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**TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES**

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**Final Rule**

LSA Document #15-34(F)

**DIGEST**

Amends [405 IAC 1-4.2-4](#) to extend through June 30, 2017, the three percent rate reduction for covered home health agency (HHA) services that is currently set to expire on June 30, 2015, and clarify the time limits for submission of requested documentation. Amends [405 IAC 1-8-3](#) to extend through June 30, 2017, the three percent rate reduction for covered outpatient hospital services that is currently set to expire on June 30, 2015. Amends [405 IAC 1-10.5-6](#) to extend through June 30, 2017, the three percent rate reduction for covered inpatient hospital services that is currently set to expire on June 30, 2015. Amends [405 IAC 1-11.5-2](#) to substitute the language "Centers for Medicare and Medicaid Services" for "Health Care Financing Administration" and remove the list of procedure codes exempt from the physician global surgery policy. Amends [405 IAC 1-12-21](#) to modify the Medicaid reimbursement rule for covered services provided by privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) licensed as a comprehensive rehabilitative management needs facility (CRMNF). Amends [405 IAC 1-12-27](#) to extend through June 30, 2017, the one percent rate reduction for covered services provided by privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) that is currently set to expire on June 30, 2015. Amends [405 IAC 1-14.6-2](#) to update and add definitions. Amends [405 IAC 1-14.6-5](#) to add a penalty for untimely filing of the Checklist of Management Representations. Amends [405 IAC 1-14.6-7](#) to amend the case mix indices, inflation adjustment, and effective dates. Amends [405 IAC 1-14.6-9](#) to modify effective dates, substitute the language "total quality score" for "report card score", and modify the newly defined total quality score. Amends [405 IAC 1-14.6-18](#) to update beginning and end dates for allowable costs. Amends [405 IAC 1-14.6-24](#) to extend until June 30, 2017, the nursing facility quality assessment fee enhanced reimbursements and change the quality assessment provisions and to conform with applicable statutory provisions and the federal waiver. Amends [405 IAC 1-14.6-26](#) to modify the rate reduction for reimbursed nursing facilities. Amends [405 IAC 1-19-2](#) to revise the time period providers are required to notify the office of a change in ownership. Amends [405 IAC 1-20-2](#) to change mandatory language to permissive. Amends [405 IAC 5-24-6](#) to extend through June 30, 2017, the Medicaid dispensing fee maximum of three dollars and ninety cents that is currently set to expire on June 30, 2015. Amends [405 IAC 5-24-13](#) to revise and clarify the criteria for determining when legend and nonlegend water products are to be included in the nursing facility per diem rate and when they are to be reimbursed through the pharmacy benefit. Adds [405 IAC 5-24-14](#) to add criteria for determining when skin protectants, sealants, moisturizers, and ointments are to be included in the nursing facility per diem rate and when they are to be reimbursed through the pharmacy benefit. Amends [405 IAC 5-31-4](#) to revise the criteria for determining when legend and nonlegend water products are included in the nursing facility per diem rate and add criteria for determining when skin protectants, sealants, moisturizers, and ointments are to be included in the nursing facility per diem rate. Effective 30 days after filing with the Publisher.

[405 IAC 1-4.2-4](#); [405 IAC 1-8-3](#); [405 IAC 1-10.5-6](#); [405 IAC 1-11.5-2](#); [405 IAC 1-12-21](#); [405 IAC 1-12-27](#); [405 IAC 1-14.6-2](#); [405 IAC 1-14.6-5](#); [405 IAC 1-14.6-7](#); [405 IAC 1-14.6-9](#); [405 IAC 1-14.6-18](#); [405 IAC 1-14.6-24](#); [405 IAC 1-14.6-26](#); [405 IAC 1-19-2](#); [405 IAC 1-20-2](#); [405 IAC 5-24-6](#); [405 IAC 5-24-13](#); [405 IAC 5-24-14](#); [405 IAC 5-31-4](#)

SECTION 1. [405 IAC 1-4.2-4](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-4.2-4](#) Home health care services; reimbursement methodology****Authority:** [IC 12-15](#)**Affected:** [IC 12-15-13-2](#); [IC 12-15-22-1](#)

Sec. 4. (a) Home health agencies will be reimbursed for covered services provided to Medicaid recipients through standard, statewide rates, computed as:

- (1) one (1) overhead cost rate per provider, per recipient, per day; plus
- (2) the staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

(b) The overhead cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median overhead cost per visit. The statewide median overhead cost per visit is derived in the following manner:

- (1) Determine for each HHA total patient-related costs submitted by HHA providers on forms prescribed by the office, less direct staffing and benefit costs, divided by the total number of HHA visits during the Medicaid reporting period for that provider. The result of this calculation is an overhead cost per visit for each HHA.
  - (2) Array all HHA providers in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.
  - (3) The statewide median overhead cost per visit is the cost of the agency at the point in the overhead cost array at which one-half (1/2) of the overhead cost observations are from higher-cost agencies and one-half (1/2) are from lower-cost agencies.
- (c) The staffing cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median direct staffing and benefit costs per hour for each of the following disciplines:
- (1) Registered nurse.
  - (2) Licensed practical nurse.
  - (3) Home health aide.
  - (4) Physical therapist.
  - (5) Occupational therapist.
  - (6) Speech pathologist.
- (d) The statewide median direct staffing and benefit costs per hour is derived in the following manner:
- (1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHA providers on forms prescribed by the office, divided by the total number of HHA hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each HHA and discipline.
  - (2) Array all HHA providers in the state in accordance with their staffing cost rate per hour for each discipline, from the highest to the lowest.
  - (3) The statewide median staffing cost rate per hour for each discipline is the cost of the agency at the point in the staffing cost array in which one-half (1/2) of the cost observations are from agencies with higher staffing rates per hour and one-half (1/2) are from agencies with lower staffing rates per hour.
- (e) All HHAs must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all HHA personnel.
- (f) Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the most recently filed Medicare cost report. Non-Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the latest fiscal year end financial statements.
- (g) Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Center for Medicare & Medicaid Services Home Health Agency Market Basket index. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the next expected rate period.
- (h) The semivariable cost will be removed from the overhead cost calculated in accordance with subsection (b) and added to the staffing cost calculated in accordance with subsection (c), based on hours worked.
- (i) Field audits will be conducted yearly on a selected number of home health agencies. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.
- (j) Financial and statistical documentation may be requested by the office or its contractor. This documentation may include, but is not limited to, the following:
- (1) Medicaid cost reports.
  - (2) Medicare cost reports.
  - (3) Statistical data.
  - (4) Financial statements.
  - (5) Other supporting documents deemed necessary by the office or the rate setting contractor.
- Failure to submit requested documentation **within thirty (30) days of the date of the request** may result in the imposition of the sanctions described in section 3.1(c) and 3.1(d) of this rule and sanctions set forth in [IC 12-15-](#)

(k) Retroactive repayment will be required when any of the following occur:

(1) A field audit identifies overpayment by Medicaid.

(2) The provider knowingly receives overpayment of a Medicaid claim from the office. In this event, the provider must:

(A) complete appropriate Medicaid billing adjustment forms; and

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

(l) Notwithstanding all other provisions of this rule, ~~for the period beginning January 1, 2014, and continuing through June 30, 2015,~~ reimbursement ~~rates~~ shall be reduced, **through June 30, 2017**, by three percent (3%) for home health services that have been calculated under this rule.

*(Office of the Secretary of Family and Social Services; [405 IAC 1-4.2-4](#); filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: [20070718-IR-405070031FRA](#); readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 2. [405 IAC 1-8-3](#) IS AMENDED TO READ AS FOLLOWS:

### **[405 IAC 1-8-3](#) Reimbursement methodology**

**Authority:** [IC 12-15-21-2](#); [IC 12-15-21-3](#)

**Affected:** [IC 12-15-15-1](#)

Sec. 3. (a) The reimbursement methodology for all covered outpatient hospital and ambulatory surgical center services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(b) Surgical procedures shall be:

(1) classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology; and

(2) paid a rate established for each ASC payment group.

Outpatient surgeries that are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups or additional payment groups. Reimbursement will be based on the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003.

(c) Payments for emergent care that:

(1) do not include surgery; and

(2) are provided in an emergency department, treatment room, observation room, or clinic;

will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(d) Payments for nonemergent care that:

(1) do not include surgery; and

(2) are provided in an emergency department, treatment room, observation room, or clinic;

will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(e) Reimbursement for laboratory procedures is based on the Medicare fee schedule amounts.

Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule rates for the radiology services technical component.

(f) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., shall be equal to the Indiana Medicaid statewide fee schedule amounts in effect during state fiscal year 2003.

(g) Payments will not be made for outpatient hospital and ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

(h) The established rates for hospital outpatient and ambulatory surgical center reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section.

(i) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(j) Notwithstanding all other provisions of this rule, ~~for the period beginning January 1, 2014, and continuing through June 30, 2015;~~ reimbursement **rates** shall be reduced, **through June 30, 2017**, by three percent (3%) for outpatient hospital services (excluding ambulatory surgical center reimbursement) that have been calculated under this rule.

*(Office of the Secretary of Family and Social Services; [405 IAC 1-8-3](#); filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Aug 16, 2010, 3:35 p.m.: [20100915-IR-405100167FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 3. [405 IAC 1-10.5-6](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-10.5-6](#) Rate reduction**

**Authority:** [IC 12-15-21-2](#); [IC 12-15-21-3](#)

**Affected:** [IC 12-15-15-1](#)

Sec. 6. Notwithstanding all other provisions of this rule, ~~for the period beginning January 1, 2014, and continuing through June 30, 2015;~~ reimbursement **rates** shall be reduced, **through June 30, 2017**, by three percent (3%) for inpatient hospital services that have been calculated under this rule.

*(Office of the Secretary of Family and Social Services; [405 IAC 1-10.5-6](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 4. [405 IAC 1-11.5-2](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-11.5-2](#) Reimbursement methodology**

**Authority:** [IC 12-15-21-2](#); [IC 12-15-21-3](#)

**Affected:** [IC 12-15-13-2](#)

Sec. 2. (a) The office shall establish fee schedules with maximum allowable payment amounts for services and procedures:

- (1) covered under the Medicaid program; and
- (2) provided by eligible physicians, LLPs, and other NPPs.

(b) The reimbursement for services of physicians and LLPs shall be determined as follows:

- (1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10), shall be equal to the lower of the following:
  - (A) The submitted charges for the procedure.
  - (B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office of Medicaid policy and planning (office).
- (2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:
  - (A) Relative value units may be:

- (i) obtained from other state Medicaid programs; or
  - (ii) developed specifically for the Indiana Medicaid program, subject to review by the Medicaid director.
- (B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.
- (3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.
- (4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as established by the office.
- (5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
- (6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
- (7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by the ~~Health Care Financing Administration~~ **Centers for Medicare and Medicaid Services** for the Medicare Part B fee schedule for physician services. ~~The global surgery policy will not apply to the following codes:~~
- ~~(A) 59410—Vaginal delivery, including postpartum care.~~
  - ~~(B) 59515—Caesarean delivery, including postpartum care.~~
- (8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.
- (9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and ~~in~~ intra-arterial injections, if it is used for patients who meet the criteria established by the office.
- (10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.
- (c) Reimbursement for services of NPPs shall be in accordance with the following:
- (1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be not lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.
- (2) Reimbursement for services of:
- (A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;
  - (B) psychologists with basic certificates; and
  - (C) licensed psychologists;
- providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with [405 IAC 5-20-8](#) shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.
- (3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).
- (4) Reimbursement for services provided by certified physical therapists' assistants shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must be billed through the supervising licensed physical therapist or physician.
- (5) Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. The state MAC rate for blood factor products is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The office will review the state MAC rates for blood factor products on an ongoing basis and adjust the rates as necessary to:
- (A) reflect the prevailing market conditions; and



(B) ensure reasonable access by inpatient hospital providers to blood factor products at or below the applicable state MAC rate.

Inpatient hospitals shall submit claims for reimbursement in accordance with the instructions set forth in the provider manual or update bulletins.

(6) Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services as established under subsection (b)(1).

(d) The established rates for physician, LLP, and NPP reimbursement shall be reviewed annually by the office and adjusted as necessary.

(e) The relative value units used for the Indiana resource-based relative value scale fee schedule will be reviewed annually, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year and adjusted as necessary.

(f) Reimbursement for physician-administered drugs shall be one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For benchmark NDCs without a published WAC, the reimbursement for physician-administered drugs shall be the Medicare payment amount as published by the Centers for Medicare and Medicaid Services (CMS). If no WAC or Medicare payment amount is available, other pricing metrics may be used as determined by the office. This provision shall not apply to parenteral nutrition and blood factor products.

(g) Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of LSA Document #10-793 or June 27, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for chiropractic and podiatric services that have been calculated under this rule and for dental services that are billed using current dental terminology (CDT) codes that have been calculated under this rule.

(h) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

*(Office of the Secretary of Family and Social Services; [405 IAC 1-11.5-2](#); filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1901; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); filed Sep 12, 2008, 12:34 p.m.: [20081008-IR-405080186FRA](#); filed Aug 19, 2010, 3:32 p.m.: [20100915-IR-405100250FRA](#); filed May 9, 2011, 3:59 p.m.: [20110608-IR-405100793FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 5. [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. and~~

~~(2) The per diem rate~~ 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~~ **twenty-six**

dollars and ~~eighteen~~ **twenty-six** cents (~~\$639.18~~) (**\$626.26**) 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 **are not subject to other rate adjustments identified in this rule except for [405 IAC 1-12-27](#)** and 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](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 6. [405 IAC 1-12-27](#) IS AMENDED TO READ AS FOLLOWS:

#### **[405 IAC 1-12-27](#) Rate reduction**

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

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

Sec. 27. Notwithstanding all other provisions of this rule, ~~for the period beginning January 1, 2014, and continuing through June 30, 2015;~~ reimbursement **rates** shall be reduced, **through June 30, 2017**, by one percent (1%) for services provided by all privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; [405 IAC 1-12-27](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 7. [405 IAC 1-14.6-2](#) IS AMENDED TO READ AS FOLLOWS:

#### **[405 IAC 1-14.6-2](#) 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) "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) All staff travel and mileage.
- (7) Telephone.
- (8) License dues and subscriptions.
- (9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.
- (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).
- (16) Educational seminars for administrative staff.
- (17) Support and license fees for all general and administrative computer software and hardware such as

accounting or other data processing activities.

(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 based on the facility's **total quality score**.

- ~~(1) nursing home report card score using the latest published data as of the end of each state fiscal year for periods through June 30, 2013; or~~
- ~~(2) the total quality score for periods beginning July 1, 2013.~~

(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.

(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.

(g) "Average historical cost of property of the median bed" means the allowable patient-related property **cost** 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.

(h) "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(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.

(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.

(k) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

- (1) fifteen percent (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.

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

(m) "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the date defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the guidelines for use in determining the time-weighted CMI under section 9(e) of this rule. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(n) "Desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(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.
- (9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental ~~cost~~ **costs** for these items are limited to one dollar and fifty cents (\$1.50) per resident day.
- (10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
- (11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
- (12) Legend and nonlegend sterile water ~~used for any purpose.~~ **products used for irrigation or humidification.**
- (13) Educational seminars for direct care staff.
- (14) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis by the member, nursing facility care staff, or by prescriber's order as a part of routine care as defined in subsection (gg).**

(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.

(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.

(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%

(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.

(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.

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

(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.

(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.
- (11) Cable or satellite television throughout the nursing facility, including residents' rooms.
- (12) Pets, pet supplies and maintenance, and veterinary expenses.
- (13) Educational seminars for indirect care staff.
- (14) All costs related to nonambulance travel and transportation of residents.

(x) "Medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

(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 (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).

(z) "Normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

(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.

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

(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.

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

(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.

(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.

**(gg) "Routine care" means care that does not treat or ameliorate a specific defect or specific physical or mental illness or condition.**

~~(gg)~~ **(hh)** "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)~~ **(ii)** A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a nursing facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

- (i) meet the needs or preferences, or both, of cognitively impaired residents; and
- (ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

~~(ii)~~ **(jj)** "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~~: **total quality score**.

~~(jj)~~ **(kk)** "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.

~~(kk)~~ **(ll)** "Total quality score" means the sum of the quality points awarded to each nursing facility for all eight (8) quality measures as determined in section 7(n)(1) through 7(n)(8) of this rule.

~~(ll)~~ **(mm)** "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).

~~(mm)~~ **(nn)** "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.

(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](#); filed Nov 12, 2009, 4:01 p.m.: [20091209-IR-405090215FRA](#); filed Nov 1, 2010, 11:37 a.m.: [20101201-IR-405100183FRA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 8. [405 IAC 1-14.6-5](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-14.6-5](#) New provider; initial financial report to office; criteria for establishing initial interim rates; penalty for untimely filing of Checklist of Management Representations**

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

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

Sec. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Before the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's CMI for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's CMI for Medicaid residents. Initial interim rates shall be effective on the:

- (1) certification date; or
- (2) date that a service is established;

whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(b) Before the first annual rate review, the rate will be adjusted effective on each calendar quarter under section 6(d) of this rule to account for changes in the provider's CMI for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In conjunction with establishing an initial interim rate, a new operation shall submit a Nursing Facility Quality Assessment Form that contains projected patient census data from the first day of operation through the provider's first fiscal year end with a minimum of six (6) months of actual historical data. Following completion of the provider's first fiscal year end with a minimum of six (6) months of actual historical data, the provider shall submit a Nursing Facility Quality Assessment Form reporting actual patient census data covering the period from the first day of operation until the provider's first fiscal year end with a minimum of six (6) months of actual historical data. This form shall be submitted to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. Failure to submit a Nursing Facility Quality Assessment Form shall result in the actions specified at section 4(e) of this rule. This form will not be required after the quality assessment expires.

(d) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, **the new provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor within thirty (30) days following the date the Checklist of Management Representations request is sent to the provider.** The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor. **If the completed Checklist of Management Representations has not been submitted within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider, the Medicaid rate currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period. The penalty shall remain until the first day of the month after the completed Checklist of Management Representations is received by the office or its contractor. Reimbursement lost because of the penalty cannot be recovered by the provider.**

(e) For a new operation, the interim quality assessment and Medicaid rate add-on shall be based on projected patient days. A retroactive settlement of the quality assessment and Medicaid rate add-on will be determined, based on actual patient days, for the time period from the first day of operation until the first annual rate effective date associated with the provider's first fiscal year end with a minimum of six (6) months of actual historical data.

(Office of the Secretary of Family and Social Services; [405 IAC 1-14.6-5](#); filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2242; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2467; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 9. [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 12-15-1-10](#); [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, ~~2014~~, **2017**, 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 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 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 **and** 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 CMI's 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 CMI's contained in subsection (g), the CMI's 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 status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then 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 January 1, 2010.

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned ninety-six percent (96%) of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	CMI Table	CMI Table
		Effective 10/1/2011, through 12/31/2014	Effective 1/1/2012, and thereafter
Reduced Physical Functions	PB2	0.41	0.30
Reduced Physical Functions	PB1	0.38	0.28
Reduced Physical Functions	PA2	0.32	0.24
Reduced Physical Functions	PA1	0.28	0.21

RUG-III Group	RUG-III Code	CMI Table
Reduced Physical Functions	PB2	0.30
Reduced Physical Functions	PB1	0.28
Reduced Physical Functions	PA2	0.24
Reduced Physical Functions	PA1	0.21

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

(1) A preliminary CMI report that will:

- (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 preliminary report will be provided by the twenty-fifth day of the first 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.

(j) The office will 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 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.

(k) Beginning October 1, 2011, through June 30, 2013, 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. For purposes of determining the nursing home report card score rate add-on 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 the 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	\$14.30
83 – 265	$\$14.30 - ((\text{Nursing Home Report Card Score} - 82) \times \$0.0777)$
266 and above	\$0

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

(l) ~~Beginning effective July 1, 2003, Through June 30, 2014,~~ **2017**, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. Medicaid ~~Alzheimer's~~ **Alzheimer's** and dementia residents shall be determined to be in the SCU based on an exact match of room numbers reported on Schedule Z with the room numbers reported on resident assessments and tracking forms. Resident assessments and tracking forms with room numbers that are not an exact match to the room numbers reported on Schedule Z will be excluded in calculating the number of Medicaid ~~Alzheimer's~~ **Alzheimer's** and dementia resident days in their SCU. The additional Medicaid reimbursement shall equal twelve dollars (\$12) per Medicaid ~~Alzheimer's~~ **Alzheimer's** and dementia resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(m) ~~Beginning July 1, 2013, Through June 30, 2014,~~ **2017**, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on each facility's total quality score. For purposes of determining the nursing facility quality rate add-on, each facility's total quality score will be determined annually. Each nursing facility's quality rate add-on shall be determined as follows:

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 – 18	\$0
19 – 83	$\$14.30 - ((84 - \text{Nursing Facility Total Quality Score}) \times 0.216667)$
84 – 100	\$14.30

(n) Each nursing facility shall be awarded no more than one hundred (100) quality points as determined by the following eight (8) quality measures:

(1) Nursing home report card score. The office or its contractor shall determine each nursing facility's quality points using the report card score published by the Indiana state department of health. Each nursing facility shall be awarded not more than seventy-five (75) quality points based on its nursing home report card score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published report card score as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Report Card Scores	Quality Points Awarded
0 – 82	75
83 – 265	Proportional quality points awarded as follows: $75 - [(\text{facility report card score} - 82) \times 0.407609]$
266 and above	0

Facilities that did not have a nursing home report card score published as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(2) Normalized weighted average nursing hours per resident day. The office or its contractor shall determine each nursing facility's normalized weighted average nursing hours per resident day using data from its annual financial report. Nursing hours per resident day include nurse staff hours for RN, LPN, nursing assistants, and other nursing personnel categories. Nursing hours per resident day for each nurse staff category shall be weighted by the facility-specific CNA average wage rates, and normalized by dividing each facility's weighted average nursing hours per resident day by the facility's case mix index for all residents. Each nursing facility shall be awarded not more than ten (10) quality points based on the normalized weighted average nursing hours per resident day. Quality points shall be determined using each nursing facility's most recently completed annual financial report as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Normalized Weighted Average Nursing Hours Per Resident Day	Quality Points Awarded
Less than or equal to 3.315	0
Greater than 3.315 and less than 4.401	Proportional quality points awarded as follows: $10 - [(4.401 - \text{facility's normalized weighted average nursing hours per resident day}) \times 9.208103]$
Equal to or greater than 4.401	10

Facilities that are a new operation and did not have a normalized weighted average nursing hours per resident day from the most recently completed annual financial report as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

(3) RN/LPN retention rate. The office or its contractor shall determine each nursing facility's RN/LPN retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's RN/LPN retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's RN/LPN Retention Rates	Quality Points Awarded
Less than or equal to 58.3%	0
Greater than 58.3% and less than 83.3%	Proportional quality points awarded as follows: $3 - [(83.3\% - \text{facility's annual RN/LPN retention rate}) \times 12]$
Equal to or greater than 83.3%	3

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(4) CNA retention rate. The office or its contractor shall determine each nursing facility's CNA retention rate using data from its Schedule X. Each nursing facility shall be awarded no more than three (3) quality points based on the facility's CNA retention rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's CNA Retention Rates	Quality Points Awarded
Less than or equal to 49.5%	0
Greater than 49.5% and less than 76.0%	Proportional quality points awarded as follows: $3 - [(76.0\% - \text{facility's annual CNA retention rate}) \times 11.320755]$
Equal to or greater than 76.0%	3

Facilities that are a new operation and did not have CNAs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(5) RN/LPN turnover rate. The office or its contractor shall determine each nursing facility's RN/LPN turnover rate using data from its Schedule X. Each nursing facility shall be awarded not more than one (1) quality point based on the facility's RN/LPN turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility's Annual RN/LPN Turnover Rate	Quality Points Awarded
Less than or equal to 26.1%	1
Greater than 26.1% and less than 71.4%	Proportional quality points awarded as follows: $1 - [(26.1\% - \text{facility's annual RN/LPN turnover rate}) \times (-2.207506)]$
Equal to or greater than 71.4%	0

Facilities that are a new operation and did not have RNs/LPNs for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(6) CNA turnover rate. The office or its contractor shall determine each nursing facility's CNA turnover rate using data from its Schedule X. Each nursing facility shall be awarded no more than two (2) quality points based on the facility's CNA turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Facility Annual CNA Turnover	Quality Points Awarded
--------------------------------------	------------------------

Rates	
Less than or equal to 39.4%	2
Greater than 39.4% and less than 96.2%	Proportional quality points awarded as follows: $2 - [39.4\% - \text{facility's annual CNA turnover rate}] \times (-3.521127)$
Equal to or greater than 96.2%	0

Facilities that are a new operation and did not have a CNA for the entire calendar year preceding March 31, 2013, or each March 31 thereafter, shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(7) Administrator turnover. The office or its contractor shall determine each nursing facility's administrator turnover ~~rate~~ using data from its Schedule X. The nursing facility administrator turnover ~~rate~~ shall be based on the number of nursing home administrators employed or designated by the facility during the most recent five (5) year period. A nursing facility administrator hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous administrator is reasonably expected to return to the position and whose employment or designation as facility administrator is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing facility shall be awarded not more than three (3) quality points based on the facility's administrator turnover rate. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of Administrators Employed Within the Lasts Last Five (5) Years	Quality Points Awarded
6 or more	0
5	1
4	2
3 or fewer	3

Facilities that did not have a facility administrator employed or designated for the previous five (5) years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(8) Director of nursing (DON) turnover. The office or its contractor shall determine each nursing facility's DON turnover ~~rate~~ using data from its Schedule X. The nursing facility DON turnover ~~rate~~ shall be based on the number of DONs employed or designated by the facility during the most recent five (5) year period. A nursing facility DON hired on a temporary basis due to a documented medical or other temporary leave of absence shall not be counted in cases where the previous DON is reasonably expected to return to the position and whose employment or designation as facility DON is not terminated. Any such leave of absence shall be documented to the satisfaction of the office. Each nursing facility shall be awarded no more than three (3) quality points based on the number of DONs employed or designated by the facility during the most recent five (5) year period. Quality points shall be determined using each nursing facility's most recently completed Schedule X as of March 31, 2013, and each March 31 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Number of DONs Employed Within the Lasts Last Five (5) Years	Quality Points Awarded
6 or more	0
5	1
4	2
3 or fewer	3

Facilities that did not have a facility DON employed or designated for the previous five (5) years shall be awarded the statewide average quality points for this measure. Facilities that did not submit a Schedule X as of March 31 shall receive zero (0) quality points for this measure.

(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](#); filed Nov 12, 2009, 4:01 p.m.: [20091209-IR-405090215FRA](#); filed Nov 1, 2010, 11:37 a.m.: [20101201-IR-405100183FRA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))



SECTION 10. [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 12-15-1-10](#); [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 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).
- (2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.
- (3) The indirect care 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).
- (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				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2014, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2014, 2017, 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				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2014, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2014, 2017, 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, or the facility's total quality score, as applicable.

Table 3	
Allowed Profit Add-On Percentage	
Nursing Home Report Card Score for Period 7/1/2012 through 6/30/2013	
0—82	100%
83—279	100% — ((Nursing Home Report Card Score — 82) ×

	0-50505%)
280 and greater	0%
Total Quality Score for Period 7/1/2013 through 6/30/2014	
84—100	100%
19—83	$100\% + ((\text{Total Quality Score} - 84) / 66)$
18 and below	0%

Table 3	
Total Quality Score	Percentage
84 – 100	100%
19 – 83	$100\% + ((\text{Total Quality Score} - 84) / 66)$
18 and below	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 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 4; minus

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

Table 4				
Effective Date	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2014	July 1, 2014, 2017, and after	July 1, 2003, through June 30, 2014	July 1, 2014, 2017, and after
Percentage	60%	52%	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 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, or the facility's total quality score, as applicable.

(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; minus

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

Table 5		
Capital Component Profit Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2014	July 1, 2014, 2017, 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 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, or the facility's total quality score, as applicable.

(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.

Table 6		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2014	July 1, 2014, 2017, 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.

Table 7		
Indirect Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2014 <b>2017</b>	July 1, 2014, <b>2017</b> , and after
Percentage	115%	100%

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

Table 8		
Capital Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2014 <b>2017</b>	July 1, 2014, <b>2017</b> , and after
Percentage	100%	80%

(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-40507031RFA](#); filed Nov 12, 2009, 4:01 p.m.: [20091209-IR-405090215FRA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 11. [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 12-15-1-10](#); [IC 12-15-21-2](#)

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

Sec. 18. (a) Compensation for:

- (1) an owner, a 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, 2014, 2017,~~ compensation subject to this limitation includes wages, salaries, and fees for the 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, 2014, 2017,~~ and thereafter, wages, salaries, and fees paid for the 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, 2014, 2017,~~ 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 subsection (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, 2014, **2017**, 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](#); filed Nov 12, 2009, 4:01 p.m.: [20091209-IR-405090215FRA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 12. [405 IAC 1-14.6-24](#) IS AMENDED TO READ AS FOLLOWS:

#### **[405 IAC 1-14.6-24](#) Nursing facility quality assessment**

**Authority:** [IC 12-15-1-10](#); [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 16-28-15](#); [IC 23-2-4](#)

Sec. 24. (a) Effective from July 1, 2011, through September 30, 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) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than

~~seventy thousand (70,000), fourteen dollars and seventy cents (\$14.70) per non-Medicare day.~~  
~~(2) Privately owned or operated nursing facilities with total annual nursing facility census days equal to or greater than seventy thousand (70,000), three dollars and sixty-eight cents (\$3.68) per non-Medicare day.~~  
~~(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, three dollars and sixty-eight cents (\$3.68) per non-Medicare day.~~  
~~(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, fourteen dollars and seventy cents (\$14.70) per non-Medicare day.~~

~~(b) Effective from October 1, 2011, (a) Through June 30, 2014, 2017, 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) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than seventy~~ **sixty-two thousand (70,000), (62,000), sixteen dollars (\$16) and thirty-seven cents (\$16.37)** per non-Medicare day.
- ~~(2) Privately owned or operated~~ **and nonstate government owned or operated** nursing facilities with total annual nursing facility census days equal to or greater than ~~seventy sixty-two thousand (70,000), (62,000),~~ four dollars ~~(\$4) and nine cents (\$4.09)~~ per non-Medicare day.
- ~~(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, four dollars (\$4) and nine cents (\$4.09) per non-Medicare day.~~
- ~~(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, with total annual nursing facility census fewer than sixty-two thousand (62,000), sixteen dollars (\$16) and thirty-seven cents (\$16.37) per non-Medicare day.~~

~~(e) (b) Under [IC 16-28-15-7](#)(2), the following nursing facilities shall be exempt from the quality assessment described in subsection (a):~~

- ~~(1) A continuing care retirement community that meets one (1) of the following:~~
  - ~~(A) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on or before January 1, 2007, and that has continuously maintained at least one (1) continuing care agreement since on or before January 1, 2007, with an individual residing in the continuing care retirement community.~~
  - ~~(B) A continuing care retirement community that for the entire period from January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars (\$25,000).~~
  - ~~(C) An organization registered under [IC 23-2-4](#) before July 1, 2009, that provides housing in an independent living unit for a religious order.~~
  - ~~(D) A continuing care retirement community that meets the definition set forth in [IC 16-28-15-2](#).~~
- ~~(2) A hospital-based nursing facility licensed under [IC 16-21](#).~~
- ~~(3) The Indiana Veterans' Home.~~

~~(d) (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.~~

~~(e) (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 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).~~

~~(f) (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 not later than 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](#).

~~(g)~~ (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.

~~(h)~~ (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).

~~(i)~~ (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).

~~(j)~~ (i) The office shall offset the collection of the assessment fee for a facility as follows:

- (1) Against a Medicaid payment to the facility.
- (2) Against a Medicaid payment to another health facility that is related to the facility through common ownership or control.
- (3) In another manner determined by the office.

~~(k)~~ (j) If a facility:

- (1) fails to submit patient day information requested by the office to calculate the quality assessment fee; or
- (2) fails to pay the quality assessment fee;

not later than one hundred twenty (120) days after the patient day information is requested, or payment of the quality assessment is due, the office shall report each facility to the state department of health to initiate license revocation proceedings in accordance with [IC 16-28-15-12](#).

*(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](#); filed Nov 12, 2009, 4:01 p.m.: [20091209-IR-405090215FRA](#); filed Nov 1, 2010, 11:45 a.m.: [20101201-IR-405100065FRA](#); filed May 31, 2013, 8:52 a.m.: [20130626-IR-405120279FRA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 13. [405 IAC 1-14.6-26](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-14.6-26](#) Rate reduction**

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

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

Sec. 26. Notwithstanding all other provisions of this rule, ~~for the period beginning January 1, 2014, and continuing through June 30, 2015;~~ reimbursement **rates** shall be reduced by three percent (3%) per resident day, **through June 30, 2017**, for nursing facility services that have been calculated under this rule **except for the following:**

**(1) The difference between:**

**(A) the nursing facility quality rate add-on, as described in section 7(m) of this rule; and**

**(B) the nursing home report card score rate add-on calculated using each facility's current nursing**

home report card score, and the nursing home report card score rate add-on parameters contained in [405 IAC 1-14.6-7\(k\)](#) of LSA Document #10-183, posted as a final rule in the Indiana Register at [20101201-IR-405100183FRA](#), effective December 1, 2010.

(2) The difference between:

- (A) the quality assessment rate add-on, as described in section 24(a) of this rule; and
- (B) the quality assessment rate add-on calculated using the assessment rates in [405 IAC 1-14.6-24\(a\)](#) of LSA Document #10-65, posted as a final rule in the Indiana Register at [20101201-IR-405100065FRA](#), effective December 1, 2010.

(Office of the Secretary of Family and Social Services; [405 IAC 1-14.6-26](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 14. [405 IAC 1-19-2](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-19-2](#) Time and manner of disclosure**

**Authority:** [IC 12-15-1-10](#); [IC 12-15-21-2](#); [IC 12-15-21-3](#)

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

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity ~~that is not a long term care facility~~ must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any ~~new~~ provider must supply the information specified in this rule at the time of filing a complete application.

**(d) Any provider must supply the information specified in this rule upon executing the provider agreement.**

~~(d)~~ **(e)** Providers are required to notify the office upon such time as the information specified in this rule changes within ~~forty-five (45)~~ **thirty-five (35)** days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall **also** provide notification in accordance with [405 IAC 1-20](#). New nursing facility providers are required to notify the office in accordance with this rule and [405 IAC 1-14.6-5](#).

(Office of the Secretary of Family and Social Services; [405 IAC 1-19-2](#); filed Apr 17, 2003, 5:15 p.m.: 26 IR 2865; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))

SECTION 15. [405 IAC 1-20-2](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 1-20-2](#) Notification requirements**

**Authority:** [IC 12-15-1-10](#); [IC 12-15-21-2](#); [IC 12-15-21-3](#)

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

Sec. 2. (a) When a change of ownership in a long term care facility is contemplated, the transferor provider shall notify the office, or its fiscal agent, no less than forty-five (45) days prior to the effective date of sale or lease agreement that a change of ownership may take place.

(b) Notification shall be in writing and include the following:

- (1) A copy of the agreement of sale or transfer.
- (2) The expected date of transfer.
- (3) If applicable, the name of any individual who has an ownership or control interest, is a managing employee, or an agent of the transferor, who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee.

(c) The transferee shall make application to the office for an amendment to the transferor's provider agreement no less than forty-five (45) days prior to the expected date of transfer in accordance with this rule and [405 IAC 1-14.6-5\(c\)](#).

(d) If notification requirements from both the transferor and the transferee have not been met on or before the forty-fifth day before the effective date of the change of ownership, all Medicaid payments due to the transferor ~~will~~ **may** be held until such time as the information is received, reviewed, and approved for completeness. **Any** payments **held** will **not** be ~~held~~ **paid**, until such time as the transferee has fulfilled enrollment requirements in the Medicaid program as set forth in the provider manual and provider enrollment packet.

(e) The effective date of the change of ownership will be determined by the Indiana state department of health's certification and transmittal and amended by the Indiana state department of health, if necessary, to correspond with the transferor/transferee agreement of sale or transfer.

*(Office of the Secretary of Family and Social Services; [405 IAC 1-20-2](#); filed Apr 17, 2003, 5:15 p.m.: 26 IR 2866; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 16. [405 IAC 5-24-6](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 5-24-6](#) Dispensing fee**

**Authority:** [IC 12-15](#)

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

Sec. 6. (a) For purposes of this rule, **through June 30, 2017**, the Indiana Medicaid dispensing fee maximum ~~is four dollars and ninety cents (\$4.90) per legend drug. For the period beginning upon the later of the effective date of this rule or January 1, 2014, and continuing through June 30, 2015, the Indiana Medicaid dispensing fee maximum~~ is three dollars and ninety cents (\$3.90) per legend drug.

(b) A maximum of one (1) dispensing fee per month is allowable per recipient per drug order for legend drugs provided to Medicaid recipients residing in Medicaid certified long term care facilities.

(c) The practice of split billing of legend drugs, defined as the dispensing of less than the prescribed amount of drug solely for the purpose of collecting more dispensing fees than would otherwise be allowed, is prohibited. In cases in which the pharmacist's professional judgment dictates that a quantity less than the amount prescribed be dispensed, the pharmacist should contact the prescribing practitioner for authorization to dispense a lesser quantity. The pharmacist must document the result of the contact and the pharmacist's rationale for dispensing less than the amount prescribed on the prescription or in the pharmacist's records.

*(Office of the Secretary of Family and Social Services; [405 IAC 5-24-6](#); filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Nov 8, 2013, 2:56 p.m.: [20131204-IR-405130422FRA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 17. [405 IAC 5-24-13](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 5-24-13](#) Legend and nonlegend solutions for nursing facility residents**

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

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

Sec. 13. The cost of legend and nonlegend water products ~~in all forms and for all uses, used for irrigation or humidification~~ are included in the per diem rate for nursing facilities. ~~When these drugs~~ **water products used**

**for irrigation or humidification** are furnished to a nursing facility resident, they are not separately reimbursable by Medicaid and are not to be billed separately to Medicaid by either the nursing facility or another Medicaid provider furnishing the products, **as set forth in [405 IAC 5-31-4\(7\)](#). Water agents used (or to be used) as a vehicle to deliver a drug therapy into the body must be reimbursed through the pharmacy benefit and not included in the nursing facility per diem reimbursement.**

*(Office of the Secretary of Family and Social Services; [405 IAC 5-24-13](#); filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 18. [405 IAC 5-24-14](#) IS ADDED TO READ AS FOLLOWS:

**[405 IAC 5-24-14](#) Skin protectants, sealants, moisturizers, and ointments for nursing facility residents**

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

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

**Sec. 14. (a) The cost of skin protectants, sealants, moisturizers, and ointments for nursing facility residents are to be reimbursed as follows:**

- (1) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis, by the member, nursing facility care staff, or by prescriber's order, as a part of routine care, as defined in [405 IAC 1-14.6-2\(gg\)](#), must be included in the per diem reimbursement and must not be reimbursed through the pharmacy benefit.**
- (2) If all of the following conditions are met, skin protectants, sealants, moisturizers, and ointments must be reimbursed through the pharmacy benefit:**
  - (A) Legend or nonlegend (listed on the OTC drug formulary only).**
  - (B) Prescribed for regular application or applications, or both, as a single agent or compounded with other drug agents.**
  - (C) Used to treat or ameliorate a defect or physical or mental illness or condition.**

**(b) Non-drug skin protectants, sealants, moisturizers, and ointments must be reimbursed through the pharmacy benefit only when they are compounded with other drug agents, otherwise they are to be included in the per diem reimbursement, as set forth in [405 IAC 5-31-4\(8\)](#).**

*(Office of the Secretary of Family and Social Services; [405 IAC 5-24-14](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

SECTION 19. [405 IAC 5-31-4](#) IS AMENDED TO READ AS FOLLOWS:

**[405 IAC 5-31-4](#) Per diem services**

**Authority:** [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. 4. Those services and products furnished by the facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with [405 IAC 1-14.6](#). The per diem rate for nursing facilities includes the following services:**

- (1) Room and board (room accommodations, all dietary services, and laundry services). The per diem rate includes accommodations for semiprivate rooms. Medicaid reimbursement is available for medically necessary private rooms. Private rooms will be considered medically necessary only under one (1) or both of the following circumstances:**
  - (A) The recipient's condition requires isolation for health reasons, such as communicable disease.**
  - (B) The recipient exhibits behavior that is or may be physically harmful to self or others in the facility.**
- (2) Nursing care.**
- (3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients. ~~is included in the nursing facility per diem.~~**
- (4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:**

- (A) ice bags;
- (B) bed rails;
- (C) canes;
- (D) walkers;
- (E) crutches;
- (F) standard wheelchairs; ~~and~~
- (G) traction equipment; ~~and~~
- (H) oxygen and equipment and supplies for its delivery;

are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require recipients to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the office of Medicaid policy and planning. The county office of family and children must be notified when the recipient no longer needs the equipment.

(5) Medically necessary and reasonable therapy services, which include physical, occupational, respiratory, and speech pathology services.

(6) Transportation to vocational/habilitation service programs.

(7) The cost of both legend and nonlegend water products ~~in all forms and for all uses.~~ **used for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit. Water agents used alone (not intended to deliver a drug) for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit.**

(8) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis, by the member, nursing facility care staff, or by prescriber's order, as a part of routine care, as defined in [405 IAC 1-14.6-2\(gg\)](#), must be included in the per diem reimbursement and must not be reimbursed by the pharmacy benefit.

*(Office of the Secretary of Family and Social Services; [405 IAC 5-31-4](#); filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#); readopted filed Oct 28, 2013, 3:18 p.m.: [20131127-IR-405130241RFA](#); filed Apr 29, 2015, 3:38 p.m.: [20150527-IR-405150034FRA](#))*

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