TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Notice of Second Public Comment Period
LSA Document #24-88

NURSING FACILITY RULE

PURPOSE OF NOTICE
The Office of Medicaid Policy and Planning (OMPP) is soliciting public comment on adding, amending, and repealing rules at 405 IAC 1 concerning fee-for-service nursing facility reimbursement. The OMPP seeks comment on the affected citations listed and any other provisions of Title 405 that may be affected by this rulemaking.

HISTORY
Notice of First Public Comment Period published March 13, 2024: 20240313-IR-405240088FNA.
Regulatory Analysis submitted with Notice of First Public Comment Period: 20240313-IR-405240088RAA.
Date of First Hearing: April 15, 2024.

CITATIONS AFFECTED: 405 IAC 1-14.6; 405 IAC 1-14.7; 405 IAC 1-15

AUTHORITY: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

OVERVIEW
Basic Purpose and Background
The proposed rule change implements reimbursement methodology changes to accommodate the transition to a managed long term services and supports delivery system by eliminating retroactivity and creating a fully prospective reimbursement system. Additionally, the changes will align reimbursement incentives to facilitate achieving higher staffing levels and better resident outcomes. Further, identified special resident populations will have additional reimbursement dedicated to the specific individual, further incentivizing access to care.

For purposes of IC 4-22-2-28.1, small businesses affected by this rulemaking may contact the Small Business Regulatory Coordinator:
Keith McConomy
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
Indiana Government Center South
402 West Washington Street, Room W374
Indianapolis, IN 46204
(317) 233-9640
keith.mcconomy@fssa.in.gov
For purposes of IC 4-22-2-28.1, the Small Business Ombudsman designated by IC 5-28-17-6 is:
Matthew Jaworowski
Small Business Ombudsman
Indiana Economic Development Corporation
One North Capitol, Suite 700
Indianapolis, IN 46204
(317) 650-0126
majaworowski@iedc.in.gov
Resources available to regulated entities through the small business ombudsman include the ombudsman's duties stated in IC 5-28-17-6, specifically IC 5-28-17-6(9), investigating and attempting to resolve any matter regarding compliance by a small business with a law, rule, or policy administered by a state agency, either as a party to a proceeding or as a mediator.

SUMMARY/RESPONSE TO COMMENTS
The OMPP requested public comment from March 13, 2024, through April 15, 2024, on alternative ways to achieve the purpose of the rule and suggestions for the development of draft rule language. The OMPP received comments from the following parties by the comment period deadline:

Commentor: Rasheedah Hunter-Krebs, Home of my Own LLC
Summary of Comments: Rasheedah Hunter-Krebs pointed out an inconsistency in the proposed rule language.
Response to Rasheedah Hunter-Krebs: The OMPP appreciates the feedback from Rasheedah Hunter-Krebs.

Upon review, rule sections 405 IAC 1-14.7-8(e) and 405 IAC 1-14.7-12(g)(3)(D) did contain inconsistent language. The OMPP has accordingly revised 405 IAC 1-14.7-8(e) to remove the inconsistent language.

REQUEST FOR PUBLIC COMMENTS

The OMPP is soliciting public comments on the proposed rule. Comments may be submitted in one of the following ways:

(1) By mail or common carrier to the following address:
LSA Document #23-88 Nursing Facility Rule
Amanda DeRoss
Office of General Counsel
Indiana Family and Social Services Administration
402 West Washington Street, Room W451
Indianapolis, IN 46204

(2) By electronic mail to amanda.deross@fssa.in.gov. To confirm timely delivery of submitted comments, please request a document receipt when sending the electronic mail. **PLEASE NOTE: Electronic mail comments will not be considered part of the official written comment period unless they are sent to the address indicated in this notice.**

(3) Attend scheduled public hearing.

COMMENT PERIOD DEADLINE

All comments must be postmarked or time stamped not later than July 1, 2024.

The rule, Regulatory Analysis, appendices referenced in the Regulatory Analysis, and materials incorporated by reference (if applicable) are on file at the Office of Medicaid Policy and Planning, 402 West Washington Street, Room W451, Indianapolis, Indiana and are available for public inspection. Copies of the rule, Regulatory Analysis, and appendices referenced in the Regulatory Analysis are available at the Office of Medicaid Policy and Planning.

This notice is the second of two (2) thirty (30) day periods in which the public may comment on the proposed rule. Following this second public comment period, the OMPP may adopt a version of the proposed rule that is the same as or does not substantially differ from the text of the proposed rule published during the second public comment period.

ADDITIONAL DOCUMENTS

Regulatory Analysis: No changes were made to the Regulatory Analysis, as submitted with the Notice of First Public Comment Period, posted at 20240313-IR-405240088RAA.

Notice of Public Hearing: 20240529-IR-405240088PHA

EXPLANATION OF DIFFERENCES IN PROPOSED RULE

The OMPP made the following change to the LSA #23-88 proposed rule based on public comments:

In 405 IAC 1-14.7-8(e), removed the sentence "A CMI change as a result of the MDS review shall not be incorporated into either the legacy system or prospective system rate calculations under section 6 of this rule.".

PROPOSED RULE

SECTION 1. 405 IAC 1-14.7 IS ADDED TO READ AS FOLLOWS:

Rule 14.7. Rate Setting Criteria for Nursing Facilities

405 IAC 1-14.7-1 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 services rendered to members covered by the Indiana health coverage program by nursing facilities. Payments referred to in this rule are contingent on the following:

(1) Proper and current certification.

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

(b) The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule and the IMPRM that establish parameters regarding the allowability of ordinary patient related costs and define reasonable nursing facility allowable costs.

(c) An action that results in recoupment, rate reduction, or retrospective payment may be addressed through a prospective rate calculation, retroactive reprocessing of claims, or settlement process.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-1)

405 IAC 1-14.7-2 Definitions

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

(b) "Administrative component" means the portion of the Medicaid rate that reimburses providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Allowable administrative services and supplies are the patient related costs necessary for the operation of a nursing facility, but cannot be directly associated with a specific member.

(c) As set forth in section 6(e) of this rule, "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 or field audited cost report, plus a ratio between allowable fixed costs and patient days using the greater of the minimum occupancy requirements, or each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report. As set forth in section 6(d) of this rule, the term means a ratio between allowable cost and patient days using each provider's actual occupancy from the most recently completed desk review or field audited cost report using the greater of the minimum occupancy requirements, or each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report.

(d) "Bed days available" means the number of licensed beds reported during the cost reporting period multiplied by the number of calendar days in that period. If the number of licensed beds changed during a reporting period, the:
(1) number of licensed beds reported on the cost report as of the calendar day immediately after the end of the cost report period shall be used in the calculation of the rate and the related bed days available;
(2) provider may request in writing, with the cost report submission, for the weighted average of the number of beds licensed during the cost report period to be used in the calculation of the rate and the related bed days available; or
(3) provider may request the office to calculate bed days available under section 6 of this rule.

(e) "Biannual" means a six (6) month period beginning January 1 and July 1.

(f) "Capital component" means the portion of the Medicaid rate that reimburses providers for the use of allowable capital related items. Allowable capital related items are the patient related costs associated with a nursing facility's physical assets and related ownership costs.

(g) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident in the groups of the resident classification system prescribed by the office, as described in the MDS and Case Mix Index Supportive Documentation Manual, and based on an assessment of each resident. The facility CMI is based on the resident CMI, calculated on a facility average, time-weighted basis for the following:
(1) Medicaid residents.
(2) Each resident of the facility.

(h) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:
(1) fifteen percent (15%) or more residents less than twenty-one (21) years of age; and
(2) received written approval from the office to be designated as a children's nursing facility.

(i) "Cost 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 to that data at that time, in compliance with the reporting requirements of this rule.

(j) "Delinquent MDS resident assessment" means an assessment that is inactive or expired due to exceeding maximum thresholds set by the office for filing and inclusion in the time-weighted CMI calculation. This determination is made as described for required filing in the MDS and Case Mix Index Supportive Documentation Manual.

(k) "Desk review" means a review and application of the regulations to a provider submitted cost report, including accompanying notes and supplemental information within the scope, as defined by the office.

(l) "Direct care component" means the portion of the Medicaid rate that reimburses providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Allowable direct patient care services and supplies are patient related costs associated with direct hands-on care or related support of a member.

(m) "Employee benefits" means total allowable employee benefits costs from the most recently desk reviewed or field audited cost report, excluding owners' benefits as described in the IMPRM, unless specified otherwise.

(n) "Field audit" means a review and application of the regulations to a provider submitted cost report, including accompanying notes and supplemental information within the scope, as defined by the office.

(o) "Fixed costs" means the portion of each rate component based on the minimum occupancy requirements.

(p) "Forms prescribed by the office" means either of the following:
(1) Cost report forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(q) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the Financial Accounting Standards Board.

(r) "IDOH" means the Indiana department of health.

(s) "Indiana Medicaid provider reimbursement manual" or "IMPRM" means the policy document supporting the reporting requirements, allowable cost classifications, and calculation of the Medicaid rate.

(t) "Indirect care component" means the portion of the Medicaid rate that reimburses providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Allowable indirect patient care services and supplies are patient related costs necessary in the care of a member, but not directly based on providing hands-on care.

(u) "Inflation factor" means inflating costs using the CMS Nursing Home without Capital Market Basket Index, as published by IHS Markit, using the period prescribed by the office.

(v) "Legacy system" means the historic system used to calculate the Medicaid nursing facility per patient day rate under section 6 of this rule.

(w) "Medicaid patient days" means total Medicaid days from the most recently desk reviewed or field audited cost report.

(x) "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 residents of long term care facilities certified to participate in Medicaid. The Indiana system uses the MDS 3.0 or later revisions as approved by CMS, as detailed in the MDS and Case Mix Index Supportive Documentation Manual.

(y) "MDS and Case Mix Index Supportive Documentation Manual" means the policy document supporting the following:
(1) The MDS assessment instrument.
(2) MDS assessment processing.
(3) MDS supportive documentation requirements.
(4) The resident classification system.
(5) The CMI calculation.

(z) "MDS review" means a formal official verification and methodical examination and review of resident assessment data and its supporting documentation by the office or their designee.

(aa) "Nonemergency medical transportation" or "NEMT" means medical transportation to a covered service whenever needs are not immediate, such as to and from a doctor's office, a hospital, or other medical offices for covered care. NEMT services provided by ambulance providers are neither the financial responsibility of nursing facility providers and included in the nursing facility Medicaid per diem, nor covered under this definition.

(bb) "Nursing facility census data collection form" means the form designated by the office for providers to file their monthly census information.

(cc) "Ordinary patient related costs" means costs of allowable per diem services and supplies necessary in the delivery of patient care by similar providers in this state. Services or supplies Medicaid covers outside the per diem rate are not ordinary patient related costs.

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

(ee) "Patient days" means total patient days, inclusive of paid leave days, from the most recently desk reviewed or field audited cost report.

(ff) "Prospective system" means the methodology used to calculate the Indiana Medicaid reimbursement per patient day rate under section 6 of this rule.

(gg) "Quality program manual" means the policy document supporting the calculation of the total quality score.

(hh) "Rate year" means the period beginning July 1 and ending June 30.

(ii) "RSMeans Construction Cost Index" means the simple average of construction costs for Indiana cities listed in the Construction Cost Indexes with RSMeans Data, as published by Gordian.

(jj) "Reasonable allowable costs" means the price a prudent, cost-conscious buyer pays a willing

seller for goods or services in an arms length transaction, not to exceed the limitations set forth in this rule or other policy documents.

(kk) "Rebase" means the process of reestablishing rate component medians, percentiles, prices, and reimbursement rates by incorporating the most recently completed desk or field audited qualifying Medicaid cost reports.

(ll) "Rental rate" means 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 the index is published for each of the twelve (12) months immediately preceding the rate effective date, as determined in section 6 of this rule.

(mm) "Resident classification system" means the classification system used to classify residents into groups to determine CMI values and reimbursement levels, as supported by the MDS and Case Mix Index Supportive Documentation Manual.

(nn) "Special care unit (SCU) for Alzheimer's disease or dementia" means the nursing facility that meets all the following requirements:

(1) Has a locked, secure, segregated unit, or provides a special program or 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 the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, 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 at least one (1) year work experience with dementia or Alzheimer's residents, or both, in the past five (5) years.

(C) Completed at least 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.

(oo) "Therapy component" means the portion of each facility's direct costs for providing therapy services, including prorated employee benefits based on total salaries and wages, rendered to Medicaid residents not reimbursed by other payors.

(pp) "Total quality score" means the sum of the quality points awarded to each nursing facility for the quality measures as described by the quality program manual.

(qq) "Unsupported MDS resident assessment" means an assessment missing one (1) or more data items required to classify a resident through the resident classification system under the MDS and Case Mix Index Supportive Documentation Manual.

(rr) "Ventilator program" means a nursing facility that meets all the following requirements:

(1) The nursing facility uses an active, ongoing interdisciplinary approach to resident care, including participation as needed by a:

(A) physician;

(B) practitioner;

(C) pulmonologist;

(D) registered nurse;
(E) pharmacist;
(F) dietitian;
(G) speech therapist;
(H) respiratory therapist;
(I) physical or occupational therapist;
(J) resident; and
(K) resident's representative.

The interdisciplinary approach includes a physician who is board certified in pulmonary disease or critical care, as recognized by either the American Board of Medical Specialties or American Osteopathic Associations, as applicable.

(2) The nursing facility has a licensed respiratory care practitioner, as defined by 844 IAC 11, onsite twenty-four (24) hours a day, seven (7) days a week.

(3) The nursing facility has ventilator back-up provisions, including:

(A) internal or external battery back-up systems, or both, to provide at least eight (8) hours of power;
(B) enough emergency oxygen delivery devices (e.g., compressed gas or battery operated concentrators);
(C) at least one (1) battery operated suction device available for every nine (9) residents on a mechanical ventilator or with a tracheostomy;
(D) at least one (1) resident ready back-up ventilator available in the facility at all times;
(E) an audible, redundant external alarm system connected to emergency power or battery back-up, or both, located outside the room of each ventilator-dependent resident, for the purpose of alerting staff of resident ventilator disconnection or ventilator failure; and
(F) ventilator equipment, and preferably physiologic monitoring equipment, connected to back-up generator power through clearly marked wall outlets.

(4) The nursing facility has a plan specific for ventilator-dependent residents, which specifically addresses total power failures, such as the loss of power and generator, as well as other emergency circumstances.

(5) The nursing facility has a written training program, including an annual demonstration of competencies, for nursing and respiratory therapy staff, including nurse aides, registered nurses, and licensed practical nurses, providing direct care services for ventilator-dependent residents.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-2)

405 IAC 1-14.7-3 Cost report submission and requirements

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. 3. (a) The basis of accounting under this rule is a comprehensive basis of accounting, other than GAAP. Costs and charges reported on the provider's cost report shall also be recorded on the provider's financial statements. Costs and charges shall be reported on the cost report under the following authorities, in the hierarchical order listed:

(1) This rule, the IMPRM, provider bulletins, and any other policy communications.
(2) 42 CFR 413 and the Medicare Provider Reimbursement Manual, CMS 15-1.
(3) GAAP.

The burden of supporting that costs are allowable and patient related, reasonable, and properly classified is on the provider.

(b) The provider's cost report shall be completed under the IMPRM and submitted using cost report forms prescribed by the office. The data elements and attachments identified in subdivisions (1) through (8) shall be completed to provide full financial disclosure. A complete cost report consists of the following items fully and properly completed:

(1) The Medicaid cost report and supporting schedules, as prescribed by the office.
(2) The Medicare cost report for Medicare certified providers, as prescribed by the office, as follows:

(A) Providers with a Medicare cost report with a fiscal year end other than December 31 shall provide their most recently filed Medicare cost report with the Medicare administrative contractor.
(B) Providers may elect to submit a Medicare/Medicaid reconciliation form approved by the office that provides modifications to the Medicare cost report as filed due to differences between Medicare and Medicaid allowable cost definitions and classification of costs between cost centers. A revised

facility Medicare cost report that incorporates the modifications on the Medicare/Medicaid reconciliation form shall also be submitted with the Medicare/Medicaid reconciliation form and Medicare cost report as submitted.

(3) Certification by the provider that:

(A) the data are true, accurate, and based on patient care; and

(B) expenses not based on patient care have been clearly identified.

Amendments to the cost report require updated provider certifications.

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

(5) A copy of the working trial balance that is a direct product of the accounting system for both the nursing facility and home office, if applicable, used in the preparation of their submitted cost report in the format described in the IMPRM. The working trial balance includes a summation of expense accounts that agree to the total expense amount used to prepare the trial balance crosswalk.

(6) A copy of the trial balance crosswalk document used to prepare the Medicaid cost report (facility and home office, if applicable) containing an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report. Costs removed from the working trial balance and not reported on the cost report are to be clearly identified in a supporting document. Costs reported on the cost report and not verifiable on the working trial balance are to be clearly identified and supported with compelling documentation. The crosswalk shall be sorted and subtotaled by Medicaid line number and provided in the manner described in the IMPRM.

(7) A workpaper providing a detailed accounting of the amounts reported in column 24 – Provider Adjustments, by line and column number. The workpaper shall distinguish costs by source (e.g., home office, reclassification from another line, etc.). The workpaper shall also distinguish whether the cost is a personnel or nonpersonnel cost. Costs on lines with both columns 2 (personnel) and 3 (other) shall be treated as personnel unless clearly identified.

(8) Other documents considered necessary by the office to accomplish full financial disclosure of the provider's operation.

(c) For cost report periods ending March 31, 2023, or earlier, a provider shall submit a cost report to the office not later than the last day of the fifth calendar month after the end of the provider's reporting year. The cost report shall coincide with the fiscal year used by the provider to report federal income taxes. Nursing facilities certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report covering their most recently completed historical reporting period.

(d) For cost report periods ending April 1, 2023, or later, a provider is required to maintain a fiscal year end of December 31. Each provider shall submit a cost report to the office not later than May 31 after the end of the provider's reporting year. Requirements regarding short period cost reports are as set forth in section 9 of this rule. Nursing facilities certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report covering their most recently completed historical reporting period.

(e) The nursing facility census data collection form is required to be submitted monthly and is due thirty (30) days after the reporting month. The nursing facility census data collection form is required to be filed on the form prescribed by the office and in conformance with the instructions contained in that form.

(f) Whenever 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 a cost report coinciding with the period for any individual facility receiving central office allocations.

(g) A provider shall maintain financial records for at least three (3) years after the date of submission of cost reports to the office. Copies of financial records or supporting documentation shall be provided to the office on request. The accrual basis of accounting shall be used in the data submitted to the office, except for government operated providers otherwise required by law to use a different basis. The provider's accounting records shall establish a clear audit trail from their records to the costs reported on their cost reports submitted to the office.

(h) A cost report submission shall contain full disclosure and reporting of revenue, expenses, and property clearly separated between Medicaid, non-Medicaid, patient, and nonpatient, including the following:

(1) 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 those enterprises or activities shall be clearly identified and distinguished from the revenues, expenses, and statistical and financial records of the operations reimbursed by Medicaid.

(2) The detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider if the basis is reasonably based on the allocated costs and consistent between accounting periods. The following relationships are required:

(A) Reported expenses and patient census information shall be for the same reporting period.

(B) Nursing salary allocations shall be based on nursing hours worked or patient days for the reporting period, except when specific identification is used based on the actual salaries paid for the reporting period.

(C) No allocation of costs between cost report line items shall be permitted.

(D) Allocation methodologies shall have a reasonable relationship to the costs they are allocating.

(E) For allocation of expenses between nursing facilities and other services, accumulated cost or patient days, or both, are presumed to be a reasonable allocation methodology.

(F) The office shall approve any changes in the allocation or classification of costs before the changes are implemented, unless implementing earlier period audit adjustments. Proposed changes in allocation or classification methods shall be submitted to the office for approval not less than ninety (90) days before the provider's cost report due date.

(3) Costs and revenues shall be reported as required on the cost report forms. Allowable patient care costs shall be clearly identified.

(4) The provider shall report as patient care costs only costs that have been incurred in providing patient care services. The provider shall certify on the cost report that costs not based on patient care have been separately identified on the cost report and as prescribed in the IMPRM.

(i) A provider shall maintain detailed property documentation, including documentation from a related party property company, to provide a permanent record of the historical costs and balances of facilities and equipment. Summaries of that documentation shall be submitted with each cost report, and a complete copy of the documentation shall be submitted to the office on request.

(j) A provider shall report the patient related personnel costs and hours, as well as patient related contract costs, incurred to perform the function for which the provider was certified. Total personnel costs and total hours shall be reported for each employee. Hours for contracted staff are not required to be reported.

(k) Payroll records shall be maintained by a provider to justify the staffing costs reported to the office. These records shall indicate:

(1) each employee's:

(A) classification;

(B) hours worked; and

(C) rate of pay; and

(2) the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments. These allocations are to be supported through time studies or actual time worked.

(l) Allocation of home office costs shall be reasonable, conform to GAAP, and be consistent between years. A change of central office allocation bases shall be approved by the office before the changes are implemented. Proposed changes in allocation methods shall be submitted to the office not less than ninety (90) days before the cost report due date. These costs are allowable only to the extent that the central office is providing services based on patient care, and the provider is able to demonstrate that the central office costs improved the efficiency, economy, and quality of member care.

(m) Costs from non-bona fide separate related organizations, such as from operating divisions of the

provider organization or central office, shall be maintained as a separate set of records, with costs separately identified and appropriately allocated to individual facilities. Costs from these related organizations shall be documented and allocated using the Medicaid Home Office Cost Report Form.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-3)

405 IAC 1-14.7-4 Scope of reviews

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. 4. (a) The office shall perform a desk review or field audit of a submitted cost report to determine the reasonableness, appropriate classification, and allowability of reporting. The office may request documentation to justify the submitted cost report.

(b) The office shall contact a provider to notify them that they have been selected for a field audit as follows:

(1) The office shall provide an audit notification letter to the provider identifying the information the provider is required to submit in advance of the field audit date. Failure to submit the required information by the due date in the audit notification letter shall result in the implementation of the prefield information rate reduction as identified in section 12 of this rule.

(2) The office shall schedule the field audit date with the provider. If the office and provider are unable to reach an agreement on a scheduled field audit date, the office shall assign a date for the field audit to begin not earlier than fifteen (15) days after the date the provider was initially contacted to schedule the field visit. The office shall confirm the field audit date by providing a written notice identifying the date of the scheduled field audit.

(3) After assignment of a field audit date, a provider may submit a one (1) time request that the scheduled field audit be postponed to a later date as follows:

(A) The office shall approve or deny the request in writing within fifteen (15) days of receiving the request.

(B) A delay of the scheduled field audit date does not extend the due date of the required information.

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

(1) The office shall provide a written notice listing the deficiencies in documentation.

(2) The provider shall be allowed fifteen (15) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not earlier than fifteen (15) days from the date of the notice, the office shall give a final written notice (follow-up letter) listing the outstanding deficiencies in documentation.

(4) Failure to submit the required information by the due date in the written notice shall result in the implementation of the field work – follow-up letter and rate reduction as identified in section 12 of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-4)

405 IAC 1-14.7-5 New provider reimbursement

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. 5. (a) This section describes the treatment of nursing facility providers that have not previously been certified to participate in the Medicaid nursing facility program.

(b) Rate requests to establish an initial rate for a new provider rate shall be filed by submitting an initial rate request to the office on or before the thirtieth day after notification of the enrollment date.

(c) Initial rates shall be effective on the:
(1) enrollment date; or
(2) date a service is established;
whichever is later.

(d) Initial rates shall be set at the sum of the following:
(1) The statewide average nursing facility quality add-on of the preceding July 1.
(2) Assessment add-on, as determined in subsection (g).
(3) NEMT add-on, as determined in section 7 of this rule.
(4) Legacy system medians at the preceding July 1 for each of the following components:
(A) Direct care component, as follows:
(i) Until the provider has one (1) full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the statewide average Medicaid CMI used as determined for the previous July 1 rate effective date.
(ii) Once a provider has one (1) full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the facility's own facility average Medicaid CMI and updated each rate effective date thereafter.
(B) Therapy component.
(C) Indirect care component.
(D) Administrative component.
(E) Eighty percent (80%) of the capital component.

(e) A provider shall remain under the initial rate calculation process until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or more in length available for use in the rebase.

(f) The initial monthly quality assessment value owed to the office shall be determined based on six (6) months of patient days from the required monthly nursing facility census data collection form provider filings. The initial monthly quality assessment value owed to the office shall remain in effect until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or more in length available for use in the rebase. A retroactive settlement of the initial quality assessment total for unpaid periods shall occur after the provider's assessment value is determined by the office and the fiscal intermediary has established the monthly assessment receivable.

(g) The assessment add-on is twelve dollars and twenty cents ($12.20) a patient day unless exempt from the assessment add-on, as noted in section 11 of this rule. Once the office collects six (6) months of patient days from the required monthly nursing facility census data collection forms, the office shall establish the provider specific assessment add-on and implement on the next rate effective date.

(h) Providers are eligible to participate in the special care unit and ventilator programs and receive additional reimbursement if the qualifications in sections 2 and 7 of this rule are met.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-5)

405 IAC 1-14.7-6 Rate calculation

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 6-8.1-10-1; IC 12-13-7-3; IC 12-15-13-4

Sec. 6. (a) This section prescribes the detailed rate methodology calculation for each rate component.

(b) Until June 30, 2024, the rate effective date of the annual rebase shall be the first July 1 after the first calendar quarter after a provider's fiscal year end. Beginning July 1, 2024, the annual rebase shall be each July 1 using the most recently desk or field audited cost reports, with a fiscal year ending not less than eighteen (18) months before the rate effective date.

(c) The annual Medicaid per patient day rate shall be calculated as the sum of the:

(1) prospective system rate calculated under subsection (d), multiplied by the system's rate percentage; and

(2) legacy system rate calculated under subsection (e), multiplied by the system's rate percentage; as shown in the following table:

Rate Effective Date	Prospective System Rate Percentage	Legacy System Rate Percentage
Before January 1, 2025	0%	100%
January 1, 2025	17%	83%
July 1, 2025	33%	67%
January 1, 2026	50%	50%
July 1, 2026	67%	33%
January 1, 2027	83%	17%
July 1, 2027, and later	100%	0%

(d) The prospective system is as follows:

(1) The prospective system rate is calculated as the sum of the following:

(A) Direct care component. This component is price based with a limit (floor) placed on provider profit, calculated as follows:

Table D.1 - Direct Care Component Calculation		
A.	Direct Care Per Patient Day Cost for CMI Adjustment	Value as determined in Table D.2 (F)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Total CMI Adjusted Direct Care Per Patient Day Costs	C * D
F.	Non-CMI Adjusted Direct Care Per Patient Day Cost	Valued as determined in Table D.4 (E)
G.	Total Direct Care Per Patient Day Cost	E + F
H.	Determination of the Statewide Price for the Normalized Direct Care Per Patient Day Cost and Non-CMI Adjusted Direct Care Per Patient Day Cost	The normalized direct care per patient day costs and the non-CMI adjusted direct care per patient day costs (C + F) for each provider are used for the percentile array. The allowable cost of the provider identified as the 85th percentile of the Medicaid day-weighted direct care component costs shall be selected as the statewide price for the two components, under subdivision (4).
I.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
J.	CMI Adjusted Direct Care Per Patient Day Cost Ceiling	Statewide Normalized Direct Care Price determined in H * I

K.	Total Direct Care Per Patient Day Ceiling	J + Statewide Non-CMI Adjusted Direct Care Price determined in H
L.	Allowable Profit	K * 0.05
M.	Direct Care Plus Profit Per Patient Day	G + L
N.	Direct Care Component	Lesser of K or M

Table D.2 - Direct Care Per Patient Day Cost for CMI Adjustment Calculation		
A.	Total Direct Care Costs for CMI Adjustment	Allowable direct care costs for CMI adjustment as described in the IMPRM
B.	Direct Care Costs for CMI Adjustment Pro Rata Employee Benefits	Allowable direct care salaries for CMI adjustment / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Table D.3 (G)
D.	Allowable Direct Care Costs for CMI Adjustment	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
F.	Direct Care Per Patient Day Cost for CMI Adjustment	D / E

Table D.3 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0, then D – C. If D – C ≥ 0, then 0.
F.	Patient Days	
G.	Excess Medical Equipment Rental Cost	E * F

Table D.4 - Non-CMI Adjusted Direct Care Per Patient Day Cost Calculation		
A.	Total Non-CMI Adjusted Direct Care Cost	Allowable non-CMI adjusted direct care costs as described in the IMPRM
B.	Non-CMI Adjusted Direct Care Pro Rata Employee Benefits	Allowable non-CMI adjusted direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Allowable Non-CMI Adjusted Direct Care Costs	A + B
D.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
E.	Non-CMI Adjusted Direct Care Per Patient Day Costs	C / D

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost, calculated as follows:

Table D.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in Table D.6 (L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient Days	
F.	Therapy Component	D / E

Table D.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in

		the IMPRM
B.	**Total Ancillary Revenue**	**Total Ancillary Revenue as described in the IMPRM**
C.	**Medicaid Utilization Ratio**	**A / B**
D.	**Direct Ancillary Cost from Medicaid Cost Report**	**Direct ancillary costs as described in the IMPRM**
E.	**Direct Ancillary Employee Benefits from Medicaid Cost Report**	**Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM**
F.	**Total Direct Ancillary Costs**	**D + E**
G.	**Medicaid Direct Ancillary Costs**	**C * F**
H.	**Medicaid Patient Days**	
I.	**Medicaid Direct Ancillary Costs Per Patient Day**	**G / H**
J.	**Patient Days**	
K.	**Allowable Direct Ancillary Costs**	**I * J**
L.	**Direct Ancillary Cost Adjustment**	**K – F**

The therapy direct ancillary adjustment calculation in Table D.6 is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This is a statewide price based component, calculated as follows:

Table D.7 - Indirect Care Component Calculation		
A.	**Total Indirect Cost**	**Allowable indirect care cost as described in the IMPRM**
B.	**Indirect Care Pro Rata Employee Benefits**	**Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM**
C.	**Indirect Ancillary Cost Adjustment (negative value)**	**Value as described in Table D.8 (L)**
D.	**Allowable Indirect Care Costs**	**A + B + C**
E.	**Patient Days or Minimum Occupancy**	**Patient days or 85% * bed days available, whichever is greater**
F.	**Indirect Care Per Patient Day Cost**	**D / E**
G.	**Determination of the Statewide Price for the Indirect Care Per Patient Day Cost**	**Indirect care per patient day costs (F) for each provider are used for the percentile array. The allowable cost of the provider identified at the specified percentile shall be selected as the statewide price under subdivision (4). The specified percentile shall be set each July 1 at the percentile of the Medicaid day-weighted indirect care component costs necessary to achieve the estimated aggregate prospective system spending equivalent to the estimated payments calculated in the legacy system under subsection (e).**
H.	**Indirect Care Component**	**G**

Table D.8 - Indirect Ancillary Cost Adjustment Calculation		
A.	**Total Ancillary Costs Per Medicare Cost Report**	**Ancillary costs per the Medicare cost report as described in the IMPRM**
B.	**Capital Costs Per Medicare Cost Report**	**Capital costs per the Medicare cost report as described in the IMPRM**
C.	**Ancillary Costs without Capital**	**A - B**
D.	**Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report**	**Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits). All costs are from the Medicare cost report as described by the IMPRM.**
E.	**Indirect Costs per Medicare Cost Report**	**C - D**
F.	**Indirect Costs as a Percentage of Direct Costs**	**E / D**
G.	**Indirect Care Component Adjustment**	**Value determined in Table D.6 (L) * F**
H.	**Total Indirect Care Costs Excluding Dietary**	**Table D.7 (A + B) – ((allowable dietary cost) +**

		(allowable dietary salaries / total allowable salaries * allowable employee benefits)). All costs are described by the IMPRM.
I.	Total Administrative Costs	Table D.9 (A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))
K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in Table D.10 (I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The indirect ancillary cost adjustment calculation in Table D.8 is performed by each ancillary cost center as described by the IMPRM. For providers not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), an adjustment resulting from the indirect ancillary cost adjustment shall not be made, and the provider shall be excluded from the administrative and indirect percentile calculation.

(D) Administrative component. This component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the selected Medicaid day-weighted percentile, calculated as follows:

Table D.9 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM
C.	Owner, Related Party, Management (ORPM) Compensation Limitation (negative value)	Value as determined in Table D.10 (I)
D.	Ancillary Adjustment (negative value)	Value as determined in Table D.8 (M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Patient Days or Minimum Occupancy	Patient days or 85% * bed days available, whichever is greater
G.	Administrative Per Patient Day Cost	E / F
H.	Determination of the Statewide Price for the Administrative Care Per Patient Day Cost	Administrative per patient day costs (G) calculated with uninflated working capital interest for each provider are used for the percentile array. The allowable cost of the provider identified as the 50th percentile of the Medicaid day-weighted administrative component costs shall be selected as the statewide price under subdivision (4).
I.	Administrative Component	H

Table D.10 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	
E.	ORPM Per Patient Day Cost	C / D
F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year.
G.	Excess ORPM Per Patient Day Cost	If F – E < 0, then F – E. If F – E ≥ 0, then 0.

H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This component is calculated using a fair rental value allowance statewide price and provider specific other capital costs, based on an overall cost limitation, calculated as follows:

Table D.11 - Capital Component Calculation		
A.	Capital Per Patient Day Cost	Value determined in Table D.12 (F)
B.	Median Capital Cost	The capital per patient day cost (A) for each provider is used in the median calculation. The capital per patient day cost of the median provider shall be selected under subdivision (5).
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-on	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0, then 0.
E.	Total Quality Score Percentage	Calculated using the scale provided in the quality program manual
F.	Allowed Profit Add-on	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table D.12 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM
C.	Fair Rental Value Allowance	Value as determined in Table D.13 (E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table D.13 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is used in the median calculation. The average historical cost of property per bed of the median provider shall be selected under subdivision (6).
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in subdivision (2)
E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables in subdivision (1) are based on the provider's allowable nursing facility costs, which are annualized to a full year cost report period, recognizing the provider's allowable costs as described in the IMPRM.

(3) The allowable rate component costs as identified in the tables in subdivision (1) shall be adjusted using the inflation factor. This inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the Medicaid patient day-weighted percentile as identified in the tables in subdivision (1) shall be calculated on a statewide basis each July 1 for the direct care, indirect care, and administrative components as follows:

(A) Providers are arrayed in ascending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables in subdivision (1), which include the impact of minimum occupancy adjustments, as applicable.

(B) Cumulative Medicaid patient days are calculated for each provider within the array, by adding that provider's Medicaid patient days to the total of the Medicaid patient days within the array for preceding providers.

(C) The percentage of total cumulative Medicaid patient days for each provider within the array is calculated by dividing their cumulative Medicaid patient days by total Medicaid patient days within the array.

(D) If no provider is exactly equal to the Medicaid day-weighted percentile, the provider within the array, whose percentage of total cumulative Medicaid patient days is equal to or immediately less than the rate component Medicaid day-weighted percentile, is selected as the allowable cost of the Medicaid patient day-weighted percentile.

(5) The allowable cost of the median patient day as identified in the tables in subdivision (1) shall be calculated on a statewide basis each July 1 for the capital component from the most recently desk reviewed or field audited cost report as follows:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs, as identified in the component calculations in the tables in subdivision (1), which include the impact of minimum occupancy adjustments, as applicable.

(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to the total of the patient days within the array for preceding providers.

(C) The median patient day within the array is calculated by dividing the cumulative patient days by two (2).

(D) The provider within the array, whose total cumulative patient days is equal to or immediately greater than the median patient day, is selected as the allowable cost of the median patient day.

(6) The average historical cost of property of the median bed in Table D.13 shall be calculated on a statewide basis for facilities not acquired through an operating lease arrangement each July 1 as follows:

(A) Land, building, 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 RSMeans Construction Index.

(B) Inflated land and building historical costs are added to equipment and other historical property costs, which are divided by beds, to calculate the average inflated historical costs of property per bed.

(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.

(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of the beds within the array for preceding providers.

(E) The median bed is calculated by dividing the total cumulative beds by two (2).

(F) The provider within the array, whose total cumulative beds is equal to or immediately greater than the median bed, is selected as the average inflated historical costs of property per bed median.

(7) Beginning July 1, 2024, after the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's CMI for Medicaid residents. If the facility has no Medicaid residents during a six (6) month period, the facility's average CMI for each resident shall be used instead of the CMI for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase. The CMI for Medicaid residents in each facility shall be:

(A) updated each January 1; and

(B) used to adjust the direct care component that becomes effective on the six (6) month period after the updated CMI for Medicaid residents.

In addition, each facility's total quality score shall be redetermined biannually based on the criteria in the quality program manual.

(8) The rate setting parameters and components used to calculate the annual rebase, except for the CMI for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in the Medicaid rate authorized under subdivision (7).

(9) Providers shall pay interest on overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set forth in IC 6-8.1-10-1(c). The interest shall:

(A) accrue from the date of the overpayment to the provider; and

(B) apply to the net outstanding overpayment during the periods in which that overpayment exists.

(10) Whenever the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes under the following requirements:

(A) For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted before January 31 preceding the July 1 annual rebase.

(B) For the January 1 biannual update, the notification of the licensed bed change shall be in writing and submitted before July 31 preceding the January 1 biannual update.

(C) For notifications received by the due date, the July 1 annual rebase and January 1 biannual rate shall be calculated using the new number of nursing facility licensed beds.

(e) The legacy system is as follows:

(1) The legacy system rate is calculated as the sum of the following:

(A) Direct care component. This component is calculated using provider specific costs based on an overall cost limitation, calculated as follows:

Table E.1 - Direct Care Component Calculation (Non-Children's Nursing Facilities)		
A.	Direct Care Per Patient Day Cost	Value as determined in Table E.3 (K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident, time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (A) for each provider is used in the median calculation. The direct care per patient day cost of the median provider shall be selected under subdivision (4).
G.	Profit Ceiling	(F * 110%) * D
H.	Tentative Profit Add-on	If G – E > 0, then 30% * (G – E). If G – E ≤ 0, then 0.
I.	Total Quality Score Percentage	Calculated using the scale provided in the quality program manual
J.	Allowed Profit Add-on	H * I
K.	Overall Profit Limit	F * 10%
L.	Medicaid Case Mix Adjusted Costs Plus Profit	E + Lesser of J or K
M.	Overall Rate Component Limit	(F * 120%) * D
N.	Direct Care Component	Lesser of L or M

Table E.2 - Direct Care Component Calculation (Children's Nursing Facilities Only)		
A.	Direct Care Per Patient Day Cost	Value as determined in Table E.3 (K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident, time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (A) for each provider is used in the median calculation. The direct care per patient day cost of the median provider shall be selected under subdivision (4).
G.	Profit Ceiling	(F * 110%) * D
H.	Profit Add-on	If G – E > 0, then 30% * (G – E). If G – E ≤ 0, then 0.
I.	Medicaid Case Mix Adjusted Costs Plus Profit	E + H

J.	Overall Rate Component Limit	(F * 120%) * D
K.	Direct Care Component	Lesser of I or J

Table E.3 - Direct Care Per Patient Day Cost Calculation		
A.	Total Direct Care Costs	Allowable direct care costs as described in the IMPRM
B.	Direct Care Pro Rata Employee Benefits	Allowable direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Table E.4 (G)
D.	Allowable Direct Care Costs	A + B + C
E.	Variable Direct Care Costs (75% of allowable direct care costs are considered variable)	D * 75%
F.	Patient Days	
G.	Variable Direct Care Costs Per Patient Day	E / F
H.	Fixed Direct Care Costs (25% of allowable direct care costs are considered fixed)	D * 25%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater.
		For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater.
J.	Fixed Direct Care Costs Per Patient Day	H / I
K.	Direct Care Per Patient Day Cost	G + J

Table E.4 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0, then D – C. If D – C ≥ 0, then 0.
F.	Patient Days	
G.	Excess Medicaid Equipment Rental Cost	E * F

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost, calculated as follows:

Table E.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in Table E.6 (L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient Days	
F.	Therapy Component	D / E

Table E.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in the IMPRM
B.	Total Ancillary Revenue	Total Ancillary Revenue as described in the IMPRM
C.	Medicaid Utilization Ratio	A / B
D.	Direct Ancillary Cost from Medicaid Cost Report	Direct ancillary costs as described in the IMPRM

E.	Direct Ancillary Employee Benefits from Medicaid Cost Report	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
F.	Total Direct Ancillary Costs	D + E
G.	Medicaid Direct Ancillary Costs	C * F
H.	Medicaid Patient Days	
I.	Medicaid Direct Ancillary Costs Per Patient Day	G / H
J.	Patient Days	
K.	Allowable Direct Ancillary Costs	I * J
L.	Direct Ancillary Cost Adjustment	K – F

The therapy direct ancillary adjustment calculation in Table E.6 is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This component is calculated using provider specific costs based on an overall cost limitation, calculated as follows:

Table E.7 - Indirect Care Component Calculation		
A.	Indirect Care Per Patient Day Cost	Value as determined in Table E.8 (K)
B.	Median Indirect Care Cost	The indirect care per patient day cost (A) for each provider is used in the median calculation. The indirect care per patient day cost of the median provider shall be selected under subdivision (4).
C.	Profit Ceiling	B * 105%
D.	Tentative Profit Add-on	If (C – A) > 0, then 60% * (C – A). If (C – A) ≤ 0, then 0.
E.	Total Quality Score Percentage	Calculated using the scale provided in the quality program manual
F.	Allowed Profit Add-on	D * E
G.	Indirect Care Cost Plus Profit	A + F
H.	Overall Rate Component Limit	B * 115%
I.	Indirect Care Component	Lesser of G or H

Table E.8 - Indirect Care Per Patient Day Cost		
A.	Total Indirect Cost	Allowable indirect care cost as described in the IMPRM
B.	Indirect Care Pro Rata Employee Benefits	Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Indirect Ancillary Adjustment (negative value)	Value as described in Table E.9 (L)
D.	Allowable Indirect Care Costs	A + B + C
E.	Variable Indirect Care Costs (63% of allowable indirect care costs are considered variable)	D * 63%
F.	Patient Days	
G.	Variable Indirect Care Costs Per Patient Day	E / F
H.	Fixed Indirect Care Costs (37% of allowable indirect care costs are considered fixed)	D * 37%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, actual patient days or 90% * bed days available, whichever is greater.
		For nursing facilities with less than 51 beds, actual patient days or 85% * bed days available, whichever is greater.
J.	Fixed Indirect Care Costs Per Patient Day	H / I
K.	Indirect Care Per Patient Day Cost	G + J

Table E.9 - Indirect Ancillary Cost Adjustment Calculation		
A.	Total Ancillary Costs Per Medicare Cost Report	Ancillary costs per the Medicare cost report as described in the IMPRM
B.	Capital Costs Per Medicare Cost Report	Capital costs per the Medicare cost report as described in the IMPRM

C.	Ancillary Costs without Capital	A - B
D.	Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report	Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits)
		All costs are from the Medicare cost report as described by the IMPRM.
E.	Indirect Costs per Medicare Cost Report	C - D
F.	Indirect Costs as a Percentage of Direct Costs	E / D
G.	Indirect Care Component Adjustment	Value determined in Table E.6 (L) * F
H.	Total Indirect Care Costs Excluding Dietary	Table E.7 (A + B) – ((allowable dietary cost) + (allowable dietary salaries / total allowable salaries * allowable employee benefits)). All costs are described by the IMPRM.
I.	Total Administrative Costs	Table E.10 (A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))
K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in Table E.11 (I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The indirect ancillary cost adjustment calculation in Table E.9 is performed by each ancillary cost center as described by the IMPRM. For providers not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), the following ratios shall be used instead of the Indirect Costs as a Percentage of Direct Costs (F) as described in Table E.9:

Physical Therapy	Speech Therapy	Occupational Therapy	Respiratory Therapy	X-Ray	Laboratory	Pharmacy
23.11%	28.84%	22.15%	5.49%	2.50%	2.75%	1.60%

(D) Administrative component. This component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the median, calculated as follows:

Table E.10 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM
C.	Owner, Related Party, Management Compensation Limit (negative value)	Value as determined in Table E.11 (I for applicable rate effective date)
D.	Ancillary Adjustment (negative value)	Value as determined in Table E.9 (M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Variable Administrative Costs (16% of allowable administrative costs are considered variable)	E * 16%
G.	Patient Days	
H.	Variable Administrative Costs Per Patient Day	F / G
I.	Fixed Administrative Costs (84% of allowable administrative costs are considered fixed)	E * 84%
J.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater.
		For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater.
K.	Fixed Administrative Costs Per Patient Day	I / J
L.	Administrative Per Patient Day Cost	H + K

M.	Determination of the Statewide Price for the Administrative Per Patient Day Cost	The administrative per patient day cost of the median provider calculated with uninflated working capital interest shall be selected under subdivision (4).
N.	Administrative Component	M

Table E.11 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	
E.	ORPM Per Patient Day Cost	C / D
F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year.
G.	Excess ORPM Per Patient Day Cost	If F – E < 0, then F – E. If F – E ≥ 0, then 0.
H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This component is calculated using a fair rental value allowance statewide price and provider specific other capital costs based on an overall cost limitation, calculated as follows:

Table E.12 - Capital Component Calculation		
A.	Capital Per Patient Day Cost	Value determined in Table E.13 (F)
B.	Median Capital Cost	The capital per patient day cost (A) for each provider is used in the median calculation. The capital per patient day cost of the median provider shall be selected under subdivision (4).
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-On	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0, then 0.
E.	Total Quality Score Percentage	Calculated using the scale provided in the quality program manual
F.	Allowed Profit Add-On	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table E.13 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM
C.	Fair Rental Value Allowance	Value as determined in Table E.14 (E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table E.14 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is used in the median calculation. The average historical cost of property per bed of the median provider shall be selected under subdivision (5).
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in subdivision (2)

E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables in subdivision (1) are based on the provider's allowable nursing facility costs, which are annualized to a full year cost report period recognizing the provider's allowable costs, as described in the IMPRM.

(3) The allowable rate component costs as identified in the tables in subdivision (1) shall be adjusted using the inflation factor. This inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the median patient day as identified in the tables in subdivision (1) shall be calculated on a statewide basis each July 1 for the direct care, indirect care, administrative, and capital component from the most recently desk reviewed or field audited cost report as follows:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs, as identified in the component calculations in the tables in subdivision (1), which include the impact of minimum occupancy adjustments, as applicable.

(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to the total of the patient days within the array for preceding providers.

(C) The median patient day within the array is calculated by dividing cumulative patient days by two (2).

(D) The provider within the array whose total cumulative patient days is equal to or immediately greater than the median patient day is selected as the allowable cost of the median patient day.

(5) The average historical cost of property of the median bed in Table E.14 shall be calculated on a statewide basis for facilities not acquired through an operating lease arrangement each July 1 as follows:

(A) Land, building, 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 RSMeans Construction Index.

(B) Inflated land and building historical costs are added to equipment and other historical property costs, which are divided by beds, to calculate the average inflated historical costs of property per bed.

(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.

(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of the beds within the array for preceding providers.

(E) The median bed is calculated by dividing the total cumulative beds by two (2).

(F) The provider within the array whose total cumulative beds is equal to or immediately greater than the median bed is selected as the average inflated historical costs of property per bed median.

(6) Until June 30, 2024, after the annual rebase, the direct care component of the Medicaid rate shall be adjusted quarterly to reflect changes in the provider's CMI for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average CMI for each resident shall be used instead of the CMI for Medicaid residents. This adjustment shall be effective the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rebase. The CMI for Medicaid residents in each facility shall be:

(A) updated each calendar quarter; and

(B) used to adjust the direct care component that becomes effective on the second calendar quarter after the updated CMI for Medicaid residents.

(7) Beginning July 1, 2024, after the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's CMI for Medicaid residents. If the facility has no Medicaid residents during a six (6) month period, the facility's average CMI for each resident shall be used instead of the CMI for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase. The CMI for Medicaid residents in each facility shall be:

(A) updated each January 1; and

(B) used to adjust the direct care component that becomes effective on the six (6) month period after the updated CMI for Medicaid residents.

In addition, each facility's total quality score shall be redetermined biannually based on the criteria in the quality program manual.

(8) The rate setting parameters and components used to calculate the annual rebase, except for the CMI for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in the Medicaid rate authorized under subdivision (6).

(9) For rates effective until June 30, 2024, retroactive payment or repayment shall be required if an audit verifies an underpayment or overpayment due to:

(A) an intentional misrepresentation;

(B) billing or payment errors;
(C) a misstatement of historical financial or statistical data; or
(D) resident assessment data that caused a lower or higher rate than would have been allowed had the data been true and accurate. On discovery that a provider has received overpayment of a Medicaid claim from the office, the provider shall 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.

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

(11) Until January 31, 2024, whenever the number of nursing facility beds licensed by IDOH is changed after the cost reporting period, the provider may request in writing, before the effective date of their next annual rebase, an additional rebase effective the first day of the calendar quarter on or after the date of the change in licensed beds. This additional rebase shall be determined using the rate setting parameters in effect at the provider's latest annual rebase, but 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.

(12) Beginning February 1, 2024, whenever the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes under the following requirements:
(A) For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted before January 31 preceding the July 1 rebase.
(B) For the January 1 biannual update, the notification of the licensed bed change shall be in writing and submitted before July 31 preceding the January 1 biannual update.
(C) For notifications received by the due date, the July 1 annual rebase and January 1 biannual rate shall be calculated using the new number of nursing facility licensed beds.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-6)

405 IAC 1-14.7-7 Additional reimbursement

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. 7. (a) For purposes of this section, "Schedule Z" refers to the special facility qualification report, which shall be completed by a provider requesting reimbursement for an SCU or a ventilator program, or both, as follows:

(1) Nursing facilities previously qualified as an SCU or a ventilator facility, or both, shall annually recertify that the facility is still in compliance with the requirements to continue to receive reimbursement. For annual recertifications, Schedule Z shall be completed based on a calendar year reporting period, January 1 through December 31, and submitted to the office not later than March 31 after the end of each calendar year.
(2) Nursing facilities that have developed an SCU or a ventilator program, or both, between October 1 and March 31 shall submit Schedule Z not later than March 31 to determine qualification and eligibility for reimbursement at the following July 1 rate effective date.
(3) Nursing facilities that have developed an SCU or a ventilator program, or both, between April 1 and September 30 shall submit Schedule Z not later than September 30 to determine qualification and eligibility for reimbursement at the following January 1 rate effective date.
(4) Nursing facilities that have discontinued an SCU or a ventilator program, or both, shall notify the office and indicate the date in which the program was discontinued.
(5) Nursing facilities that have developed an SCU or a ventilator program, or both, before December 31, 2023, may submit Schedule Z to determine qualification and eligibility for reimbursement beginning on the effective date of the submission, if the applicable criteria were met.

(b) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying ventilator program. Additional Medicaid reimbursement shall be made to those facilities at a rate of eighty dollars ($80) an eligible Medicaid resident day. The additional reimbursement shall:

(1) begin with the later of the effective date of the program, or the first day for residents considered ventilator- dependent under the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual) or its successor published by CMS; and

(2) remain in effect until the earlier of the first day the resident is no longer considered ventilator-dependent under the RAI Manual, or the program terminates.

(c) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying SCU program. The additional Medicaid reimbursement shall be made to the facilities at a rate of twelve dollars ($12) an eligible Medicaid Alzheimer's and dementia resident day in their SCU. The additional reimbursement shall:

(1) begin with the later of the effective date of the program, or the first day for residents diagnosed with Alzheimer's or dementia; and

(2) remain in effect until the earlier of the first day the resident no longer has a diagnosis of Alzheimer's or dementia, or the program terminates.

(d) The office shall increase Medicaid reimbursement to all nursing facilities for NEMT through an add-on in the amount of one dollar and twenty-one cents ($1.21) a Medicaid resident day.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-7)

405 IAC 1-14.7-8 Minimum data set

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. 8. (a) Nursing facilities are required to electronically transmit MDS resident assessments in a complete, accurate, and timely manner as prescribed in the MDS and Case Mix Index Supportive Documentation Manual. An extension of the electronic MDS assessment 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 is able to prove to the office circumstances preventing timely electronic transmission.

(b) If the office determines a nursing facility has a delinquent MDS resident assessment, the assessment shall be assigned the delinquent classification as prescribed in the MDS and Case Mix Index Supportive Documentation Manual.

(c) The office shall adjust or revise MDS data items that an MDS review determines are unsupported to reflect a resident's highest functioning level supported by the MDS and Case Mix Index Supportive Documentation Manual. Incorporation of adjustments or revisions may result in a reclassification of the resident under the resident classification system.

(d) For rates effective prior to June 30, 2024, after an MDS 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 is recalculated; and

(2) any payment adjustment is made.

(e) For rates effective beginning July 1, 2024, and after, the result of an MDS review shall be applied as prescribed in section 12 of this rule.

(f) CMIs are determined as prescribed in the MDS and Case Mix Index Supportive Documentation Manual for each resident to calculate the facility average CMI for all residents, as well as the facility average CMI for Medicaid residents.

(g) The office shall provide each nursing facility with the following:

(1) A preliminary CMI report.

(2) A final CMI report that shall be used to establish the facility average CMI, and the facility average CMI for Medicaid residents used in establishing the nursing facility's Medicaid rate.

(h) To determine the normalized allowable direct care costs from each facility's cost report, the office

shall determine each facility's CMI for all residents that corresponds to the cost reporting period under the MDS and Case Mix Index Supportive Documentation Manual.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-8)

405 IAC 1-14.7-9 Change of ownership or structure

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. 9. (a) The office shall be notified within thirty (30) days of a transaction affecting the following:
(1) Ownership (operational license).
(2) Property ownership.
(3) The lessor or lessee, or both.
(4) A management company.
(5) A change in control or structure (e.g., mergers, exchange of stock, etc.).
The provider shall submit a completed checklist of management representations concerning change in ownership (checklist) to the office within thirty (30) days after the date requested by the office. The completed checklist shall include the supporting documentation to fully explain the transaction. For providers with an outstanding checklist, a field audit or desk review shall not be performed on an affected cost report, nor shall the affected cost report be used to establish reimbursement rates, as prescribed by section 12 of this rule.

(b) For transactions prior to July 1, 2023, a cost report shall be filed for the first fiscal year end after the transaction date in which the provider has at least six (6) full calendar months of actual historical data. The provider shall submit the cost report by the date identified on a change of ownership letter.

(c) For transactions beginning July 1, 2023, the following shall apply:
(1) The office shall determine the nature of the transaction.
(2) If the nature of the transaction is determined to be one (1) of the following, the fiscal period shall be determined under subdivision (3):
(A) A change:
(i) in;
(ii) to; or
(iii) from;
the related party management company.
(B) A change in a privately owned or operated nursing facility's ownership (operational license), except when the seller or their related entity becomes the management company.
(3) The fiscal period shall be:
(A) from the beginning of the provider's required fiscal year through the day immediately preceding the transaction date; or
(B) from the transaction date through December 31.
(4) For a fiscal period identified in subdivision (3), a cost report shall be filed for the fiscal period that has at least six (6) full calendar months of actual historical data. The cost report is due not later than the last day of the fifth calendar month after the fiscal period, or thirty (30) days after notification by the office that the cost report shall be filed.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-9)

405 IAC 1-14.7-10 Related parties

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. 10. (a) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of not less than five percent (5%) in a 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. For purposes of this subsection, the following individuals are considered immediate family:

(1) Spouse.
(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.
(7) Anyone previously considered immediate family.

(b) Control exists where an individual or 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.

(c) Transactions between related parties are not considered to have arisen through arms length negotiations. Costs applicable to services, facilities, and supplies issued 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 arms 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 rebase effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that each condition in subsection (d) has been met. This representation shall include the percentage of business the provider transacts with related and nonrelated parties based on revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to prove the provider's charges for services, facilities, or supplies to related and nonrelated parties.

(d) The office may grant an exception when a related organization meets all 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 issued by the organization. Transactions with residents of nursing facilities owned, operated, or managed by the provider, or organizations related to the provider or a former provider or related entity currently serving as the management company or entity in a similar decision making capacity for a nonstate government owned (NSGO) provider shall not be considered an arms length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those commonly obtained by institutions, such as the provider, from other organizations and not a basic element of patient care ordinarily issued directly to patients by those institutions.
(4) For facilities other than NSGO nursing facilities, the organization provides the services, facilities, or supplies to other nonrelated party organizations. The charge to the provider shall be:
(A) in line with the charge for those 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 those services, facilities, or supplies.
(5) For NSGO nursing facilities, the organization issues the services, facilities, or supplies to organizations not related to the NSGO provider or a former provider or related entity currently serving 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 those 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 those services, facilities, or supplies.

(e) A related party exception shall be granted for any period, up to the maximum period of two (2) years.

(f) If a provider rents, leases, or purchases facilities or equipment from a related party property company, the historical cost to the related party, not to exceed fair market value, shall be used in computing the average historical cost of property of the median bed, except as described in this section for the sale of facilities between family members.

(g) If a sale of facilities between family members meets the following conditions, the cost basis of the facility shall be recognized for the purpose of computing the average historical cost of property of the median bed under this rule as a bona fide sale arising from an arms length transaction, based on the limitations of subsection (h):

(1) There is no current or previous spousal relationship between parties.

(2) The following individuals are considered family members:

(A) Natural parent, child, and sibling.

(B) Adopted child and adoptive parent.

(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.

(E) Grandparent and grandchild.

(F) Anyone previously considered a family member.

(3) The transfer is recognized and reported by each party as a sale for federal income tax purposes.

(4) The seller is not associated with the facility in any way after the sale other than as a passive creditor.

(5) The buyer is actively engaged in the operation of the facility after the sale, with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.

(6) The family sale exception has not been used during the previous eight (8) years on this facility.

(7) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.

(8) If any of the entities involved are corporations, they shall be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(h) To establish a historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal. The MAI appraisal is based on the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis for purposes of determining the average historical cost of property of the median bed shall be the lower of the historical cost basis of the buyer or the MAI appraisal of facilities and equipment.

(i) If a lease of facilities between family members under subsection (g) qualifies as a capitalized lease under the Statement of Financial Accountant Standards Number 13 as issued by the Financial Accounting Standards Board, the transaction shall be treated as a sale of facilities between family members for purposes of determining the average historical cost of property of the median bed.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-10)

405 IAC 1-14.7-11 Quality assessment fee

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15-21-3; IC 16-21; IC 16-28-15-7; IC 16-28-15-12; IC 23-2-4

Sec. 11. (a) Under IC 16-28-15, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility. The census days used in the calculation shall be based on the most recently completed desk reviewed or field audited cost report or the nursing facility census data collection form, and the organization type shall be determined based on the organization's type at the rate effective date being established. Unless otherwise specified, the rate used is calculated as follows:

(1) For 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) a non-Medicare day.

(2) For 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) a non-Medicare day.

(3) For 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) a non-Medicare day.

(4) For 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 days fewer than sixty-two thousand (62,000), sixteen dollars and thirty-seven cents ($16.37) a 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 meeting one (1) of the following:

(A) A continuing care retirement community registered with the securities commissioner as a continuing care retirement community on or before January 1, 2007, and 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, not less than twenty-five percent (25%) of which are provided under contracts requiring the payment of a minimum entrance fee of not less than twenty-five thousand dollars ($25,000).

(C) An organization registered under IC 23-2-4 before July 1, 2009, providing housing in an independent living unit for a religious order.

(D) A continuing care retirement community as defined 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 cost report.

(d) For nursing facilities 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 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) Contains 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 shall be received by the office not later than fifteen (15) days after the notice of the assessment is mailed.

On 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. If a timely response is not made by the office to the facility's reconsideration request, the request shall be considered denied and the provider may initiate an appeal under IC 4-21.5-3.

(f) An 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. This agreement shall set forth the amount of the assessment that

shall be paid in installments, and include provisions for the collection of interest. This interest shall not exceed the percentage set forth 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 related to the facility through common ownership or control.
(3) In another manner determined by the office.

(j) If a facility fails to:
(1) submit patient day information requested by the office to calculate the quality assessment fee; or
(2) 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 IDOH to initiate license revocation proceedings under IC 16-28-15-12.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-11)

405 IAC 1-14.7-12 Rate reductions and settlements

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. 12. (a) Rate reductions and corrective remedies shall be assessed on a per nursing facility basis.

(b) Reimbursement lost because of an imposed rate reduction or corrective remedy cannot be recovered by the provider.

(c) Rate reductions and corrective remedies may be addressed through a prospective rate calculation, retroactive reprocessing of claims, or settlement process.

(d) Beginning April 1, 2024, the following events shall result in a reduction of the Medicaid per diem rate:

(1)

Event	Event Due Date	Rate Reduction Amount
Cost Report Submission for Annual Rebase	15 to 45 calendar days after the end of the fifth month after the fiscal period	2% of the per diem rate in effect as of the event date
	46 or more calendar days after the end of the fifth month after the fiscal period	10% of the per diem rate in effect as of the event date

(2)

Event	Event Due Date	Rate Reduction Amount
Cost Report Submission Following a Change in Ownership	1 to 30 calendar days after the due date identified on the Change of Ownership Letter	1% of the per diem rate in effect as of the event date
	31 or more calendar days after the due date identified on the Change of Ownership Letter	5% of the per diem rate in effect as of the event date

(3)

Event	Event Due Date	Rate Reduction Amount
Prefield Information Request	1 to 30 calendar days after the due date identified on the Audit Notification Letter	2% of the per diem rate in effect as of the event date
	31 or more calendar days after the due date identified on the Audit Notification Letter	10% of the per diem rate in effect as of the event date

(4)

Event	Event Due Date	Rate Reduction Amount
Field Work – Follow-Up Letter (exception noted in subsection (e))	1 to 30 calendar days after the due date identified on the Follow-Up Letter	1% of the per diem rate in effect as of the event date
	31 or more calendar days after the due date identified on the Follow-Up Letter	5% of the per diem rate in effect as of the event date

(5)

Event	Event Due Date	Rate Reduction Amount
Change in Ownership Checklist Submission	1 to 30 calendar days from checklist request	1% of the per diem rate in effect as of the event date
	31 or more calendar days from checklist request	5% of the per diem rate in effect as of the event date

(6) The rate reduction for events in subdivisions (1), (2), and (3) shall begin January 1 of the subsequent year and end July 1 of the subsequent year. If a complete cost report or prefield information is not submitted by September 30 after the fiscal period, a review shall not be performed on the delinquent information nor shall the cost report be used to calculate biannual rates.

(7) The rate reduction for the event in subdivision (4) shall begin on the date described in the table in subdivision (8) and remain in effect until the biannual period after the effective date of the rate reduction. Information received forty-five (45) or more days after the event due date may not be accepted, and applicable adjustments shall be made. The rate reduction shall be effective for at least one (1) biannual period.

(8) Rate Reduction Beginning Date:

Event Due Date	Effective Date of Rate Reduction
January 1 – April 30 (Year 1)	July 1 (Year 1)
May 1 – October 31 (Year 1)	January 1 (Year 2)
November 1 – December 31 (Year 1)	July 1 (Year 2)

(9) The rate reduction for the event in subdivision (5) shall begin and end as described in the table in subdivision (10). The rate reduction shall continue until a completed checklist is submitted.

(10) Change of Ownership Checklist Rate Reduction:

Month Change of Ownership Checklist is Delinquent	Rate Reduction Beginning Date	Month Delinquent Checklist is Submitted	Rate Reduction End Date
January (Year 1)	July 1 (Year 1)	February (Year 1)	December 31 (Year 1)
February (Year 1)	July 1 (Year 1)	March (Year 1)	December 31 (Year 1)
March (Year 1)	July 1 (Year 1)	April (Year 1)	December 31 (Year 1)
April (Year 1)	July 1 (Year 1)	May (Year 1)	December 31 (Year 1)
May (Year 1)	January 1 (Year 2)	June (Year 1)	June 30 (Year 2)
June (Year 1)	January 1 (Year 2)	July (Year 1)	June 30 (Year 2)
July (Year 1)	January 1 (Year 2)	August (Year 1)	June 30 (Year 2)
August (Year 1)	January 1 (Year 2)	September (Year 1)	June 30 (Year 2)
September (Year 1)	January 1 (Year 2)	October (Year 1)	June 30 (Year 2)
October (Year 1)	January 1 (Year 2)	November (Year 1)	June 30 (Year 2)
November (Year 1)	July 1 (Year 2)	December (Year 1)	December 31 (Year 2)
December (Year 1)	July 1 (Year 2)	January (Year 2)	December 31 (Year 2)

(e) If a nursing facility cannot locate requested information in the field work – follow-up letter under subsection (d)(4), they shall supply a signed declaration, prescribed by the office, that they are unable to produce the requested documentation. This declaration shall be submitted at least one (1) day before the due date on the field work – follow-up letter to avoid the rate reduction.

(f) Until March 31, 2024, a rate reduction shall be assessed as follows:

(1) Failure to submit a complete cost report as described in section 3 of this rule in the period required shall result in the following actions:

(A) When a complete cost report is more than one (1) calendar month past due, the following shall apply:

(i) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%),

effective the first day of the seventh month after the provider's fiscal year end.

(ii) The reduced rate shall remain in effect until the first day of the month after the delinquent complete cost report is received by the office.

(iii) Rate adjustments shall not be allowed until the first day of the calendar quarter after receipt of the delinquent complete cost report.

(iv) A desk review or field audit shall not be performed on incomplete submissions.

(B) If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the provider fails to submit its Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, the following shall apply:

(i) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective the first day of the month after the due date, as extended by the Medicare fiscal intermediary.

(ii) The reduced rate shall remain in effect until the first day of the month after the delinquent Medicare cost report is received by the office.

(iii) Rate adjustments shall not be allowed until the first day of the calendar quarter after receipt of the delinquent complete cost report.

(iv) A desk review or field audit shall not be performed on incomplete submissions.

(2) Failure to submit a completed checklist of management representations concerning change in ownership (checklist) to the office within ninety (90) days after the date the checklist request is sent to the provider shall result in the following actions:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective the first day of the month after the end of the ninety (90) day period.

(B) The reduced rate shall remain in effect until the first day of the month after the completed checklist is received by the office.

(C) A desk review or field audit shall not be performed until the completed checklist is received and reviewed.

(3) If the required prefield information has not been submitted by the due date indicated in the audit notification letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective the first day after the date the response was due.

(B) The reduced rate shall remain in effect until:

(i) the first day after the office's receipt of a complete response; or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) Rate adjustments shall not be allowed until the first day of the calendar quarter after:

(i) receipt of the information requested in the written notice; or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(4) If the required field work information has not been submitted by the due date indicated in the field work – follow-up letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective the first day after the date the response was due.

(B) The reduced rate shall remain in effect until:

(i) the first day after the office's receipt of a complete response; or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) Rate adjustments shall not be allowed until the first day of the calendar quarter after:

(i) receipt of the information requested in the written notice; or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(5) If the documentation submitted for the field audit is inadequate or incomplete, or the ten percent (10%) reduction has expired, the following additional actions shall be taken:

(A) Appropriate adjustments to the applicable cost report shall be made.

(B) The office shall document the adjustments in a finalized exception report.

(C) The office shall incorporate the adjustments in the prospective rate calculations.

(g) If the office determines, due to an MDS review, a nursing facility has unsupported MDS resident assessments, the following procedures shall be followed in applying a corrective remedy:

(1) The office shall:

(A) 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:

(A) greater than twenty percent (20%), the office shall expand to a larger sample of resident assessments; or

(B) equal to or less than twenty percent (20%), the office shall conclude the field portion of the MDS review.

(3) For rates effective beginning July 1, 2024, and later, a corrective remedy for unsupported MDS resident assessments shall be calculated as follows:

(A) If the percentage of unsupported assessments for the initial and expanded sample of the assessments reviewed is greater than twenty percent (20%), a corrective remedy shall be applied. The corrective remedy shall be calculated as the administrative component portion of the legacy system Medicaid rate in effect for the current biannual period, multiplied by the applicable percentage as shown in the following table, and applied to the aggregate rate:

MDS Field Review for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS Review	7.5%
Second consecutive MDS Review	10%
Third consecutive MDS Review	15%
Fourth or more consecutive MDS Review or Reviews	25%

(B) Shall be applied as follows:

MDS Review Exit Date*	Administrative Component Corrective Remedy Implementation Date*
April 1, 2024 – September 30, 2024	January 1, 2025
October 1, 2024 – March 31, 2025	July 1, 2025
*And each year thereafter	

(C) If a corrective remedy is imposed, for purposes of determining the average allowable cost of the patient day for the administrative component, an adjustment shall not be made by the office to the provider's allowable administrative costs.

(D) After completing an MDS review, the office shall recalculate the facility's Medicaid CMI. If the recalculated Medicaid CMI results in a change from the originally calculated Medicaid CMI, the value of the Medicaid CMI change shall be incorporated into a prospective reimbursement rate calculation as follows:

MDS Period Under Review**	MDS Change Implementation Date**
March 1, 2024 – August 31, 2024	July 1, 2025
September 1, 2024 – February 28*, 2025	January 1, 2026
*February 29 in Leap Years	
**And each year thereafter	

(4) For rates effective prior to June 30, 2024, if the percentage of unsupported assessments for the initial and expanded sample of the assessments reviewed is greater than twenty percent (20%), a corrective remedy shall apply, calculated as follows:

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

MDS Field Review for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS Review	15%
Second consecutive MDS Review	20%
Third consecutive MDS Review	30%
Fourth or more consecutive MDS Review or Reviews	50%

(B) If a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, an adjustment shall not be made by the office to the provider's allowable administrative costs.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-12)

405 IAC 1-14.7-13 Administrative reconsideration and appeal process

Authority: IC 12-15-1-10; IC 12-15-21-3
Affected: IC 4-21.5-3-2; IC 12-13-7-3; IC 12-15-13-4

Sec. 13. (a) A reconsideration request shall be in writing, and contain specific issues to be considered and the rationale for the provider's position. The provider shall timely request administrative reconsideration before filing an appeal. The events detailed in subdivisions (1) through (4) shall be communicated to nursing facilities through a formal letter, either through United States mail or a secure web portal, which begins the period for a timely request. The events are as follows:

(1) Schedule of adjustments or a summary of findings resulting from a review performed under section 4 of this rule.

(2) CMI quarterly or biannual updates, or a recalculation of CMIs due to an MDS review.

(3) The parameters used to calculate an issued rate other than the schedule of adjustments in subdivision (1) and CMIs in subdivision (2).

(4) Rate reductions or corrective remedies under section 12 of this rule.

The request shall be signed by the provider or authorized representative of the provider, and shall be received by the office not later than fifteen (15) days after the date of issuance. The office shall evaluate the reconsideration request and may affirm or amend the original decision. The office shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days after the office's receipt of the request for reconsideration. If a timely response is not made by the office to the provider's reconsideration request, the request shall be considered denied and the provider may pursue its administrative remedies under subsection (c).

(b) Under IC 4-21.5-3-2(e), for a notification letter served through United States mail, the fifteen (15) day reconsideration period begins three (3) days after the date of the notification letter.

(c) After completion of the reconsideration procedure under subsection (a), the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal shall be signed by the nursing facility provider. Only issues raised by the provider through administrative reconsideration may be later raised in an appeal.

(d) The office may take action to implement changes made under subsection (a) before the outcome of an appeal filed under subsection (c).

(e) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, before the outcome of the administrative appeal process as prescribed by IC 12-15-13-4(e).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.7-13)

SECTION 2. 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. **(a)** Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit minimum data set (MDS) information for ~~all~~ **each** nursing facility ~~residents~~ **resident** to the office. ~~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.

(b) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit the end of therapy date for physical, occupational, and speech therapy services provided to a resident in a format specified by the office.

(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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA; readopted filed May 30, 2023, 11:54 a.m.: 20230628-IR-405230292RFA)

SECTION 3. 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~~ **pay** for resources needed to serve different types of residents.

(c) "End of therapy date" means the date each therapy regimen ended for physical, occupational, or speech therapy, which is the last date the resident received the therapy treatment.

~~(c)~~ **(d)** "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~~
(1) in the facilities;
(2) between facilities; and
(3) between facilities and outside agencies.
The Indiana system ~~will employ~~ **shall use** the MDS 3.0 or ~~subsequent~~ **later** revisions as approved by CMS.

(e) "Resident classification system" means the classification system used to classify residents into groups to determine reimbursement levels, as supported by the MDS and Case Mix Index Supportive Documentation Manual.

(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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA; readopted filed May 30, 2023, 11:54 a.m.: 20230628-IR-405230292RFA)

SECTION 4. 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 requirements for ~~all~~ **the** MDS data elements ~~that are utilized~~ **used** to classify nursing facility residents ~~in accordance with~~ **under** the ~~RUG-IV~~ resident classification system ~~The requirements shall be~~ **are contained in the MDS and Case Mix Supportive Documentation Manual. Additional guidance may be** published as a provider bulletin and ~~may be~~ updated by the office as needed. ~~Any such~~ Updates shall be made effective ~~no~~ **not** earlier than permitted under IC 12-15-13-6(a).

(b) Nursing facilities shall maintain supporting documentation in ~~the~~ **a** resident's medical chart for ~~all~~ **the** MDS data elements ~~that are utilized~~ **used** to classify nursing facility residents ~~in accordance with~~ **under** the ~~RUG-IV~~ resident classification system. ~~Such~~ **This** supporting documentation shall be maintained by the nursing facility for ~~all~~ **its** residents in a ~~manner~~ **way** that ~~is accessible~~ **allows availability** and ~~conducive to~~ **ease of access for** 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; filed Oct

13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA; readopted filed May 30, 2023, 11:54 a.m.: 20230628-IR-405230292RFA)

SECTION 5. 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 review the MDS **assessments and** supporting documentation **data** maintained by **a** nursing ~~facilities~~ **facility** for ~~all~~ **its** residents, regardless of payer type. The reviews shall be conducted as frequently as ~~deemed~~ **considered** necessary by the office, and each nursing facility shall be reviewed ~~no~~ **not** 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~~ **the** MDS reviews, except for follow-up reviews ~~that are~~ intended to ensure compliance with validation improvement plans. ~~Advance notification for follow-up reviews shall not be required.~~

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

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

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

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments **data** have been transmitted, shall be referred to the ~~IMFCU~~ **Indiana Medicaid fraud control unit** for investigation of possible fraud. ~~Such an~~ **This** investigation ~~could~~ **may** 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; filed Oct 13, 2017, 12:09 p.m.: 20171108-IR-405160327FRA; readopted filed May 30, 2023, 11:54 a.m.: 20230628-IR-405230292RFA)

SECTION 6. 405 IAC 1-14.6 IS REPEALED.

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