TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #17-552

DIGEST

Amends 405 IAC 1-8-5 and 405 IAC 1-10.5-7 to extend the hospital assessment fee that is imposed on certain hospitals and make language changes to remove the hospital assessment fee adjustment factors and the frequency of changing the adjustment factors. Amends 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, 405 IAC 1-14.6-18, and 405 IAC 1-14.6-24 to extend the nursing facility quality assessment fee (QAF) as well as the enhanced reimbursements associated with the QAF. This rule amendment implements the assessment fee extension for hospitals and nursing facilities authorized by 2017 House Enrolled Act (HEA) 1001 (P.L. 217-2017), and these statutory changes are effective July 1, 2017, and continue through June 30, 2019. Effective 30 days after filing with the Publisher.

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

405 IAC 1-8-5; 405 IAC 1-10.5-7; 405 IAC 1-14.6-7; 405 IAC 1-14.6-9; 405 IAC 1-14.6-18; 405 IAC 1-14.6-24

SECTION 1. 405 IAC 1-8-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-5 Outpatient hospital assessment fee

Authority: IC 12-15-21-2; IC 12-15-21-3; IC 16-21-10-16
Affected: IC 4-21.5-3; IC 12-15-15-1; IC 12-15-21-3; IC 12-25; IC 16-18-2-179; IC 16-21-2; IC 16-21-10

Sec. 5. (a) Effective through June 30, ~~2017,~~ **2019,** the office shall collect an outpatient hospital assessment fee (HAF) from each outpatient hospital that:
(1) meets the definition set forth in IC 16-18-2-179(b); and
(2) is licensed under either:
(A) IC 16-21-2 as an acute care hospital; or
(B) IC 12-25 as a private psychiatric hospital.

(b) The outpatient hospital assessment fee applies to equivalent outpatient days. Equivalent outpatient days are derived by dividing each hospital's outpatient revenue by its inpatient revenue per day. Each hospital's equivalent outpatient days will be reduced to account for services provided to patients residing outside of Indiana. Cost report data shall be obtained from each eligible hospital's most recent cost report on file with the office, as of the last day of February preceding the HAF period, defined in subsection (c). Cost report data will be adjusted to account for fiscal years other than twelve (12) months and to exclude hospitals that have closed. Hospitals that are newly licensed in the HAF period that do not have a cost report on file with the office as of the last day of February preceding the HAF period defined in subsection (c) will be excluded from the assessment fee. For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) and that do not have a cost report on file, information for computing the assessment fee will be obtained from the hospital by the office or its designee.

(c) The HAF period is defined as separate two (2) year periods during the fee period, defined at IC 16-21-10-3.

(d) The following hospitals are excluded from the assessment fee:
(1) Long term care hospitals.
(2) State-owned hospitals.
(3) Hospitals operated by the federal government.
(4) Freestanding rehabilitation hospitals.
(5) Freestanding psychiatric hospitals with:
(A) greater than forty percent (40%) of admissions having a primary diagnosis of chemical dependency; or
(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging.
A freestanding psychiatric hospital that was certified as part of a community mental health center at any time

during the HAF period is subject to the assessment fee.
(6) Out-of-state hospitals.

(e) The assessment fee rate for the following hospitals shall be reduced by the following percentages:
(1) Seventy-five percent (75%) of the full rate for:
(A) hospitals qualifying for disproportionate share hospital (DSH) payments during each HAF period through meeting Medicaid inpatient utilization rate (MIUR) criteria; or
(B) acute care hospitals that:
(i) qualify for DSH payments during each HAF period through meeting low income utilization rate (LIUR) criteria; and
(ii) did not have LIUR status in 2010.
(2) Fifty percent (50%) of the full rate for acute hospitals that:
(A) qualify for DSH payments during each HAF period through meeting LIUR criteria; and
(B) met LIUR status in 2010.
(3) Fifty percent (50%) of the full rate for psychiatric hospitals qualifying for DSH payments during each HAF period through meeting LIUR criteria.
(4) Fifty percent (50%) of the full rate for all hospitals qualifying for DSH payments during each HAF period when more than twenty-five percent (25%) of the hospital's Medicaid days are provided to patients residing outside Indiana.

(f) The office or its contractor shall notify each hospital of the amount of the hospital's assessment after the amount of the assessment has been computed. If the hospital disagrees with either the computation or the amount of the assessment, the hospital may request an administrative reconsideration by the Medicaid rate-setting contractor. A reconsideration request shall meet the following requirements:
(1) Be in writing.
(2) Contain the following:
(A) Specific issues to be reconsidered.
(B) The rationale for the hospital's position.
(3) Be signed by the authorized representative of the hospital.
(4) Be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.
Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the hospital of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. If the rate-setting contractor does not make a timely response to the hospital's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

(g) The office shall collect the assessment fee for a hospital as follows:
(1) Offset the amount owed against either of the following:
(A) A Medicaid payment to the hospital.
(B) A Medicaid payment to another provider that is related to the hospital through common ownership or control.
(2) In another manner determined by the office.

(h) A hospital may file a request to pay the assessment fee on an installment plan. The request shall be:
(1) made in writing setting forth the hospital's rationale for the request; and
(2) submitted to the office or its designee.
If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. The 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 shall include provisions for the collection of interest. The interest shall not exceed the percentage determined in IC 12-15-21-3(6)(A).

(i) If a hospital fails to pay the assessment fee due under this section within ten (10) days after the date the payment is due, the hospital shall pay interest on the assessment fee at the same rate as determined under IC 12-15-21-3(6)(A).

(j) For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal

Social Security Act (42 U.S.C. 1396 et seq.), the hospital shall remit the assessment fee to the state of Indiana within ten (10) days after the due date. If a hospital fails to pay the hospital assessment under this subsection within ten (10) days after the due date, the hospital shall pay interest on the assessment fee at the rate as determined under IC 12-15-21-3(6)(A).

(k) If a hospital fails to pay the assessment fee within one hundred twenty (120) days after the payment is due, the office shall report the hospital to the Indiana state department of health to initiate license revocation proceedings.

(l) For hospitals certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital assessment fee shall be an allowable cost for cost reporting and auditing purposes.

(m) The office may adjust the assessment fee to incorporate DSH eligibility information for each HAF period and to make changes as necessary to the assessment fee because of administrative reconsideration requests and appeals. Adjustments of the assessment fee as a result of administrative reconsideration requests or appeals are available only for reconsideration requests and appeals filed timely in accordance with subsection (f). If the assessment fee is adjusted as described in this subsection, the determination of the assessment fee as adjusted for each HAF period will be final and shall not be subject to additional reconsideration requests or appeals.

(n) For the fee period, as defined at IC 16-21-10-3, outpatient hospital rates are subject to an outpatient hospital adjustment factor. ~~that may be changed but not more frequently than every six (6) months.~~ The outpatient hospital adjustment factors shall result in aggregate payments that reasonably approximate the federal Medicare upper payment limit under 42 CFR 447.321, but shall not result in payments in excess of the federal Medicare upper payment limit. The outpatient hospital adjustment factors are ~~as follows:~~ **published in provider bulletins.**

~~(1) The initial outpatient hospital adjustment factor is three and twenty-hundredths (3.20) for the following:~~
~~(A) Acute care hospitals licensed under IC 16-21, except for those specified in subdivision (2).~~
~~(B) Psychiatric institutions licensed under IC 12-25.~~
~~(2) For the period through June 30, 2015, the outpatient hospital adjustment factor is ninety-seven hundredths (0.97), and thereafter is one (1.0), for the following:~~
~~(A) Long term care hospitals.~~
~~(B) Freestanding rehabilitation hospitals.~~
~~(C) Out-of-state hospitals.~~
~~(D) Clinical laboratory services.~~

(o) For the period through June 30, ~~2017,~~ **2019,** the limitation on payments for an individual claim to the lesser of the amount computed or billed charges shall not apply.

(Office of the Secretary of Family and Social Services; 405 IAC 1-8-5; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)

SECTION 2. 405 IAC 1-10.5-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-7 Inpatient hospital assessment fee

Authority: IC 12-15-21-2; IC 12-15-21-3; IC 16-21-10-16
Affected: IC 4-21.5-3; IC 12-15-15-1; IC 12-15-15-11; IC 12-15-21-3; IC 12-25; IC 16-18-2-179; IC 16-21-2; IC 16-21-10

Sec. 7. (a) Effective through June 30, ~~2017,~~ **2019,** the office shall collect an inpatient hospital assessment fee (HAF) from each inpatient hospital that:
(1) meets the definition set forth in IC 16-18-2-179(b); and
(2) is licensed under either:
(A) IC 16-21-2 as an acute care hospital; or
(B) IC 12-25 as a private psychiatric hospital.

(b) The inpatient hospital assessment fee applies to inpatient days from each eligible hospital's most recent cost report on file with the office as of the last day of February preceding the HAF period, defined in subsection

(c). Cost report data will be adjusted as follows:

(1) To account for fiscal years other than twelve (12) months.

(2) To exclude hospitals that have closed.

Hospitals that are newly licensed in each HAF period that do not have a cost report on file with the office as of the last day of February preceding the HAF period, defined in subsection (c), shall be excluded from the assessment fee. For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) and that do not have a cost report on file, information for computing the assessment fee will be obtained from the hospital by the office or its designee. For purposes of computing the assessment fee, the total number of inpatient hospital days shall include days for sub-providers, employee discount days, and labor and delivery days. Days on which services are provided to patients residing outside of Indiana shall be excluded from the assessment fee.

(c) The HAF period is defined as separate two (2) year periods during the fee period, defined at IC 16-21-10-3.

(d) If a hospital's cost report that is used for purposes of calculating the hospital's assessment fee for the HAF period includes inpatient days attributable to a distinct part rehabilitation or psychiatric unit of the hospital that was terminated by the hospital prior to or during that HAF period, the date of the unit's termination as stated in the letter referenced in subdivision (1) shall be deemed to be the date of termination, and the assessment fee for the hospital for that HAF period shall be adjusted consistent with the process for adjusting fees for the closing of hospitals, provided that the hospital:

(1) provides written notice to the Indiana state department of health of the termination of the distinct part unit, along with an effective date of the termination;

(2) no longer provides rehabilitation or psychiatric services in the physical space where the distinct part unit was located, beginning no later than the effective date of termination;

(3) does not relocate any of the services previously provided in the distinct part unit to another part of the hospital;

(4) does not replicate in another part of the hospital any of the services previously provided in the distinct part unit; and

(5) provides the office with a copy of the letter referenced in subdivision (1) and written confirmation of the hospital's compliance with the requirements of subdivisions (2) through (4) within fifteen (15) days following the effective date of termination stated in the letter referenced in subdivision (1).

(e) The following hospitals shall be excluded from the assessment fee:

(1) Long term care hospitals.

(2) State-owned hospitals.

(3) Hospitals operated by the federal government.

(4) Freestanding rehabilitation hospitals.

(5) Freestanding psychiatric hospitals with:

(A) greater than forty percent (40%) of admissions having a primary diagnosis of chemical dependency; or

(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging.

A freestanding psychiatric hospital that was certified as part of a community mental health center at any time during the HAF period is subject to the assessment fee.

(6) Out-of-state hospitals.

(f) The assessment fee rate for the following hospitals shall be reduced by the following percentages:

(1) Seventy-five percent (75%) of the full rate for:

(A) hospitals that qualify for disproportionate share hospital (DSH) payments during each HAF period through meeting Medicaid inpatient utilization rate (MIUR) criteria; or

(B) acute care hospitals that:

(i) qualify for DSH payments during each HAF period through meeting low income utilization rate (LIUR) criteria; and

(ii) did not have LIUR status in 2010.

(2) Fifty percent (50%) of the full rate for acute hospitals that qualify for DSH payments during the fee period through meeting LIUR criteria and that met LIUR status in 2010.

(3) Fifty percent (50%) of the full rate for psychiatric hospitals that qualify for DSH payments during each HAF period through meeting LIUR criteria.

(4) Fifty percent (50%) of the full rate for all hospitals that qualify for DSH payments during each HAF period when more than twenty-five percent (25%) of the hospital's Medicaid days are provided to patients residing outside Indiana.

(g) The office or its contractor shall notify each hospital of the amount of the hospital's assessment after the amount of the assessment has been computed. If the hospital disagrees with the computation or the amount of the assessment, the hospital may request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall meet the following requirements:

(1) Be in writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

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

(3) Be signed by the authorized representative of the hospital.

(4) Be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.

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

(h) The office shall collect the assessment fee for a hospital as follows:

(1) Offset the amount owed against either of the following:

(A) A Medicaid payment to the hospital.

(B) A Medicaid payment to another provider that is related to the hospital through common ownership or control.

(2) In another manner determined by the office.

(i) A hospital may file a request to pay the assessment fee on an installment plan. The request shall be:

(1) made in writing setting forth the hospital's rationale for the request; and

(2) submitted to the office or its designee.

If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. 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 determined under IC 12-15-21-3(6)(A).

(j) If a hospital fails to pay the assessment fee due under this section within ten (10) days after the date the payment is due, the hospital shall pay interest on the assessment fee at the rate determined under IC 12-15-21-3(6)(A).

(k) For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital shall remit the assessment fee to the state of Indiana within ten (10) days after the due date. If a hospital fails to pay the assessment fee due under this subsection within ten (10) days after the payment is due, the hospital shall pay interest on the assessment fee at the rate determined under IC 12-15-21-3(6)(A).

(l) If a hospital fails to pay the assessment fee within one hundred twenty (120) days after the payment is due, the office shall report the hospital to the Indiana state department of health to initiate license revocation proceedings.

(m) For hospitals certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital assessment fee shall be an allowable cost for cost reporting and auditing purposes.

(n) The office may adjust the assessment fee to incorporate DSH eligibility information for each HAF period and to make changes as necessary to the assessment fee as a result of administrative reconsideration requests

and appeals. Adjustments of the assessment fee as a result of administrative reconsideration requests and appeals are available only for reconsideration requests and appeals filed timely in accordance with subsection (g). If the assessment fee is adjusted as described in this subsection, the determination of the assessment fee for each HAF period shall be final and shall not be subject to additional reconsideration requests or appeals.

(o) For the fee period, as defined at IC 16-21-10-3, inpatient hospital rates are subject to an inpatient hospital adjustment factor. ~~that may be changed but not more frequently than every six (6) months.~~ The inpatient hospital adjustment factors shall result in aggregate payments that reasonably approximate the federal Medicare upper payment limit under 42 CFR 447.272, but shall not result in payments in excess of the federal Medicare upper payment limit. The initial inpatient hospital adjustment factors are ~~as follows:~~ **published in provider bulletins.**

~~(1) The initial hospital adjustment factor for the DRG base rate is three (3.00).~~
~~(2) The initial hospital adjustment factor for psychiatric level of care rates is two and twenty-hundredths (2.20).~~
~~(3) The initial hospital adjustment factor for acute care hospital rehabilitation level of care rates is three (3.00).~~
~~(4) The initial hospital adjustment factor for burn level of care rates is one (1.00).~~

~~(p) The inpatient hospital adjustment factors in subsection (o) apply to the following:~~
~~(1) Acute care hospitals licensed under IC 16-21, except for those specified in subsection (q).~~
~~(2) Psychiatric institutions licensed under IC 12-25.~~

~~(q) For the period through June 30, 2015, the inpatient hospital adjustment factor is ninety-seven hundredths (.97), and thereafter is one (1.0), for the following:~~
~~(1) Long term care hospitals.~~
~~(2) Freestanding rehabilitation hospitals.~~
~~(3) Out-of-state hospitals.~~

~~(r)~~ **(p)** Effective through June 30, ~~2017,~~ **2019,** the limitation on payments for an individual claim to the lesser of the amount computed or billed charges shall not apply to those hospitals eligible for the HAF adjustments.

~~(s)~~ **(q)** Following the close of each state fiscal year, the office or its contractor shall perform a test to ensure that annual aggregate inpatient payments to a hospital do not exceed the hospital's total inpatient billed charges for the fiscal year. Annual aggregate inpatient payments to a hospital in excess of the hospital's billed charges for the fiscal year shall be recovered by the office or its designee. As permitted by 42 CFR 447.271(b), payments to nominal charge hospitals identified in IC 12-15-15-11 are not subject to this inpatient billed charge limitation.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-7; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)

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

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

Authority: IC 12-15-1-10; 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 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,~~ **2019,** 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 – 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-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-IV group determined in this subsection.

RUG-IV Group	RUG-IV Code	CMI Table
Reduced Physical Functions	PB2	0.29
Reduced Physical Functions	PB1	0.28
Reduced Physical Functions	PA2	0.21
Reduced Physical Functions	PA1	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 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) Through June 30, ~~2017,~~ **2019,** 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.

(l) Through June 30, ~~2017,~~ **2019,** 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

(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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA)

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

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

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

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

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

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

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

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

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

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

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

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

Table 1				
Children's Nursing Facilities				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, ~~2017~~ **2019**	July 1, ~~2017,~~ **2019,** and after	July 1, 2003, through June 30, ~~2017~~ **2019**	July 1, ~~2017,~~ **2019,** and after
Percentage	30%	52%	110%	105%

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

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

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

Table 2				
Non-Children's Nursing Facilities				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, ~~2017~~ **2019**	July 1, ~~2017,~~ **2019,** and after	July 1, 2003, through June 30, ~~2017~~ **2019**	July 1, ~~2017,~~ **2019,** 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~~ **2019**	July 1, ~~2017,~~ **2019,** and after	July 1, 2003, through June 30, ~~2017~~ **2019**	July 1, ~~2017,~~ **2019,** 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~~ **2019**	July 1, ~~2017,~~ **2019,** 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~~ **2019**	July 1, ~~2017,~~ **2019,** 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~~ **2019**	July 1, ~~2017,~~ **2019,** 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~~ **2019**	July 1, ~~2017,~~ **2019,** 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	Beginning Calendar Quarter to Determine CMI	Cost Report End Date	Ending Calendar Quarter to Determine CMI
(a)	(b)	(c)	(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 requirements for use in determining the time-weighted CMI. These 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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA)

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

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

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

Sec. 18. (a) Compensation for:
(1) an owner, a related party, management, general line personnel, and consultants who perform management functions; or
(2) any individual or entity rendering services above the department head level;
shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. Through June 30, ~~2017,~~ **2019,** compensation subject to this limitation includes wages, salaries, and fees for the owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning July 1, ~~2017,~~ **2019,** and thereafter, wages, salaries, and fees paid for the owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.

(b) Through June 30, ~~2017,~~ **2019,** the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in subjection (a). The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.

(c) Beginning July 1, ~~2017,~~ **2019,** the maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:
(1) under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or
(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.
If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

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

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081

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

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-18; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2982; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)*

SECTION 6. 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 16-28-15-2; IC 16-28-15-7; IC 23-2-4

Sec. 24. (a) Through June 30, ~~2017,~~ **2019,** 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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA)

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Posted: 02/07/2018 by Legislative Services Agency
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