a Medicaid ICF/MR and licensure by the division of disability and rehabilitative services. ICFs/MR that are licensed as CRMNFs will not receive a base rate nor be subject to the base rate reporting requirements at section 5 of this rule.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-21](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

SECTION 5. [405 IAC 1-12-24](#) IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-24 Assessment methodology

Authority: [IC 12-15-1-10](#); [IC 12-15-21-2](#)

Affected: [IC 12-13-7-3](#); [IC 12-15-32-11](#)

Sec. 24. (a) CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount that is based on total annual facility revenue. In determining total annual revenue when the financial report period is other than three hundred sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period. The assessment percentage applied to total annual revenue shall be ~~five and one-half percent (5.5%) for the period January 1, 2008, through September 30, 2011. Beginning October 1, 2011, the assessment percentage applied to total annual revenue shall be six percent (6%).~~ In no event shall the assessment percentage exceed the percentage determined to be eligible for federal financial participation under federal law.

(b) The assessment on provider total annual revenue authorized by [IC 12-15-32-11](#) shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is ~~defined~~ **determined** as revenue from the provider's: **follows:**

(1) For an annual rate review, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule. ~~or~~

(2) For a base rate review, from the provider's previous base rate financial reporting period as set out in section 5(c) of this rule.

(3) For an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in section 5(a) of this rule. The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the annualized bed days available to determine the new provider's annualized assessment.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes.

(d) ~~Notwithstanding all other provisions of this rule, all annual and base Medicaid rates in effect from the effective date of this rule through September 30, 2011, shall be reduced by the following amounts:~~

Licensure Type	Rate Reduction Amount
Sheltered living	\$1.34
Intensive training	\$1.55
Child rearing	\$1.89
Developmental training	\$1.66
Child rearing with a specialized program	\$2.01
Small behavior management residence for children	\$2.37
Basic developmental	\$2.00
Small extensive medical needs residences for adults	\$2.76
Extensive support needs residences for adults	\$4.13
Nonstate-operated ICF/MR	\$1.38

(e) ~~Notwithstanding all other provisions of this rule, all initial interim Medicaid rates established on or after the effective date of this rule through the end of the first calendar quarter following the effective date of this rule shall be reduced by the following amounts and shall remain reduced for the entire interim rate period:~~

Licensure Type	Rate Reduction Amount
Sheltered living	\$1.34
Intensive training	\$1.55
Child rearing	\$1.89
Developmental training	\$1.66
Child rearing with a specialized program	\$2.01
Small behavior management residence for children	\$2.37
Basic developmental	\$2.00
Small extensive medical needs residences for adults	\$2.76
Extensive support needs residences for adults	\$4.13
Nonstate-operated ICF/MR	\$1.38

(f) ~~For all annual and base rates calculated under this rule effective from the effective date of this rule through September 30, 2011, each provider's assessment costs reported on the cost report and included in allowable costs will be adjusted to reflect assessment costs at five and one-half percent (5.5%) of total annual facility revenue. Beginning October 1, 2011, each provider's assessment costs reported on the cost report and included in allowable costs will be adjusted to reflect assessment costs at six percent (6%) of total annual facility revenue. In no event shall the allowable cost for the assessment exceed the percentage determined to be eligible for federal financial participation under federal law.~~

(d) For an ICFs/MR that is licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-24](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Jul 31, 2008, 4:12 p.m.: [20080827-IR-405070647FRA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

SECTION 6. [405 IAC 1-12-25](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-12-25](#) Reimbursement for day services

Authority: [IC 12-15-1-10](#); [IC 12-15-21-2](#)

Affected: [IC 12-13-7-3](#); [IC 12-15](#)

Sec. 25. For **ICF/MR and CRF/DD** facilities, the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-25](#); filed Jun 1, 1994, 5:00 p.m.: 17 IR 2330; filed Aug 14, 1998, 4:27 p.m.: 22 IR 68; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Aug 28, 2013, 10:20 a.m.: [20130925-IR-405120637FRA](#))

LSA Document #12-637(F)

Notice of Intent: [20121212-IR-405120637NIA](#)

Proposed Rule: [20130710-IR-405120637PRA](#)

Hearing Held: August 2, 2013

Approved by Attorney General: August 19, 2013

Approved by Governor: August 27, 2013

Filed with Publisher: August 28, 2013, 10:20 a.m.

Documents Incorporated by Reference: None Received by Publisher

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Posted: 09/25/2013 by Legislative Services Agency

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