TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #16-327

DIGEST

Amends 405 IAC 1-12-1 to clarify policy language regarding payment for services rendered by intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD). Amends 405 IAC 1-12-2 to add a definition for the department head position. Amends 405 IAC 1-12-3 to clarify provider responsibility to substantiate that their costs are related to patient care. Amends 405 IAC 1-12-4 to clarify the penalty for untimely cost report filings. Amends 405 IAC 1-12-5 to add a penalty for untimely filing of the Checklist of Management Representations. Amends 405 IAC 1-12-7 to clarify the criteria for excluding a provider from the average allowable cost of the median patient day computations. Amends 405 IAC 1-12-20 to update language. Amends 405 IAC 1-12-21 to revise the reimbursement rate for comprehensive rehabilitative management needs facilities (CRMNF) pursuant with state law. Amends 405 IAC 1-14.6-1 to clarify policy language regarding payment for services rendered to members by nursing facilities. Amends 405 IAC 1-14.6-2 to update definitions to reflect the change from the resource utilization group, version III (RUG-III), to RUG-IV, update the minimum data set resident assessment (MDS), version 2.0 to MDS version 3.0, and to clarify and add several definitions. Amends 405 IAC 1-14.6-3 to clarify the information required on the Medicaid cost report form, to require financial records or supporting documentation to be made available to the office, add penalty for failure to submit requested information, and to clarify compliance review scheduling procedures, and clarify provider responsibility to substantiate that their costs are related to patient care. Amends 405 IAC 1-14.6-4 to clarify the information required by providers with their annual cost report submission, and to make other changes as a result of the change to RUG-IV. Amends 405 IAC 1-14.6-6 to update and clarify language regarding rate reviews. Amends 405 IAC 1-14.6-7 to add the case mix index (CMI) table for RUG-IV and to make other changes as a result of the change to RUG-IV. Amends 405 IAC 1-14.6-9 to clarify the calendar quarters utilized in determining a facility's CMI. Amends 405 IAC 1-14.6-10 to clarify certain costs as not allowable. Amends 405 IAC 1-14.6-11 to clarify the reporting of costs incurred by parties defined by the rule to be related to the Medicaid certified nursing facilities. Amends 405 IAC 1-14.6-12 to clarify what costs are included in the fair rental value allowance. Amends 405 IAC 1-14.6-21 to clarify that changes to the allocation of reported costs due to prior period audit findings are authorized by OMPP. Amends 405 IAC 1-14.6-22 to update and clarify language regarding MDS review processes. Amends 405 IAC 1-14.6-24 to clarify how the quality assessment fee (QAF) is determined. Amends 405 IAC 1-15-1 to clarify and update MDS electronic transmission requirements for nursing facilities. Amends 405 IAC 1-15-2 to modify the Medicaid rule for the electronic transmission of the MDS to reflect the change from RUG-III to RUG-IV, and MDS 2.0 to MDS 3.0. Amends 405 IAC 1-15-4 to clarify scope of review by OMPP of nursing facility MDS resident assessment data, and to reflect the change from RUG-III to RUG-IV. Amends 405 IAC 1-15-5 to clarify scope of review of MDS resident assessments. Repeals 405 IAC 1-14.5, 405 IAC 1-15-3, and 405 IAC 1-15-6. Effective 30 days after filing with the Publisher.

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

405 IAC 1-12-1; 405 IAC 1-12-2; 405 IAC 1-12-3; 405 IAC 1-12-4; 405 IAC 1-12-5; 405 IAC 1-12-7; 405 IAC 1-12-20; 405 IAC 1-12-21; 405 IAC 1-14.5; 405 IAC 1-14.6-1; 405 IAC 1-14.6-2; 405 IAC 1-14.6-3; 405 IAC 1-14.6-4; 405 IAC 1-14.6-6; 405 IAC 1-14.6-7; 405 IAC 1-14.6-9; 405 IAC 1-14.6-10; 405 IAC 1-14.6-11; 405 IAC 1-14.6-12; 405 IAC 1-14.6-21; 405 IAC 1-14.6-22; 405 IAC 1-14.6-24; 405 IAC 1-15-1; 405 IAC 1-15-2; 405 IAC 1-15-3; 405 IAC 1-15-4; 405 IAC 1-15-5; 405 IAC 1-15-6

SECTION 1. 405 IAC 1-12-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid members by duly certified nonstate-operated ICFs/IID, nonstate-operated CRMNFs, and nonstate-operated CRFs/DD. ~~Reimbursement for facilities operated by the state is governed by 405 IAC 1-17.~~ All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) ~~The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs.~~ The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule, which establish parameters regarding the allowability of **ordinary patient or member-related** costs and define reasonable allowable costs.

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 2. 405 IAC 1-12-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-2 Definitions

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

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

(b) "All-inclusive rate" means a per diem rate that, at a minimum, reimburses for all nursing or resident:
(1) care;
(2) room and board;
(3) supplies; and
(4) ancillary services;
within a single, comprehensive amount.

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

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

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

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

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable resident-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 16(a) of this rule.

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

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.

(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.

(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental homes multiplied by one hundred fifty-nine percent (159%).

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

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

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

(k) "DDRS" means the Indiana division of disability and rehabilitative services.

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

(m) "Department head" means an individual or individuals responsible for the supervision and management of an ICF/IID or CRF/DD department. Home office personnel responsible for the supervision and oversight of facility department heads qualify as general line personnel.

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

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

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

~~(p)~~ **(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 by auditors.

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

~~(r)~~ **(s)** "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

~~(s)~~ **(t)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the ~~American Institute of Certified Public Accountants.~~ **designated authority that governs the preparation of financial statements based on whether an entity is government or nongovernment owned, or whether it is governed by the requirements of the state board of accounts.**

~~(t)~~ **(u)** "Like levels of care" means care:
(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ICF/IID; or
(3) provided in a nonstate-operated ICF/IID licensed as a CRMNF.

~~(u)~~ **(v)** "Non-rebasing year" means the year during which nonstate-operated ICFs/IID and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:
October 1, ~~2011,~~ **2015,** through September 30, ~~2012~~ **2016**
October 1, ~~2013,~~ **2017,** through September 30, ~~2014~~ **2018**
October 1, ~~2015,~~ **2019,** through September 30, ~~2016~~ **2020**
October 1, ~~2017,~~ **2021,** through September 30, ~~2018~~ **2022**
And every second year thereafter.

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

~~(w)~~ **(x)** "Patient or resident/member care" means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

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

~~(y)~~ **(z)** "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.

~~(z)~~ **(aa)** "Rebasing year" means the year during which nonstate-operated ICFs/IID and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:
October 1, ~~2012,~~ **2014,** through September 30, ~~2013~~ **2015**
October 1, ~~2014,~~ **2016,** through September 30, ~~2015~~ **2017**
October 1, ~~2016,~~ **2018,** through September 30, ~~2017~~ **2019**
October 1, ~~2018,~~ **2020,** through September 30, ~~2019~~ **2021**
And every second year thereafter.

~~(aa)~~ **(bb)** "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.

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 3. 405 IAC 1-12-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than ~~generally accepted accounting principles.~~ **GAAP. All costs and charges reported on the provider's cost report must also be recorded on the provider's financial statements.** Costs must be reported in the cost report in accordance with the following authorities, in the hierarchical order listed:
(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.
(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.
(3) Costs must be reported in conformance with ~~generally accepted accounting principles.~~ **GAAP.**

(b) Each provider must maintain financial records for a **minimum** period of three (3) years after the date of submission of financial reports to the office. **Copies of any financial records or supporting documentation must be provided to the office upon request.** The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) The auditor shall schedule the field audit visit with the provider. If the auditor and provider are unable to reach an agreement on a scheduled field audit date, the auditor will assign a date for the field audit to begin no earlier than sixty (60) days after the date that the provider was initially contacted to schedule the field visit as follows:
(1) The auditor will confirm the field audit date by providing a written notice identifying the date of the scheduled field audit and all information the provider is required to submit in advance of the field audit date. The notice will be provided at least sixty (60) days prior to the commencement of field work, and will allow the provider a minimum of thirty (30) days to submit the required information, which shall be

due to the auditor no less than thirty (30) days prior to the date of the scheduled field audit.

(2) After assignment of a field audit date, a provider may submit a one-time request that the scheduled field audit be postponed to a later date. The office shall approve or deny the request in writing within fifteen (15) days of receiving the request. Any delay of the scheduled field audit date does not extend the due date of the required information.

(3) Failure to submit the required information by the due date in the written notice shall result in the following actions being taken:

(A) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(B) The ten percent (10%) rate reduction shall remain in place until the first day of the month following the earlier of the receipt of information requested in the written notice or one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate increases will be allowed until the first day of the month following the earlier of the receipt of information requested in the written notice, or one (1) year after the effective date of the ten percent (10%) rate reduction.

(D) No reimbursement for the difference between the rate that would have otherwise been in effect and the reduced rate is recoverable by the provider.

~~(c)~~ **(d)** When a field audit indicates that the provider's records are inadequate to support data submitted to the office or the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason or reasons the extension is necessary.

~~(d)~~ **(e)** In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection ~~(c),~~ **(d),** the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

~~(e)~~ **(f)** In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The office shall document such adjustments in a finalized exception report.

(3) The office shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

~~(f)~~ **(g)** If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

~~(g)~~ **(h)** When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial

report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care. ~~The burden of demonstrating that costs are patient or resident related lies with the provider.~~

(i) The burden of substantiating that costs are patient or resident-related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-3; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; 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 May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 4. 405 IAC 1-12-4 IS AMENDED TO READ AS FOLLOWS:

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

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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial enrollment of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

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

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and customary charge.
(8) Certification statement signed by the provider that:
  (A) the data are true, accurate, related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review ~~the request~~ **timely requests** for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office. ~~or its representatives.~~ **Untimely requests for an extension will not result in a change to the original due date, nor will it alleviate the provider from the penalty provision in subsection (d).**

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-4; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; filed Aug 14, 1998, 4:27 p.m.: 22 IR 64; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 720; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 5. 405 IAC 1-12-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting; 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 initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the enrollment date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:
(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or
(2) the fiftieth percentile rates as computed in this subsection.
Initial interim rates shall be effective upon the later of the enrollment date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/IID providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) Until the identified threshold number of homes is obtained, the fiftieth percentile rates shall be determined as follows:
(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental homes multiplied by one hundred fifty-nine percent (159%).
(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences for adults, the fiftieth percentile rate for extensive support needs residences for adults shall be the fiftieth percentile rate for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of enrolled operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year-end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of enrollment falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of enrollment falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

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

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and customary charge.
(8) Certification by the provider that:
  (A) the data are true, accurate, and related to patient or resident care; and
  (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(h) In the event of a change in 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 to the office 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 facility shall be performed until the completed checklist is submitted to the office. 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. Reimbursement lost because of the penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123; filed Oct 10, 2002, 10:52 a.m.: 26 IR 721; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 6. 405 IAC 1-12-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

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

Sec. 7. (a) Rate setting during rebasing years shall be based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs during rebasing years, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by ~~DRI/WEFA.~~ **IHS.** The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. **Providers whose most recently completed rate is an initial interim rate shall be excluded from the determination of the average allowable cost of the median patient day.** All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by ~~DRI/WEFA.~~ **IHS.** The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

Median 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

(c) For ICFs/IID and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ICFs/IID and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule for all providers, except for providers of extensive support needs residences for adults.
(5) The fair rental value allowance determined in accordance with section 20.5 of this rule for providers of

extensive support needs residences for adults.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 723; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 7. 405 IAC 1-12-20 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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

Sec. 20. (a) Compensation for owner, related party, ~~individuals within~~ management, **general line personnel, and** consultants who perform management functions, or 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, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, individuals within management, contractors, and consultants who perform management functions, as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient or resident-related wages, salaries, or fees actually paid or withdrawn which were properly reported to the Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient or resident-related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The owner, related party, and management compensation and expense limitation per operation effective July 1, 1993, shall be as follows:

Beds	Owner and Management Compensation Allowance	Owner's Expense (12% × bed allowance)
10	$18,527	$2,223
20	$24,717	$2,966
30	$30,887	$3,706
40	$37,049	$4,446
50	$43,241	$5,189
60	$46,948	$5,634
70	$50,657	$6,079
80	$54,362	$6,523
90	$58,055	$6,967
100	$61,763	$7,412
110	$66,731	$8,007

120	$71,663	$8,600
130	$76,628	$9,195
140	$81,546	$9,786
150	$86,496	$10,380
160	$91,427	$10,971
170	$96,378	$11,565
180	$101,313	$12,157
190	$106,262	$12,751
200	$111,196	$13,343
200 and over	$111,196 plus $225 per bed over 200	$13,343 plus $27 per bed over 200

This subsection applies to each provider of a certified Medicaid 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 1-12-20; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 8. 405 IAC 1-12-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for individuals with intellectual disabilities; 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 ICFs/IID 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 ICFs/IID is an all-inclusive rate. 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/IID~~ **ICF/IID** that is licensed as a CRMNF will be paid at a rate of ~~six hundred twenty-six dollars and twenty-six cents ($626.26)~~ **six hundred thirty-nine dollars and eighteen cents ($639.18)** per resident day. This per diem rate is available only upon certification as a Medicaid ICF/IID and licensure by ~~the division of disability and rehabilitative services.~~ **DDRS.** ICFs/IID that are licensed as CRMNFs are not subject to other rate adjustments identified in this rule except for 405 IAC 1-12-27 *[405 IAC 1-12-27 was voided by P.L.12-2016, SECTION 10, effective July 1, 2016.]* 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

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

405 IAC 1-14.6-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth **payment** procedures ~~for payment~~ for services rendered to ~~Medicaid~~ members **who are not in managed care and covered by the Indiana health coverage program (IHCP)** by nursing facilities. All payments referred to within this rule are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) ~~The procedures described in this rule set forth methods of reimbursement that promote quality of care, access, efficiency, economy, and consistency. These procedures recognize level and quality of care, access, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and, only to the extent the state is required to by state law, compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities.~~ The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule that establish parameters regarding the allowability of **ordinary patient-related** costs and define reasonable allowable costs.

(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form **prescribed by the office** and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-1; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 10. 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 **and Internet.**
(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 intellectual disability professional.
(16) Educational seminars for administrative staff.
(17) Support **and troubleshooting, maintenance,** and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.
(18) Court appointed guardian, financial institution, or third party trust costs not covered by resident personal funds.
(19) Preemployment related costs such as background checks, drug testing, and employment contingent physicals.

(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.

(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.
(4) Noncapitalized costs associated with minor equipment purchases that are not directly attributed to a specific department.

(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)~~ **(RUG-IV)** 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~~ **requirement** 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) "Department head" means an individual or individuals responsible for the supervision and management of a nursing facility department. Home office personnel responsible for the supervision and oversight of facility department heads qualify as general line personnel.

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

~~(o)~~ **(p)** "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 **directly related to the provision of hands-on resident care.**

(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 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 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 (ff).

(15) Parenteral and enteral nutrition costs other than meals, nutritional supplements, sterile water, and legend and nonlegend drugs.

(16) Costs for the coding and input of MDS data.

~~(p)~~ **(q)** "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)~~ **(r)** "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its

supporting documentation by auditors.

~~(r)~~ **(s)** "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)~~ **(t)** "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)~~ **(u)** "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)~~ **(v)** "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the ~~American Institute of Certified Public Accountants.~~ **Financial Accounting Standards Board.**

~~(v) "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office.~~

(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.~~ **costs related to activities and other noncovered services.**
(15) Admissions.
(16) Behavioral and psychological consulting services.
(17) Nursing consulting services, whether provided by internal facility personnel, central office personnel, or contracted, that are not directly related to the provision of hands-on resident care. Such nursing consulting services include, but are not limited to:
(A) health surveys;
(B) quality assurance processes; and
(C) MDS consultation (excluding data input and coding).

(x) "Medical and nonmedical supplies and equipment" includes those items generally required to ~~assure~~ **ensure** 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 Medicaid. 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~~ **3.0** or subsequent revisions as approved by 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 ISDH that quantifies each facility's key survey results.

(bb) "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.

(cc) "Patient/member care" means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

(dd) "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.

(ee) "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

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

(gg) ~~"RUG-III~~ **"RUG-IV** resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) ~~RUG-III~~ **RUG-IV** group, the ~~RUG-III~~ **RUG-IV** 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) 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) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's total quality score.

(jj) "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) "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)~~ **7(m)(1)** through ~~7(n)(8)~~ **7(m)(8)** of this rule.

(ll) "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) "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~~ **RUG-IV** resident classification system:

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

(2) result in the assessment being classified into a different ~~RUG-III~~ **RUG-IV** 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 11. 405 IAC 1-14.6-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) The basis of accounting under this rule is a comprehensive basis of accounting other than ~~generally accepted accounting principles.~~ **GAAP. All costs and charges reported on the provider's cost report must also be recorded on the provider's financial statements.** Costs **and charges** must be reported ~~in~~ **on** the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with ~~generally accepted accounting principles.~~ **GAAP.**

(b) Each provider must maintain financial records for a **minimum** period of three (3) years after the date of submission of financial reports to the office. **Copies of any financial records or supporting documentation must be provided to the office upon request.** The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) The auditor shall schedule the field audit visit with the provider. If the auditor and provider are unable to reach an agreement on a scheduled field audit date, the auditor will assign a date for the field audit to begin no earlier than sixty (60) days after the date that the provider was initially contacted to schedule the field visit as follows:

(1) The auditor will confirm the field audit date by providing a written notice identifying the date of the

scheduled field audit and all information the provider is required to submit in advance of the field audit date. The notice will be provided at least sixty (60) days prior to the commencement of field work, and will allow the provider a minimum of thirty (30) days to submit the required information, which shall be due to the auditor no less than thirty (30) days prior to the date of the scheduled field audit.

(2) After assignment of a field audit date, a provider may submit a one-time request that the scheduled field audit be postponed to a later date. The office shall approve or deny the request in writing within fifteen (15) days of receiving the request. Any delay of the scheduled field audit date does not extend the due date of the required information.

(3) Failure to submit the required information by the due date in the written notice shall result in the following actions being taken:

(A) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(B) The ten percent (10%) rate reduction shall remain in place until the first day of the month following the earlier of the receipt of information requested in the written notice or one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate increases will be allowed until the first day of the calendar quarter following the earlier of the receipt of information requested in the written notice, or one (1) year after the effective date of the ten percent (10%) rate reduction.

(D) No reimbursement for the difference between the rate that would have otherwise been in effect and the reduced rate is recoverable by the provider.

~~(c)~~ **(d)** When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason or reasons the extension is necessary.

~~(d)~~ **(e)** In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection ~~(c),~~ **(d),** the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the office's receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the calendar quarter following the **earlier of the** office's receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

~~(e)~~ **(f)** In the event that the documentation submitted is inadequate or incomplete **or the ten percent (10%) reduction has expired,** the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The office shall document such adjustments in a finalized exception report.

(3) The office shall incorporate such adjustments in the prospective rate calculations under section ~~1(d)~~ **1(e)** of this rule.

~~(f)~~ **(g)** If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit or desk review establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

~~(g)~~ **(h)** When multiple facilities or operations are owned by a single entity with a central office, the central office

records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care. ~~The burden of demonstrating that costs are patient-related lies with the provider.~~

(i) The burden of substantiating that costs are patient-related lies with the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-3; filed Aug 12, 1998, 2:27 p.m.: 22 IR 71, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 12. 405 IAC 1-14.6-4 IS AMENDED TO READ AS FOLLOWS:

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

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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial enrollment of a provider. This option:

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

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

If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

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

(8) Certification by the provider that:

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

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

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

(10) A copy of the working trial balance **that is a direct product of the accounting system for both the facility and home office (if applicable)** that was used in the preparation of their submitted ~~Medicaid cost report.~~ **annual financial report.**

(11) A copy of the **trial balance** crosswalk document used to prepare the Medicaid cost report **(facility and home office, if applicable)** that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report. **The crosswalk should be sorted and subtotaled by Medicaid line number.**

(12) Detailed schedule of provider adjustments reported on Schedule E, column 24.

~~(12)~~ **(13)** Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

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

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

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

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

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

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

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

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

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

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

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

(1) ~~SSB~~ **LC2** classification for residents discharged before completing an initial assessment where the reason for discharge was death or a transfer to a hospital.

(2) ~~CC1~~ **RAB** classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a hospital.

~~(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.~~

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

~~(i)~~ **(h)** If the office determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the ~~RUG-III~~ **RUG-IV** group ~~"BC2~~ **"BC1** - Delinquent".

~~(j)~~ **(i)** If the office determines due to an MDS ~~field audit~~ **review** that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office **shall:**

(A) ~~shall audit~~ **review** a sample of MDS resident assessments; and

(B) determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the initial sample that are unsupported is greater than twenty percent (20%), the office shall expand to a larger sample of residents assessments. If the percent of assessments in the initial sample that are unsupported is equal to or less than twenty percent (20%):

(A) the office shall conclude the field portion of the MDS ~~audit;~~ **review;** and

(B) no corrective remedy shall be applied.

(3) For nursing facilities with MDS ~~audits~~ **reviews** performed on the initial and expanded sample of residents assessments, the office will determine the percent of all assessments ~~audited~~ **reviewed** that are unsupported.

(4) If the ~~percent~~ **percentage** of **unsupported** assessments for the initial and expanded sample of all ~~assessment audited residents that are unsupported~~ **assessments reviewed** is greater than twenty percent (20%), a corrective remedy shall apply, which shall be calculated as follows:

(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS ~~audit~~ **review** shall be reduced by the percentage as shown in the following table:

MDS Field ~~Audit~~ **Review** for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field ~~audit~~ **review**	15%
Second consecutive MDS field ~~audit~~ **review**	20%
Third consecutive MDS field ~~audit~~ **review**	30%
Fourth or more consecutive MDS field ~~audit or audits~~ **review or reviews**	50%

(B) In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office to the provider's allowable administrative costs.

(C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments for the initial and expanded sample of all assessments ~~audited~~ **reviewed** that are unsupported is equal to or less than twenty percent (20%):

(A) the office shall conclude the MDS ~~audit;~~ **review;** and

(B) no corrective remedy shall apply.

~~(k)~~ **(j)** Based on findings from the MDS ~~audit~~ **review** the office shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the ~~RUG-III~~ **RUG-IV** resident classification system that are not supported according to the MDS supporting documentation ~~guidelines~~ **requirements** as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation ~~guidelines~~ **requirements** as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the ~~RUG-III~~ **RUG-IV** resident classification system by incorporating any adjustments or revisions made by the office.

~~(l)~~ **(k)** Upon conclusion of an MDS ~~audit,~~ **review,** the office shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

~~(m)~~ **(l)** The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419;

readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 13. 405 IAC 1-14.6-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-6 Active providers; rate review

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

Sec. 6. (a) ~~The:~~ **While performing a provider's annual rate review the office shall determine the following for each provider:**

(1) Normalized average allowable cost of the median patient day for the direct care component ~~and~~ **as of the July 1st that falls after the first calendar quarter following the provider's reporting year-end.**

(2) Average allowable cost of the median patient day for the indirect, administrative, and capital components **as of the July 1st that falls after the first calendar quarter following the provider's reporting year-end.**

~~shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.~~

(b) ~~The:~~ **While performing a provider's annual rate review the office shall determine the following for each provider:**

(1) Normalized allowable per patient day cost for the direct care component ~~and~~ **based on the annual financial report used to establish the annual rate review.**

(2) Allowable per patient day costs for the therapy, indirect care, administrative, and capital components **based on the annual financial report used to establish the annual rate review.**

~~shall be established once per year for each provider based on the annual financial report.~~

(c) Beginning October 1, 2007, the rate effective date of the annual rate review shall be the first October 1 that falls after the first calendar quarter following the provider's reporting year-end. Beginning July 1, 2008, the rate effective date of the annual rate review shall be the first July 1 that falls after the first calendar quarter following the provider's reporting year-end. The rate effective date of the annual rate review for all providers shall be July 1 of each year thereafter.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be:

(1) updated each calendar quarter; and

(2) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) When the number of nursing facility beds licensed by ISDH is changed after the annual reporting period, the provider may request in writing before the effective date of ~~their~~ **its** next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate-setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; 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 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; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3872; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Oct 4, 2007, 2:05 p.m.: 20071031-IR-405070150FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 14. 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.~~ **IHS.** 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, 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 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 CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

~~RUG-III Group~~	~~RUG-III Code~~	~~CMI Table~~
~~Rehabilitation~~	~~RAD~~	~~2.02~~
~~Rehabilitation~~	~~RAC~~	~~1.69~~
~~Rehabilitation~~	~~RAB~~	~~1.50~~
~~Rehabilitation~~	~~RAA~~	~~1.24~~
~~Extensive Services~~	~~SE3~~	~~2.69~~
~~Extensive Services~~	~~SE2~~	~~2.23~~
~~Extensive Services~~	~~SE1~~	~~1.85~~
~~Special Care~~	~~SSC~~	~~1.75~~
~~Special Care~~	~~SSB~~	~~1.60~~
~~Special Care~~	~~SSA~~	~~1.51~~
~~Clinically Complex~~	~~CC2~~	~~1.33~~
~~Clinically Complex~~	~~CC1~~	~~1.27~~
~~Clinically Complex~~	~~CB2~~	~~1.14~~
~~Clinically Complex~~	~~CB1~~	~~1.07~~
~~Clinically Complex~~	~~CA2~~	~~0.95~~
~~Clinically Complex~~	~~CA1~~	~~0.87~~
~~Impaired Cognition~~	~~IB2~~	~~0.93~~
~~Impaired Cognition~~	~~IB1~~	~~0.82~~
~~Impaired Cognition~~	~~IA2~~	~~0.68~~
~~Impaired Cognition~~	~~IA1~~	~~0.62~~
~~Behavior Problems~~	~~BB2~~	~~0.89~~
~~Behavior Problems~~	~~BB1~~	~~0.77~~
~~Behavior Problems~~	~~BA2~~	~~0.67~~
~~Behavior Problems~~	~~BA1~~	~~0.54~~
~~Reduced Physical Functions~~	~~PE2~~	~~1.06~~
~~Reduced Physical Functions~~	~~PE1~~	~~0.96~~
~~Reduced Physical Functions~~	~~PD2~~	~~0.97~~
~~Reduced Physical Functions~~	~~PD1~~	~~0.87~~
~~Reduced Physical Functions~~	~~PC2~~	~~0.83~~
~~Reduced Physical Functions~~	~~PC1~~	~~0.76~~
~~Reduced Physical Functions~~	~~PB2~~	~~0.73~~
~~Reduced Physical Functions~~	~~PB1~~	~~0.66~~
~~Reduced Physical Functions~~	~~PA2~~	~~0.56~~
~~Reduced Physical Functions~~	~~PA1~~	~~0.50~~
~~Unclassifiable~~	~~BC1~~	~~0.48~~
~~Delinquent~~	~~BC2~~	~~0.48~~

RUG – IV Group	**RUG – IV Code**	**CMI Table**
Extensive Services	**ES3**	**3.00**
Extensive Services	**ES2**	**2.23**

Extensive Services	**ES1**	**2.22**
Rehabilitation	**RAE**	**1.65**
Rehabilitation	**RAD**	**1.58**
Rehabilitation	**RAC**	**1.36**
Rehabilitation	**RAB**	**1.10**
Rehabilitation	**RAA**	**0.82**
Special Care High	**HE2**	**1.88**
Special Care High	**HE1**	**1.47**
Special Care High	**HD2**	**1.69**
Special Care High	**HD1**	**1.33**
Special Care High	**HC2**	**1.57**
Special Care High	**HC1**	**1.23**
Special Care High	**HB2**	**1.55**
Special Care High	**HB1**	**1.22**
Special Care Low	**LE2**	**1.61**
Special Care Low	**LE1**	**1.26**
Special Care Low	**LD2**	**1.54**
Special Care Low	**LD1**	**1.21**
Special Care Low	**LC2**	**1.30**
Special Care Low	**LC1**	**1.02**
Special Care Low	**LB2**	**1.21**
Special Care Low	**LB1**	**0.95**
Clinically Complex	**CE2**	**1.39**
Clinically Complex	**CE1**	**1.25**
Clinically Complex	**CD2**	**1.29**
Clinically Complex	**CD1**	**1.15**
Clinically Complex	**CC2**	**1.08**
Clinically Complex	**CC1**	**0.96**
Clinically Complex	**CB2**	**0.95**
Clinically Complex	**CB1**	**0.85**
Clinically Complex	**CA2**	**0.73**
Clinically Complex	**CA1**	**0.65**
Behavior / Cognitive	**BB2**	**0.81**
Behavior / Cognitive	**BB1**	**0.75**
Behavior / Cognitive	**BA2**	**0.58**
Behavior / Cognitive	**BA1**	**0.53**
Reduced Physical Function	**PE2**	**1.25**
Reduced Physical Function	**PE1**	**1.17**
Reduced Physical Function	**PD2**	**1.15**
Reduced Physical Function	**PD1**	**1.06**
Reduced Physical Function	**PC2**	**0.91**
Reduced Physical Function	**PC1**	**0.85**
Reduced Physical Function	**PB2**	**0.70**
Reduced Physical Function	**PB1**	**0.65**
Reduced Physical Function	**PA2**	**0.49**
Reduced Physical Function	**PA1**	**0.45**
Delinquent	**BC1**	**0.43**

(h) In place of the CMIs contained in subsection (g), the CMIs contained in this subsection shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one (1) of the following ~~RUG-III~~ **RUG-IV** 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 **bowel** continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.

(5) If the office 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~~ **RUG-IV** group determined in this subsection.

~~RUG-III~~ **RUG-IV** Group	~~RUG-III~~ **RUG-IV** Code	CMI Table
Reduced Physical Functions	PB2	~~0.30~~ **0.29**
Reduced Physical Functions	PB1	~~0.28~~ **0.28**
Reduced Physical Functions	PA2	~~0.24~~ **0.21**
Reduced Physical Functions	PA1	~~0.21~~ **0.19**

(i) The office 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 **but completed** or ~~incorrect~~ **any corrected** 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 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 – ((Nursing Home Report Card Score – 82) × $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)~~ **(k)** Through June 30, 2017, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to **Medicaid** residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. Medicaid 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 and dementia resident days in their SCU. **Resident days used in this calculation shall be based on the time-weighted days from the final CMI reports utilizing MDS assessments.** The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid 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)~~ **(l)** Through June 30, 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 - Nursing Facility Total Quality Score) × 0.216667)
84 – 100	$14.30

~~(n)~~ **(m)** 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 shall determine each nursing facility's quality points using the report card score published by ISDH. 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 – [(facility report card score – 82) × 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 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 – facility's normalized weighted average nursing hours per resident day) × 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 shall determine each nursing facility's RN/LPN retention rate using data from its Schedule X. **The RN/LPN retention rate shall be calculated as follows:**

$$\text{RN/LPN Retention Rate} = \frac{\text{Total Number of RN/LPN Employees Employed at the Beginning of the Year that are still Employed at the End of the Calendar Year}}{\text{Total Number of RN/LPN Employees at the Beginning of the Calendar Year}}$$

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% - facility's annual RN/LPN retention rate) × 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 shall determine each nursing facility's CNA retention rate using data from its Schedule X. **The CNA retention rate shall be calculated as follows:**

$$\text{CNA Retention Rate} = \frac{\text{Total Number of CNA Employees Employed at the Beginning of the Year that are still Employed at the End of the Calendar Year}}{\text{Total Number of CNA Employees at the Beginning of the Calendar Year}}$$

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% – facility's annual CNA retention rate) × 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 shall determine each nursing facility's RN/LPN turnover rate using data from its Schedule X. **The RN/LPN turnover rate shall be calculated as follows:**

$$\text{RN/LPN Turnover Rate} = \frac{\text{Total Number of RN/LPN Employees who left their Positions During the Calendar Year}}{\text{Total Number of RN/LPN Employees at the Beginning of the Calendar Year}}$$

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% – facility's annual RN/LPN turnover rate) × (-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 shall determine each nursing facility's CNA turnover rate using data from its Schedule X. **The CNA turnover rate shall be calculated as follows:**

$$\text{CNA Turnover Rate} = \frac{\text{Total Number of CNA Employees who left their Positions During the Calendar Year}}{\text{Total Number of CNA Employees at the Beginning of the Calendar Year}}$$

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 Rates	Quality Points Awarded
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% – facility's annual CNA turnover rate) × (-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 shall determine each nursing facility's administrator turnover using data from its Schedule X. The nursing facility administrator turnover **quality points** 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 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 shall determine each nursing facility's DON turnover using data from its Schedule X. The nursing facility DON turnover **quality points** 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 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 15. 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				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 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				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 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 total quality score.

Table 3	
Total Quality Score	Percentage

84 – 100	100%
19 – 83	100% + ((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, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 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 total quality score.

(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, 2017	July 1, 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 total quality score.

(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, 2017	July 1, 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, 2017	July 1, 2017, 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, 2017	July 1, 2017, 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 shall determine each facility's CMI for all residents on a time-weighted basis. **For a provider's financial report beginning in the month referenced in Table 9, column a, the calendar quarters used for determining a facility's CMI will begin with the corresponding calendar quarter referenced in Table 9, column b. The calendar quarters used in determining the facility's CMI will include quarters through the provider's financial report ending in the month referenced in Table 9, column c, with the corresponding calendar quarter referenced in Table 9, column d.**

Table 9			
Cost Report Begin Date (a)	**Beginning Calendar Quarter to Determine CMI (b)**	**Cost Report End Date (c)**	**Ending Calendar Quarter to Determine CMI (d)**
January Year 1	**1st Quarter Year 1**	**January Year 1**	**1st Quarter Year 1**
February Year 1	**2nd Quarter Year 1**	**February Year 1**	**1st Quarter Year 1**
March Year 1	**2nd Quarter Year 1**	**March Year 1**	**1st Quarter Year 1**
April Year 1	**2nd Quarter Year 1**	**April Year 1**	**2nd Quarter Year 1**
May Year 1	**3rd Quarter Year 1**	**May Year 1**	**2nd Quarter Year 1**
June Year 1	**3rd Quarter Year 1**	**June Year 1**	**2nd Quarter Year 1**
July Year 1	**3rd Quarter Year 1**	**July Year 1**	**3rd Quarter Year 1**
August Year 1	**4th Quarter Year 1**	**August Year 1**	**3rd Quarter Year 1**
September Year 1	**4th Quarter Year 1**	**September Year 1**	**3rd Quarter Year 1**
October Year 1	**4th Quarter Year 1**	**October Year 1**	**4th Quarter Year 1**
November Year 1	**1st Quarter Year 2**	**November Year 1**	**4th Quarter Year 1**
December Year 1	**1st Quarter Year 2**	**December Year 1**	**4th Quarter Year 1**

(e) The office shall publish ~~guidelines~~ **requirements** for use in determining the time-weighted CMI. These ~~guidelines:~~ **requirements:**

(1) shall be published as a provider bulletin; and

(2) may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 16. 405 IAC 1-14.6-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

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

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

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

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

(e) The following costs are not considered allowable costs and shall not be included in the established rate:
(1) All over-the-counter, legend, and nonlegend drugs.
(2) Cost of replacement hearing aids and eyeglasses.
(3) All costs associated with pastoral care.
(4) All costs associated with resident and family gifts, including, but not limited to, flowers, Bibles, and memory books.
(5) All costs associated with collection fees.
(6) All costs, fees, and dues associated with lobbying activities.
(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities.
(8) All costs associated with barber and beauty shop activities.
(9) All costs associated with marketing.
(10) Travel and entertainment costs to research investments or business opportunities.
(11) Medicare Part D covered drugs or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; 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 May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 17. 405 IAC 1-14.6-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider

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

Sec. 11. (a) For facilities other than nonstate government owned nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be ~~included~~ **reported** in the ~~allowable cost in the unit of service of the provider~~ **rate component or components most descriptive of the related organization's cost** at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction in an open competitive market.

(b) For nonstate government owned (NSGO) nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related by common ownership or control to either the current NSGO provider, or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider, must be ~~included~~ **reported** in the ~~allowable cost of the NSGO provider~~ **rate component or components most descriptive of the related organization's cost** at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction in an open competitive market.

(c) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:
(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.
(6) Grandparent and grandchild.

(d) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(e) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (f) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.

(f) The office shall grant an exception when a related organization meets all of the following conditions:
(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for a NSGO provider shall not be considered an arm's-length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.
(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:
(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(g) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-11; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; 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 May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 18. 405 IAC 1-14.6-12 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

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

Sec. 12. (a) Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, **letter of credit fees,** lease, rent, **amortization**

expense, deferred loan fees, or other consideration paid for the use of property, except that rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators shall be reimbursed in the direct care component. The fair rental value allowance includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

(b) The fair rental value allowance is calculated as follows:
(1) Determine, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:
(A) land, building, improvements, vehicles, and equipment; and
(B) costs;
required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.
(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.
(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.
(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-12; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; filed Sep 1, 2000, 2:10 p.m.: 24 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 715; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 19. 405 IAC 1-14.6-21 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-21 Allocation of expenses

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

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

(b) The following relationships shall be followed:
(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) No allocation of costs between annual financial report line items shall be permitted.
(4) Any changes in the allocation or classification of costs must be approved by the office prior to the changes being implemented, **unless implementing prior period audit adjustments.** Proposed changes in allocation or classification methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-21; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 20. 405 IAC 1-14.6-22 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The office shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate the provider may request an administrative reconsideration by the office. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the office not later than forty-five (45) days after release of the rate as computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the rate, amend the challenged procedure, or affirm the original decision. The office shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with the preliminary recalculated Medicaid rate resulting from a financial audit adjustment or reportable condition the provider may request an administrative reconsideration from the office. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the office not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The office shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS ~~audit~~ **review** affecting the established Medicaid rate, the provider may request an administrative reconsideration from the office. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the office not later than forty-five (45) days after release of the rate computed by the office. After review, the office may amend the ~~audit~~ **review** adjustment or affirm the original adjustment. The office shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the nursing facility provider.

(e) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3876; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 21. 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) Through June 30, 2017, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility. **The census days utilized in the calculation shall be** based on the most recently completed annual financial report or quality assessment data collection form **and the organization type shall be determined based on the organizations type at the rate effective date being established. The rate utilized is** as follows:

(1) Privately owned or operated nursing facilities with total annual nursing facility census days fewer than sixty-two thousand (62,000), sixteen dollars 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 sixty-two thousand (62,000), four dollars 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 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 and thirty-seven cents ($16.37) per non-Medicare day.

(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.

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

(d) For nursing facilities that are not certified for participation in Medicaid 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).

(e) The office 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 office. 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 office not later than

forty-five (45) days after the notice of the assessment is mailed.

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

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

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

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

(2) Submitted to the office.

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

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

(i) The office 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.

(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 ISDH 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 22. 405 IAC 1-15-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-1 Scope

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

Sec. 1. ~~This section requires~~ Nursing facilities certified to provide nursing facility care to Medicaid members **are required** to electronically transmit minimum data set (MDS) information for all **nursing facility** residents ~~including residents in a noncertified bed,~~ to the office. ~~for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes.~~ **Such MDS information shall include the resident's room number on all comprehensive or quarterly MDS assessments and tracking forms. The MDS data is used to establish and maintain a case mix system for Medicaid reimbursement to nursing facilities and other Medicaid program management purposes.**

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-1; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 23. 405 IAC 1-15-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-2 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) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within the 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~~ **3.0** or subsequent revisions as approved by CMS.

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-2; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; 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 Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 24. 405 IAC 1-15-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-4 MDS supporting documentation requirements

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

Sec. 4. (a) The office shall publish supporting documentation ~~guidelines~~ **requirements** for all MDS data elements that are utilized to classify nursing facility residents in accordance with the ~~RUG-III~~ **RUG-IV** resident classification system. The ~~guidelines~~ **requirements** shall be published as a provider bulletin and 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).

(b) Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are utilized to classify nursing facility residents in accordance with the ~~RUG-III~~ **RUG-IV** resident classification system. Such supporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to ~~audit.~~ **review.**

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-4; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

SECTION 25. 405 IAC 1-15-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-5 MDS review requirements

Authority: IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) The office shall periodically ~~audit~~ **review** the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. The ~~audits~~ **reviews** shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be ~~audited~~ **reviewed** no less frequently than every thirty-six (36) months. Advance notification of up to seventy-two (72) hours shall be provided by the office for all MDS ~~audits,~~ **reviews,** except for follow-up ~~audits~~ **reviews** that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up ~~audits~~ **reviews** shall not be required.

(b) All MDS assessments, regardless of payer type, are subject to an MDS ~~audit.~~ **review.**

(c) When conducting the MDS ~~audits,~~ **reviews,** the office shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the ~~auditors~~ **reviewers** prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference **begins** shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office, a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 of this rule, which shall be the basis for the MDS ~~audit.~~ **review.**

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments have been transmitted, shall be referred to the IMFCU for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

(Office of the Secretary of Family and Social Services; 405 IAC 1-15-5; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

SECTION 26. THE FOLLOWING ARE REPEALED: 405 IAC 1-14.5; 405 IAC 1-15-3; 405 IAC 1-15-6.

Notice of Public Hearing

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