TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

ARTICLE 1. MEDICAID PROVIDERS AND SERVICES

Rule 1. General Provisions

405 IAC 1-1-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-6-10; IC 12-13-7-3; IC 12-15; IC 16-19; IC 16-21; IC 16-28; IC 16-29-4-2

Sec. 1. (a) The definitions in this section apply throughout this article.

(b) "Attending physician" means a physician who is responsible for developing and maintaining the plan of care for a Medicaid patient.

(c) "CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the United States Department of Health and Human Services.

(d) "CRF/DD" or "CRFs/DD" means a community residential facility or facilities for the developmentally disabled.

(e) "CRMNF" means a comprehensive rehabilitative management needs facility as defined in 460 IAC 9-1-2.

(f) "ICF/IID" or "ICFs/IID" means an institution or institutions for individuals with intellectual disabilities, as described in IC 16-29-4-2, or a medical institution or that portion thereof providing such care, which is qualified as such an institution pursuant to the provisions of Title XIX of the Social Security Act.

(g) "IMFCU" means the Medicaid fraud control unit established by the Indiana attorney general under the authority of IC 4-6-10 et seq.

(h) "ISDH" means the Indiana state department of health as defined in IC 16-19.

(i) "Medicaid" means that program described by IC 12-15 and this title, in which the office administers benefits and makes payments to providers for covered services provided to members.

(j) "Member" means an individual who has been determined by the office to be eligible for payment of covered services pursuant to IC 12-15.

(k) "Nursing facility" means a comprehensive care facility licensed under IC 16-28, or a hospital based long term care facility licensed under IC 16-21 and enrolled as a Medicaid provider.

(l) "Nursing facility services" has the meaning set forth in 405 IAC 5-31-1.1.

(m) "Office" means the Indiana family and social services administration and its offices, divisions, or designees.

(n) "Parameter" means the maximum amount or duration, or both, of a service within appropriate limits for which payment may be made without prior authorization or exception due to medical necessity or contraindications.

(o) "Prior authorization" has the meaning set forth in 405 IAC 5-2-20.

(p) "Provider" means an individual, state agency, local agency, corporate entity, or business entity that has been enrolled in Medicaid pursuant to 405 IAC 5-4.

(q) "Provider manual" means the interpretive document or documents issued by the office to providers to inform them of their obligations under Medicaid to which they must conform to retain their provider status and receive payment for appropriate services, and to provide them essential information for understanding Medicaid as it relates to the services for which they are qualified to provide under the state statutes.

(r) "Third party" means an insurer, individual, institution, corporation, or public or private agency who is or may be liable to pay all or part of the medical costs of injury, disease, or disability of an applicant or recipient of Medicaid.

(s) "Usual and customary charge" means the amount a provider offers to charge the general public for a service or supply, including applicable offered discounts. General public does not include individuals who are enrolled in or a member of an insurance plan that covers the services or supplies in question, or receive a discount of the services or supplies through a program with selective criteria that disqualify certain individuals from eligibility in the program. *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-101; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 248; filed Sep 29, 1982, 3:19 p.m.: 5 IR 2321; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1856; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA) NOTE: Transferred from the Division of Family and Children (470 IAC*

5-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-2 Choice of provider and use of Medicaid card

Authority: IC 12-13; IC 12-15
Affected: IC 12-13-2-3; IC 12-13-7-3; IC 12-15-12; IC 12-15-28-1

Sec. 2. (a) The member shall have free choice of providers for services provided in the state of Indiana and for services provided outside the state on an emergency basis, except as provided in subsections (b) and (c). Services to be provided outside the state, except for those out-of-state areas that have been designated by the office, which are not of an emergency nature, require prior authorization of the office.

(b) If a member is participating in a managed care program, the member shall select a managed care provider who is responsible for coordinating the member's health care needs. If a member fails to select a managed care provider within a reasonable time after being furnished a list of managed care providers by the office, the office shall assign a managed care provider to the member. A Medicaid member may not receive services from a provider other than the designated managed care provider except in the following cases:

(1) Medical emergencies.

(2) Where the managed care provider has authorized referral services in writing.

(3) Where specific services are excluded from coverage under the managed care program.

(4) Where specific services covered under the managed care program can be accessed through self-referral by members, as designated in IC 12-15-12 et seq.

(c) In the event that the office determines that a Medicaid member has utilized any Medicaid coverage service or supply at a frequency or amount not medically necessary, the office may restrict the benefits available to the Medicaid member for a period of two (2) years by noting any restrictions on the face of the member's Medicaid card. The office may restrict the Medicaid member's benefits by:

(1) requiring that the member only receive benefits from the provider or providers noted on the Medicaid card, except as specifically approved in advance by the office; or

(2) prohibiting the member from receiving:

(A) any specific services noted on the card; or

(B) services from any specific provider or providers noted on the card.

(d) Not later than two (2) years after a Medicaid member's benefits have been restricted, the office will review the Medicaid member's case and continue the Medicaid member's restricted benefits if review of documented services indicates continued misutilization of Medicaid coverage services or supplies. The continued period of restriction will again be for a period of two (2) years, after which the Medicaid member's case will be reviewed and the restriction may again be renewed.

(e) A Medicaid member affected by the initial restriction under subsection (c) or continued restriction of benefits under subsection (d) may appeal the restrictions. Member appeal rights shall be those provided for in 42 CFR as required by IC 12-15-28-1, and the notice and hearing will be in accordance with the requirements of 42 CFR 431.200 et seq. and 405 IAC 1.1-1-3.

(f) Before providing any Medicaid covered service, each provider shall check the Medicaid card of the individual for whom the provider is performing the service. Failure to do so shall result in denial of the provider's claim if the individual is not eligible or the service is not authorized. In checking the Medicaid card, the provider must determine all of the following:

(1) The Medicaid card is valid for the month in which the service is being provided.

(2) The individual whose name appears on the Medicaid card is the same individual for whom the service is being performed.

(3) No restriction or restrictions appearing on the Medicaid card would prohibit the provider from performing the requested service.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-102; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 249; filed Oct 7, 1982, 3:50 p.m.: 5 IR 2344; filed May 22, 1987, 12:45 p.m.: 10 IR 2280, eff Jul 1, 1987; filed Aug 22, 1994, 10:00 a.m.: 18 IR 86; 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 4, 2011, 3:59 p.m.: 20111130-IR-405110318FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44

p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-3 Filing of claims; filing date; waiver of limit; claim auditing; payment liability; third party payments

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

Sec. 3. (a) All provider claims for payment for services rendered to members must be originally filed with the office within twelve (12) months of the date of the provision of the service. A provider who is dissatisfied with the amount of reimbursement may appeal under the provisions of 405 IAC 1-1.5. However, prior to filing such an appeal, the provider must either:

(1) resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;

(2) submit, if appropriate, an adjustment request to the office; or

(3) submit a written request to the office, stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments or reconsideration, or both, of a claim that has been denied must be submitted to the office within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the office. All claims filed after twelve (12) months of the date of the provision of the service, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted. In extenuating circumstances a waiver of the filing limit may be authorized by the office when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit. Some examples of situations considered to be extenuating circumstances are:

(1) office error or action that has delayed payment;

(2) reasonable and continuous attempts on the part of the provider to resolve a claim problem;

(3) reasonable and continuous attempts on the part of the provider to first bill and collect from a third party liability source before billing Medicaid; or

(4) failure of Medicare/Medicaid claims to cross over.

(c) The fact that the provider was unaware the member was eligible for assistance at the time services were rendered is an acceptable reason for waiving the filing limitation only if the following conditions are met:

(1) The provider's records document that the member refused or was physically unable to provide the member's Medicaid number.

(2) The provider can substantiate that the provider continually pursued reimbursement from the patient until such time Medicaid eligibility was discovered.

(3) The provider billed Medicaid, or otherwise contacted Medicaid in writing regarding the situation within sixty (60) days of the date Medicaid eligibility was discovered.

In situations in which a patient receives a Medicaid covered service and is subsequently determined to be eligible, a waiver of the filing limit, where necessary, may be granted if the provider bills Medicaid within one (1) year of the date of the retroactive eligibility determination. In situations where a member receives a service outside Indiana by a provider who has not yet been enrolled or has not received a provider manual at the time services were rendered, the claims filing limitation may be waived, subject to approval by the office. Such situations will be reviewed on an individual basis by the office to ascertain if the provider made a good faith effort to enroll and submit claims in a timely manner.

(d) All claims filed for reimbursement shall be reviewed prior to payment by the office for completeness, including required documentation, appropriateness of services and charges, application of third party obligations, statement of prior authorization when required, and other areas of accuracy and appropriateness as indicated.

(e) Medicaid is only liable for the payment of claims filed by providers who were enrolled providers at the time the service was rendered and for services provided to persons who were enrolled in Medicaid as eligible members at the time service was provided. Payment may be made for services rendered during any one (1) or all of the three (3) months preceding the month of Medicaid application if the patient is found to be eligible during such period. Non-enrolled providers giving the retroactive service

must file a provider application retroactive to the beginning date of eligible service and meet provider enrollment requirements during the retroactive period. A claim for services which requires prior authorization by the office provided during the retroactive period will not be paid unless such services have been reviewed and approved by the office prior to payment. The claim will not be paid if the services provided are outside the service parameters as established by the office.

(f) Third party payment is as follows:

(1) Resources from health insurance plans available to the member shall apply first to defraying the cost of medical services before any share of the Medicaid claim for payment is approved. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services (CHAMPUS), other health insurances, and Worker's Compensation. A provider of services to a member shall not submit a claim for reimbursement by Medicaid until the provider has first ascertained whether any such resource may be liable for all or part of the cost of the services and has sought reimbursement from that resource. With approval of the office, a Medicaid claim may be paid prior to third party payment when the liability of the third party is yet to be determined through court proceedings, such as in paternity cases, or when the third party payment will not be available for an extended period of time, with recoupment by the office required when such third party resources become available.

(2) Third party payments applied to the member's cost of care shall be deducted from the total payment allowable from Medicaid, with Medicaid paying only the balance. Reimbursement rates are determined by the office according to the requirements of federal and state laws governing rate setting for Medicaid services and shall be accepted as party payor.

(g) No Medicaid reimbursement shall be available for services provided to individuals who are not eligible Medicaid members on the date the service is provided.

(h) No Medicaid reimbursement shall be available for services provided outside the parameters of a restricted status (see section 6 of this rule).

(i) A Medicaid provider shall not collect from a Medicaid member or from the family of the Medicaid member any portion of the charge for a Medicaid covered service which is not reimbursed by Medicaid except for copayment and any patient liability payment as authorized by law. (See 42 CFR 447.15.) *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-103; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 250; filed Oct 7, 1982, 3:54 p.m.: 5 IR 2345; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1857; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2850; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-3.1 Providing services to members enrolled under the Medicaid spend-down provision

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

Sec. 1. (a) This section applies to a Medicaid-participating provider furnishing services to an individual enrolled in Medicaid under the spend-down provision set out at 405 IAC 2-3-10.

(b) A provider must submit a claim to Medicaid for any service for which Medicaid reimbursement may be available under 405 IAC 5. Such services include services provided in excess of Medicaid benefit limitations. The provider must comply with any prior authorization requirements applicable to the service.

(c) Except for applicable copayments, a provider may not bill a Medicaid member for any part of the provider's charge for a service billed to Medicaid until:

(1) Medicaid has adjudicated the provider's claim for the service; and

(2) the provider has been notified of the portion of the claim that was credited to the Medicaid member's monthly spend-down obligation.

The provider may bill the member for the amount that was credited toward the member's spend-down as well as any unpaid copayment amount due.

(d) A provider may not refuse service to a Medicaid member pending verification that the member's monthly spend-down obligation has been satisfied. A provider may not refuse service to a Medicaid member solely on the basis of the member's spend-

down status. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-3.1; filed Jul 18, 2005, 1:00 p.m.: 28 IR 3579; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-1-4 Denial of claim payment; basis; discretion of assistant secretary

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

Sec. 4. (a) The office of Medicaid policy and planning (office) may deny payment, or instruct the fiscal contractor to deny payment, to any provider for medical assistance services rendered, including materials furnished to any individual or claimed to be rendered or furnished to any individual, if, after investigation by the office, the office's designee, the Indiana Medicaid Fraud Control Unit (IMFCU), or other governmental authority, the office finds any of the following:

(1) The services claimed cannot be documented by the provider in accordance with 405 IAC 1-5-1.

(2) The claims were made for services or materials determined by licensed medical staff of the office, the office's designee, the IMFCU, or other governmental authority as not medically reasonable and necessary.

(3) The amount claimed for such services or materials has been or can be paid from other sources.

(4) The services claimed were provided to a person other than a person in whose name the claim is made.

(5) The services claimed were provided to a person who was not eligible for medical assistance at the time of the provision of the service.

(6) The claim for medical assistance services or materials arises out of any of the following acts or practices:

(A) Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise.

(B) Submitting, or causing to be submitted, information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(C) Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

(D) Failure to disclose, or make available to the office, or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefor.

(E) Engaging in a course of conduct or performing an act deemed by the office to be improper or abusive of the Medicaid program or continuing such conduct following notification that the conduct should cease.

(F) Breach of the terms of the Medicaid Provider Certification Agreement or failure to comply with the terms of the Provider Certification on the Medicaid Claim Form.

(G) Overutilizing the Medicaid program by furnishing, or otherwise causing a recipient to receive, service(s) or merchandise not otherwise required or requested by the recipient.

(H) Violating any provision of state or federal Medicaid law or any rule or regulation promulgated pursuant thereto.

(I) Submission of a false or fraudulent application for provider status.

(J) Failure to meet standards required by the state of Indiana or federal law for participating in the Medicaid program.

(K) Charging a Medicaid recipient for covered services over and above that paid for by the office.

(L) Refusal to execute a new Provider Certification Agreement when requested by the office or its fiscal contractor to do so.

(M) Failure to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.

(N) Failure to repay within sixty (60) days or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments, except as provided in IC 12-15-13-3 *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*.

(O) Presenting claims for which federal financial participation is not available.

(7) The claim arises out of any act or practice prohibited by rules and regulations of the office.

(8) The provider, any person with an ownership or control interest in the provider entity, or a managing employee is convicted of a criminal offense related to the provision of medical assistance services or submission of claims for payment for such services.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the assistant secretary of the office or his duly authorized representative. This decision shall be final and:

(1) will be mailed to the provider by United States mail at the address contained in the office records and on the claims or transmitted electronically if the provider has elected to receive electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed under section 3 of this rule.

(c) The decision as to claim payment suspension is at the discretion of the assistant secretary of the office, or his duly authorized representative, and may include any of the following:

(1) The denial of payment for all claims that have been submitted by the provider pending further investigation by the office, the office's designee, the IMFCU, or other governmental authority.

(2) The suspension or withholding of payment on any or all claims of the provider pending an audit or further investigation by the office, the office's designee, the IMFCU, or other governmental authority.

(d) The decision of the assistant secretary or his duly authorized representative under subsection (c) shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) contain a brief description of the decision;

(3) become final fifteen (15) days after its receipt; and

(4) contain a statement that any appeal from the decision shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(e) If an emergency exists, as determined by the office, the assistant secretary or his duly authorized representative may issue an emergency directive suspending or withholding payment on any or all claims of the provider pending further investigation by the office, the office's designee, the IMFCU, or other governmental authority under IC 4-21.5-4. Any order issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) become effective upon receipt;

(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and

(4) contain a statement that any appeal from the decision of the assistant secretary made under this subsection shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-103.1; filed Jun 19, 1979, 2:16 p.m.: 2 IR 1123; filed Sep 29, 1982, 3:14 p.m.: 5 IR 2346; filed Dec 22, 1995, 2:15 p.m.: 19 IR 1074; errata filed Feb 12, 1996, 10:45 a.m.: 19 IR 1373; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3369; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3.5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-4) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-5 Overpayments made to providers; recovery

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-6-10; IC 4-21.5-3; IC 12-15-1; IC 12-15-6-5; IC 12-15-23-2

Sec. 5. (a) Under IC 12-15-21-3(5) and IC 12-15-21-3(7), the office of Medicaid policy and planning (office) may recover payment, or instruct the fiscal contractor to recover payment, from any Medicaid provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:

(1) the services paid for cannot be documented by the provider as required by 405 IAC 1-5-1;

(2) the amount paid for such services has been or can be paid from other sources;

(3) the services were provided to a person other than the person in whose name the claim was made and paid;

(4) the service reimbursed was provided to a person who was not eligible for medical assistance at the time of the provision of the service;

(5) the paid claim arises out of any act or practice prohibited by law or by rules of the office;

(6) overpayment resulted from:

(A) an inaccurate description of services or an inaccurate usage of procedure codes;

(B) the provider's itemization of services rather than submission of one (1) billing for a related group of services provided to a recipient (global billing) as set out in the office's medical policy;

(C) duplicate billing; or

(D) claims for services or materials determined to have been not medically reasonable or necessary; or

(7) overpayment to the provider resulted from any other reason not specified in this subsection.

(b) Under IC 12-15-21-3(5), the office may determine the amount of overcharges made by a Medicaid provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana Medicaid program. The following criteria apply to random sample audits:

(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.

(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must:

(A) be completed within one hundred eighty (180) days of the date of appeal; and

(B) demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law.

The provider must submit supporting documentation to demonstrate this compliance.

(d) If the office determines that an overcharge has occurred, the office shall notify the provider by certified mail. The notice shall include a demand that the provider reimburse the office, within sixty (60) days of the provider's receipt of the notification, for any overcharges determined by the office. A provider who receives a notice and request for repayment may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office and not repay the alleged overpayment, except as provided in subsection (e).

(e) If:

(1) a provider elects to proceed under subsection (d)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;

the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(f) Under IC 12-15-23-2, the office may enter into an agreement with the provider regarding the repayment of any overpayment made to the provider. Such agreement shall state that the amount of overpayment shall be deducted from subsequent payments to the provider. Such subsequent payment deduction shall not exceed a period of six (6) months from the date of the agreement. The repayment agreement shall include provisions for the collection of interest on the amount of the overpayment. Such interest shall not exceed the percentage as set out in IC 12-15-13-3(e)(1) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*.

(g) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the percentage set out in IC 12-15-13-3(e)(1) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*. Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. Under IC 12-15-21-3(6), the interest shall:

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

(2) apply to the net outstanding overpayment during the periods in which such overpayment exists.

When an overpayment is determined pursuant to the results of a random sample audit, the date the overpayment occurred shall

be considered to be the last day of the audit period and interest will be calculated from the last day of the audit period.

(h) If the office recovers an overpayment to a provider that is subsequently found not to have been owing to the office, either in whole or in part, then the office will pay to the provider interest on the amount erroneously recovered from the provider. Such interest will accrue:

(1) from the date that the overpayment was recovered by the office until the date the overpayment is restored to the provider; and

(2) at the rate of interest set out in IC 12-15-13-3(e)(2) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*.

Also, for hospitals that receive a notice that the provider has been underpaid by the office as a result of the cost settlement process, the office will pay interest to the hospital on the amount of the underpayment, consistent with 405 IAC 1-1.5-5(c). The office will not pay interest to a provider under any other circumstances except under the condition described in this subsection.

(i) If, after receiving a notice and request for repayment, the provider fails to elect one (1) of the options listed in subsection (d) within sixty (60) days, and the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, then the administrator shall immediately certify the facts of the case to the Indiana Medicaid fraud control unit established under IC 4-6-10.

(j) If, at any time after the discovery of the overpayment, the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, the administrator shall immediately certify the facts of the case to the Indiana Medicaid fraud control unit established under IC 4-6-10.

(k) Nothing in this section shall be construed to preclude the office from revising a provider's rate of reimbursement under 405 IAC 1-12, 405 IAC 1-14.5, or 405 IAC 1-14.6 as a result of an audit. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-5; filed Sep 23, 1982, 10:05 a.m.: 5 IR 2347; filed Mar 14, 1986, 4:35 p.m.: 9 IR 1859; filed May 22, 1987, 12:45 p.m.: 10 IR 2281, eff Jul 1, 1987; filed Jul 29, 1992, 10:00 a.m.: 15 IR 2567; filed Apr 4, 1995, 10:45 a.m.: 18 IR 2024; errata filed May 17, 1995, 8:10 a.m.: 18 IR 2415; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3371; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2129; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-3.6) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-5) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-5.1 Provider payments during pendency of appeals; recovery

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

Sec. 5.1. (a) The office of Medicaid policy and planning (office) may recover payment, or instruct the fiscal contractor to recover payment, from any Medicaid provider listed in subsection (c) for services rendered to an individual if such services are determined to have been not medically necessary or not reasonable or otherwise inappropriate. Recovery of payments may be made:

(1) when the office is required by 42 CFR 431.230(a) to maintain services to a recipient during the pendency of an appeal, and the hearing decision is favorable to the office; or

(2) when the office has been required, under 42 CFR 431.246, to make corrective payments following an evidentiary hearing decision favorable to the appellant, and the secretary or the secretary's designee thereafter renders a decision favorable to the office at administrative review.

(b) The office may recoup under subsection (a) when the appeal has been voluntarily dismissed by the appellant.

(c) Services for which the office, or its fiscal contractor, may recover payment under subsection (a) are limited to those rendered by any of the following providers:

(1) Inpatient hospital facilities.

(2) Nursing facilities.

(3) Community residential facilities.

(4) Intermediate care facilities for the mentally retarded.

(d) Interest shall be assessed on amounts recouped under this section and shall accrue from the date of the overpayment. Such interest charge shall be determined under IC 12-15-13-3(f)(1) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270,*

effective July 1, 2011.]. (Office of the Secretary of Family and Social Services; 405 IAC 1-1-5.1; filed Dec 19, 1995, 2:50 p.m.: 19 IR 1081; errata filed Feb 12, 1996, 10:45 a.m.: 19 IR 1568; 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)

405 IAC 1-1-6 Sanctions against providers; determination after investigation

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 4-21.5-4

Sec. 6. (a) If, after investigation by the office of Medicaid policy and planning (office), the office's designee, the Indiana Medicaid fraud control unit (IMFCU), or other governmental authority, the office determines that a provider has violated any provision of IC 12-15, or has violated any rule established under one (1) of those sections, the office may impose one (1) or more of the following sanctions:

(1) Deny payment to the provider for medical assistance services rendered during a specified period of time.

(2) Reject a prospective provider's application for participation in the medical assistance program.

(3) Remove a provider's certification for participation in the medical assistance program (decertify the provider).

(4) Assess a fine against the provider in an amount not to exceed three (3) times the amounts paid to the provider in excess of the amounts that were legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established by IC 12-15-13-3(e)(1) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*, on the amounts paid to the provider in excess of the amounts that were legally due. The interest charge shall accrue from the date of the overpayment to the provider.

(6) Require the provider to create a corrective action plan. A corrective action plan must include the following:

(A) A timeline for coming into compliance with state or federal requirements.

(B) The names, including title, address, and phone number, of persons responsible for ensuring compliance with state or federal requirements.

(C) A description of the actions the entity will take to come into compliance with state or federal requirements.

(D) Any other information required by the office.

If, after sixty (60) days following written notice of a request for a corrective action plan by the state, a provider has not submitted a corrective action plan, the provider may be subject to payment withholding or any other sanction under this rule.

(b) Specifically, the office may impose the sanctions in subsection (a) if, after investigation by the office, the office's designee, the IMFCU, or other governmental authority, the office determines that the provider:

(1) submitted, or caused to be submitted:

(A) claims for medical assistance services:

(i) that cannot be documented by the provider; or

(ii) provided to a person other than a person in whose name the claim is made;

(B) any false or fraudulent claims for medical assistance services or merchandise;

(C) information with the intent of obtaining greater compensation than that which the provider is legally entitled, including charges in excess of the:

(i) fee schedule; or

(ii) usual and customary charges; or

(D) false information for the purpose of meeting prior authorization requirements;

(2) engaged in a course of conduct or performed an act deemed by the office to be abusive of the Medicaid program or continuing the conduct following notification that the conduct should cease;

(3) breached, or caused to be breached, the terms of the Medicaid provider certification agreement;

(4) failed to comply with the terms of the provider certification on the Medicaid claim form;

(5) overutilized, or caused to be overutilized, the Medicaid program;

(6) submitted, or caused to be submitted:

(A) a false or fraudulent provider certification agreement;

(B) claims for medical assistance services for which federal financial participation is not available; or

(C) any claims for medical assistance services or merchandise arising out of any act or practice prohibited by the:
(i) criminal provisions of the Indiana Code; or
(ii) rules of the office;

(7) failed to:
(A) disclose or make available to the office, the office's designee, the IMFCU, or other governmental authority, after reasonable request and notice to do so, documentation of services provided to Medicaid recipients and Medicaid records of payments made therefor;
(B) comply with the requirements of 1902(a)(68) of the Social Security Act, except that such failure shall first be sanctioned with a corrective action plan before any other sanction in subsection (a) shall be applied; or
(C) meet standards required by the state of Indiana or federal law for participation;

(8) charged a Medicaid recipient for covered services over and above that paid for by the office;

(9) refused to execute a new provider certification agreement when requested to do so;

(10) failed to:
(A) correct deficiencies to provider operations after receiving written notice of these deficiencies from the office; or
(B) repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments, unless:
(i) an appeal is pending; and
(ii) the provider has elected not to repay an alleged overpayment under section 5(d)(3) of this rule; or

(11) billed the Medicaid program more than the usual and customary charge to the provider's private pay customers.

(c) The assistant secretary of the office or his or her duly authorized representative may enter a directive imposing a sanction under IC 4-21.5-3-6. Any directive issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) contain a brief description of the order;
(3) become final fifteen (15) days after its receipt; and
(4) contain a statement that any appeal from the decision of the assistant secretary made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(d) If an emergency exists, as determined by the office, the assistant secretary or his or her duly authorized representative may issue an emergency directive imposing a sanction under IC 4-21.5-4. Any order issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) become effective upon receipt;
(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and
(4) contain a statement that any appeal from the decision of the assistant secretary made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 1-1.5-2.

(e) The decision to impose a sanction shall be made at the discretion of the assistant secretary or his or her authorized representative.

(f) Prepayment review of claims is not a sanction and is not subject to appeal. *(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-105; filed Jun 19, 1979, 2:16 p.m.: 2 IR 1124; filed Sep 23, 1982, 9:59 a.m.: 5 IR 2349; filed Dec 22, 1995, 2:15 p.m.: 19 IR 1076; errata, 19 IR 1373; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3372; 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 Feb 20, 2008, 2:18 p.m.: 20080319-IR-405070540FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-4.5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-6) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-7 Nursing home rate setting; governing provisions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 7. Nursing Home Rate Setting. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity

with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates sections 100 through 1600 inclusive of a document issued by the department in July, 1976 as amended in August 1977 entitled Indiana Department of Public Welfare, Rate Setting Criteria for Nursing Homes, Medicaid Program, Skilled Nursing Facilities and Intermediate Care Facilities.

If any provision of the above cited document is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation shall govern. If the content of the above cited document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder, shall govern until such time as the above cited document can be amended.

If any part of the Indiana Department of Public Welfare, Rate Setting Criteria for Nursing Homes, Medicaid Program, Skilled Nursing Facilities and Intermediate Care Facilities document or the application of it to any person or circumstance is held invalid, and invalidity does not affect other provisions or applications of the document which can be given effect without invalid provisions or application, and to this end this document is severable.

IC 4-22-2

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-106; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 252; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-5) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-7) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-8 Level of care criteria for long-term care facilities; governing provisions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 8. Level of Care Criteria for Long-Term Care Facilities. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued by the department on January 5, 1976 as amended in May, 1977, entitled Indiana's Medicaid Program Criteria for Level of Care Provided by Long-Term Care Facilities *[405 IAC 1-3]*.

If any provision of the above cited document *[405 IAC 1-3]* is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation *[405 IAC 1-3]* shall govern. If the content of the above cited document *[405 IAC 1-3]* is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document *[405 IAC 1-3]* can be amended.

If any part of the Indiana's Medicaid Program Criteria for Level of Care Provided by Long-Term Care Facilities document *[405 IAC 1-3]* or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the document which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*

IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-107; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 253; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-6) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-8) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-9 Nursing home admission; governing provisions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 9. Nursing Home Admission. In accordance with the provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued on June 1, 1976 and amended October 12, 1976 by the department entitled Medicaid DPW Bulletin No. 3.

If any provision of the above cited document is or shall become inconsistent with any other regulation promulgated by the state board of public welfare the provision of this regulation shall govern. If the content of the above cited document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document can be amended.

If any part of the document Medicaid DPW Bulletin No. 3, as amended, or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2
IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-108; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 253; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-7) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-9) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-10 Intermediate care for the mentally retarded; governing provisions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 4-22-2; IC 12-13-7-3; IC 12-15

Sec. 10. Intermediate Care for the Mentally Retarded (ICF/MR). In accordance with provisions of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*; IC 4-22-2 as amended by Indiana Public Law 38, Acts of 1977; and in conformity with the provisions of Title XIX of the federal Social Security Act and related federal regulations, the state board of public welfare hereby promulgates a document issued on August 15, 1977 by the department entitled Medicaid Bulletin–Intermediate Care for the Mentally Retarded (ICF/MR) *[405 IAC 1-1-9]*.

If any provision of the above cited document *[405 IAC 1-1-9]* is or shall become inconsistent with any other regulation promulgated by the state board of public welfare, the provision of this regulation *[405 IAC 1-1-9]* shall govern. If the content of the above document is inconsistent with any subsequently enacted amendment of IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the federal Social Security Act or any regulation promulgated thereunder, the amendment to IC 12-1-7 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]* or the Social Security Act or the regulation promulgated thereunder shall govern until such time as the above cited document *[405 IAC 1-1-9]* can be amended.

If any part of the document *[405 IAC 1-1-9]* cited above or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end this document is severable.

IC 4-22-2
IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-109; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 254; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-8) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-10) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-11 Intermediate care for the mentally retarded; eligibility

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

Sec. 11. Intermediate Care for the Mentally Retarded (ICF/MR) is to be provided for persons in an institution which meets the Federal certification standards to participate as an eligible Medicaid provider. Intermediate care services are designed for persons who are mentally retarded or with certain other conditions as specified herein. The services and/or treatment programs are delivered on an in-patient basis and under the direction and supervision of the required professional staff. Admissions to Intermediate Care Facilities for the Mentally Retarded must be based upon a determination of the need for such care by an interdisciplinary professional team. Approval by the State Department of Public Welfare–Medicaid Division, must be received by the ICF/MR institution prior to admission, or in cases of those individuals who make application while in the institution, prior to payment for that service. Intermediate Care for the Mentally Retarded (ICF/MR) will be provided by the Medicaid program, for eligible persons who must meet these two conditions:

(1) Patient or resident has a diagnosis of mental retardation or related conditions of epilepsy, cerebral palsy, or other developmental disability found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals.

(a) Patient or resident may be severely or profoundly retarded, moderately retarded, severely physically handicapped, aggressive, assaultive, security risk, or manifesting severe hyperactive or psychotic-like behavior.

(b) Patient or resident may be moderately retarded and may require habit training, training and guidance in the activities of daily living, and development of self-help skills for maximum independence and as needed by the patient or resident.

(c) Patient or resident may be in vocational training programs or adults who work in sheltered workshops.

(2) Patient or resident must have a comprehensive evaluation covering physical, emotional, social and cognitive factors conducted by an interdisciplinary professional team.

In addition to the above required conditions, eligible persons may require any of the following professional services:

(1) Patient or resident may require professional medical supervision for the administration of medicines and/or treatments.
(2) Physician services.
(3) Dental services.
(4) Nursing services.
(5) Pharmacy services.
(6) Training and habilitation.
(7) Modified or special diets to meet nutritional needs.
(8) Physical therapy services.
(9) Speech pathology and audiological services.
(10) Occupational therapy services.
(11) Recreational therapy services.
(12) Psychological services.
(13) Social services.

(Office of the Secretary of Family and Social Services; Intermediate Care For The Mentally Retarded; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 284; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-9) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-11) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-1-12 Regular access authority to medicaid division personal information system

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

Sec. 12. Regular Access Authority to the Indiana State Department of Public Welfare Medicaid Division Personal Information System. The following individuals have regular access authority to the information contained in the personal information systems maintained by the Medicaid Division of the Indiana State Department of Public Welfare, subject to the confidentiality requirements in State Department of Public Welfare Regulation 1-201 *[470 IAC 1-3-1]*.

(1) Employees of the Indiana State Department of Public Welfare.

(2) Employees of the County Welfare Departments of the State of Indiana.

(3) Employees of other agencies of the State of Indiana which have been given the responsibility of administering any part of the programs set forth in State Department of Public Welfare Regulation 1-201 *[470 IAC 1-3-1]*.

(4) All officials and their staffs who are charged by law with the responsibility of pursuing criminal and/or civil prosecution.

(5) Employees of the fiscal agent who has entered into a contract with the State of Indiana pursuant to IC 12-1-7-17 *[Repealed by P.L.80-1984, SECTION 10.]*.

(6) Any other individual, agency or official whose duties are directly connected with the administration of a plan or program approved under Title XIX of the federal Social Security Act, or any other federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need.

IC 12-1-2-2(c) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 12-1-2-3(f) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*
IC 4-1-6-2
IC 12-1-7-15 *[Repealed by P.L.70-1978, SECTION 3.]*
IC 12-1-7-28 *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.] (Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-130; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 254; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-10) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-12) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-13 Subrogation of claims

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

Sec. 13. The office shall be subrogated to all claims by Medicaid members against third parties to the extent of Medicaid benefits received by the members, when the direct or proximate cause of the necessity to pay such benefits is the negligence or other legal liability of such third parties. *(Office of the Secretary of Family and Social Services; 5-198; filed Mar 28, 1978, 8:55 a.m.: Rules and Regs. 1979, p. 320; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-11) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-13) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-14 Severability; governing provisions; effect of provision inconsistent or invalid with federal law

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

Sec. 14. If any provision in this title is or shall become inconsistent with any subsequently enacted amendment to the federal Social Security Act or any regulation promulgated thereunder, the amendment to the Social Security Act or the regulation promulgated thereunder shall govern until such time as this title can be amended. If any part of this title or the application of it to any person, entity, or circumstance is held invalid, the invalidity does not affect other provisions or applications of this title which can be given effect without the invalid provision or application, and to this end the parts of this title are severable. *(Office of the Secretary of Family and Social Services; Title 5,Ch 1,Reg 5-199; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 255; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-12) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-14) by P.L.9-1991, SECTION 131, effective January 1, 1992*.

405 IAC 1-1-15 Third party liability; definitions

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

Sec. 15. (a) The following definitions are intended to apply only to this section:

(1) "Final settlement" means payment of money from a third party liable for the injury, illness, or disease of a member whether by compromise, judgment, court order, or restitution, which payment is intended as the total compensation for the injury, illness, or disease caused by the liable third party.

(2) "Notice" means a written statement of the office's claim bearing:

(A) a certification that the person named in the notice is a member of Medicaid; and

(B) the signature of an authorized Medicaid employee.

(3) "Certification" means a statement authenticated by the seal of the office.

(4) "Office's claim" means a statement of Medicaid payments made by the office for any Medicaid member which has been certified by an authorized Medicaid employee.

(5) "Coordination of benefits" means all activities by which an insurer notifies or is notified by other insurers or Medicaid, or both, that a claim has been received, for the purpose of establishing primary liability, and/or if previous payment has been made on all or part of the claim.

(b) The office has a lien upon any money or fund payable by any third party who is or may be liable for the medical expenses of a Medicaid member when the office provides Medicaid. Circumstances under which the office may assert its lien include, but are not limited to, cases where Medicaid has made payment because:

(1) payment from a third party was not immediately available;

(2) there are disputes and delays in the coordination of benefits;

(3) the third party was not identified;

(4) the office erroneously made payment before the third party or all other parties had made payment;

(5) a court order has been issued; or

(6) the member asserts a claim against a third party who is or may be liable for the injury, illness, or disease of a Medicaid applicant or member.

(c) The office, acting in behalf of the Medicaid member, may initiate an action against a third party that is or may be liable for the injury, illness, or disease of a Medicaid member because:

(1) the member has not done so; and

(2) the time remaining under the statute of limitations for the action is six (6) months or less.

(d) In perfecting its lien, the office shall take the following action before the third party makes final settlement to the Medicaid member as total compensation for the member's injury, illness, or disease:

(1) serve notice:

(A) to third parties in the manner described in subsection (e); and/or

(B) to insurers in the manner described in either subsection (e)(3)(C) or (f) as deemed appropriate by the office; and

(2) file a claim which:

(A) shows the amount of payment made at the time notice is served;

(B) is updated at not less than yearly intervals and shows the total of all identified expenditures and/or average daily cost of the individual's care;
(C) is prepared by the office's staff; or
(D) is a hard copy of computer generated claims payment records; and
(E) is certified by an authorized Medicaid employee.

(e) The office may perfect its lien by serving notice to third parties in the following manner:
(1) Filing a written notice in the Marion County Court stating the following:
(A) The name and address of the member.
(B) That the individual is eligible for Medicaid.
(C) The name of the person or third party alleged to be liable to the injured, ill, or diseased member.
(2) Sending a copy of the notice filed in the Marion County Court by certified mail to the third party.
(3) Sending a copy of the notice to the following persons or entities if the appropriate names and addresses are determined:
(A) The member.
(B) The member's attorney.
(C) The insurer or other third parties.

(f) The office may serve notice to insurers and/or initiate the coordination of benefits by mailing a notice to the insurer that:
(1) is on state letterhead;
(2) is sent by certified mail; and
(3) includes, if reasonably available to the office, the following information pertaining to the Medicaid member:
(A) name of employer;
(B) name of policyholder;
(C) employee identification number; and
(D) claim certificate number.

(g) When an insurer has received the notice specified in subsection (e)(3)(C) or (f) prior to making payment on a claim, and the insurer is liable for part or all of a Medicaid member's medical expenses, the insurer shall coordinate the benefits with the office and:
(1) pay the provider of service for bills submitted by the provider unless the office certifies that it has already paid the bill;
(2) reimburse the office for claims submitted by the office; or
(3) reimburse the office if the provider and the office submit claims for the same services.

(h) An insurer that is put on notice of a claim by the office under either subsection (g)(1), (g)(2), or (g)(3) and proceeds to pay the claim to a person or entity other than the office is not discharged from payment of the office's claim.

(i) Once Medicaid has been reimbursed for the office's claim by the insurer, the insurer has discharged its responsibility for that claim. Neither the insurer nor the member shall be held liable for any remaining balance. For any provider seeking adjustments in payment, recourse is limited to an administrative appeal as provided by 405 IAC 1-1.5.

(j) The rules set forth in subsection (g) shall also apply when the member notifies the insurer that the member has received Medicaid from the office. In this case, the insurer is required to initiate coordination of benefits with the office.

(k) Any clause in any insurance contract which excludes payment when the contract beneficiary is eligible for Medicaid is void and the insurer shall make payments described in subsection (g).

(l) The office may waive its lien, at its discretion. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-15; filed Sep 29, 1982, 3:09 p.m.: 5 IR 2322; filed May 22, 1987, 12:45 p.m.: 10 IR 2282, eff Jul 1, 1987; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-13) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-15) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-1-16 Insurance information; release

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-29

Sec. 16. (a) "Insurer" means any insurance company, prepaid health care delivery plan, self funded employee benefit plan, pension fund, retirement system, group coverage plan, blanket coverage plan, franchise insurance coverage plan, individual coverage plan, family-type insurance coverage plan, Blue Cross/Blue Shield plan, group practice plan, individual practice plan, labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, governmental program plans, fraternal benefits societies, any plan or coverage required or provided by any statute, or similar entity that:

(1) is doing business in this state; and

(2) is under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by a Medicaid member.

(b) In accordance with IC 12-15-29-1, a Medicaid applicant or member or one legally authorized to seek Medicaid benefits on behalf of the applicant or member shall be considered to have authorized all insurers to release to the office all available information needed by the office to secure or enforce its rights pertaining to third party liability collection.

(c) Every insurer shall provide to the office, upon written request, information pertaining to coverage or benefits, or both, paid or available to an individual under an individual, group, or blanket policy or certificate of coverage when the office certifies that such individual is an applicant for or a member of Medicaid. Information, to the extent available, regarding the insured may include, but need not be limited to:

(1) name, address, and Social Security number of the insured;

(2) policy numbers, the terms of the policy, and the benefit code;

(3) names of covered dependents whom the state certifies are applicants or members;

(4) name and address of employer, other person, or organization which holds the group policy;

(5) name and address of employer, other person, or organization through which the coverage was obtained;

(6) benefits remaining available under the policy including, but not limited to, coverage periods, life time days, life time funds;

(7) the deductible, and the amount of deductible outstanding for each benefit at the time of the request;

(8) any additional coinsurance information which may be on file;

(9) copies of claims when requested for legal proceedings;

(10) copies of checks and their endorsements when these documents are needed as part of an investigation of a member or provider, or both;

(11) other policy information which the office certifies in writing is necessary to secure and enforce its rights pertaining to third party liability collection;

(12) carrier information, including:

(A) name and address of carrier;

(B) adjustor's name and address; and

(C) policy number or claim number, or both; and

(13) claims information, including:

(A) identity of the individual to whom the service was rendered;

(B) identity of the provider rendering services;

(C) identity and position of provider's employee rendering said services, if necessary for claims processing;

(D) date on which said services were rendered; and

(E) a detailed explanation of charges and benefits.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1-16; filed Sep 29, 1982, 3:21 p.m.: 5 IR 2320; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-14) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 1.5. Provider Reimbursement Appeal Procedures

405 IAC 1-1.5-1 Scope

Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 1. (a) This rule governs the procedures for appeals to the office of Medicaid policy and planning (office) involving actions or determinations of reimbursement for all Medicaid providers.

(b) This rule governs the procedures for appeals to the office from the following actions or determinations:

(1) Setting rates of reimbursement.

(2) Any action based upon a final audit.

(3) Determination of change of provider status for purposes of setting a rate of reimbursement.

(4) Determination by the office that an overpayment to a provider has been made due to a year-end cost settlement.

(5) Any other determination by the office that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation.

(6) The office's refusal to enter into a provider agreement.

(7) The office's suspension, termination, or refusal to renew an existing provider agreement.

(8) The office's revocation of a qualified hospital's presumptive eligibility provider status under 405 IAC 2-3.3-3.

(c) Notwithstanding subsections (a) and (b), this rule does not govern determinations by the office or its contractor with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a recipient.

(d) Disputes relating to claims submitted to a managed care organization (MCO) by providers who are not under contract to the MCO, and who provide services to recipients in the risk-based managed care program are governed by 405 IAC 1-1.6. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-1; filed Oct 31, 1994, 3:30 p.m.: 18 IR 862; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 10, 2004, 3:15 p.m.: 28 IR 815; errata filed Nov 15, 2004, 10:20 a.m.: 28 IR 970; 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 Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA)*

405 IAC 1-1.5-2 Appeal requests

Authority: IC 12-15-21
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7

Sec. 2. (a) Appeals governed by this rule will be held in accordance with IC 4-21.5-3, except as specifically set out in this rule. The ultimate authority for purposes of this section is the secretary of family and social services administration, in accordance with IC 12-8-6-6 *[IC 12-8-6 expired under IC 12-8-6-10. See IC 12-8-6.5-6.]*.

(b) A request for an appeal must be filed within the following time limits:

(1) A request for an appeal of a determination that an overpayment has occurred must be filed within the time limits set out in IC 12-15-13-3 *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*.

(2) All other appeal requests governed by this rule must be filed with the ultimate authority within fifteen (15) calendar days of receipt of the determination by the office of Medicaid policy and planning (office), in accordance with IC 4-21.5-3-7. However, any provider subject to administrative review or reconsideration under this article must seek administrative review or reconsideration before filing an appeal request.

(c) An appeal request must state facts demonstrating that the petitioner is:

(1) a person to whom the order is specifically directed;

(2) aggrieved or adversely affected by the order; or

(3) entitled to review under any law.

Failure of the provider to file the appeal request within the time limits listed in subsection (b) will result in the waiver of any right to appeal from the office's determination.

(d) The provider must file with the office a statement of issues:

(1) within forty-five (45) calendar days after the provider receives notice of the determination of the office; or

(2) at the time the provider files a timely request for appeal;

whichever is later.

(e) The statement of issues shall set out in detail:

(1) the specific findings, action, or determinations of the office from which the provider is appealing; and

(2) with respect to each finding, action, or determination:

(A) why the provider believes that the office's determination was in error; and

(B) all statutes or rules supporting the provider's contentions of error.

(f) The statement of issues shall govern the scope of the issues to be adjudicated in the appeal under this rule. The provider will not be permitted to expand the appeal beyond the statement of issues with respect to the:

(1) specific findings, action, or determination of the office; or

(2) reason or rationale supporting the provider's appeal.

(g) The provider may supplement or modify its statement of issues for good cause shown, up to sixty (60) calendar days after the appeal request is mailed to the office. The administrative law judge assigned to hear the appeal will determine good cause.

(h) Within thirty (30) days after filing a petition for review, and upon a finding of good cause by the administrative law judge, a hospital appealing an action described in IC 4-21.5-3-6(a)(3) and IC 4-21.5-3-6(a)(4) may amend the statement of issues contained in a petition for review to add one (1) or more additional issues.

(i) Failure of the provider to timely file a statement of issues within forty-five (45) calendar days from the date the provider files the appeal request will result in automatic certification to the secretary for summary review, in accordance with section 3 of this rule.

(j) Notwithstanding subsections (d) through (f), a hospital provider that files an appeal after a determination regarding year-end cost settlement may preserve any Medicaid issues that are affected by any Medicare appeal issues, by indicating in its statement of issues that Medicare issues timely filed before the fiscal intermediary are also preserved in its Medicaid statement of issues. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-2; filed Oct 31, 1994, 3:30 p.m.: 18 IR 862; errata filed Feb 28, 1995, 2:30 p.m.: 18 IR 1836; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3374; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2131; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-1.5-3 Summary review

Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 3. (a) The office of Medicaid policy and planning (office) will provide a summary review by the secretary of family and social services administration (secretary) of certain issues set out in the provider's statement of issues. Issues in the provider's statement of issues that challenge the propriety of:

(1) all or part of the general methodology or criteria utilized by the office for setting rates;

(2) all or part of the general methodology or criteria utilized by the office with respect to any audits;

(3) all or part of the general methodology or criteria utilized by the office for making determinations with respect to change of provider status; and

(4) all or part of any other general methodology or criteria utilized by the office for making any determination set out in section 1(b) of this rule;

will be certified for summary review by the secretary.

(b) The office shall not certify for summary review any issue in which the provider challenges the application of the office's methodology or criteria in the provider's particular circumstances. Issues involving application of the office's methodology or criteria will be set for an evidentiary hearing under IC 4-21.5-3. The administrative law judge shall exclude any:

(1) evidence or argumentation on issues certified to the secretary; or

(2) issues not specifically enumerated in the provider's statement or amended statement of issues.

(c) For appeals filed before the effective date of this rule, the office may certify issues determined under subsection (a) to the secretary or the secretary's designee, according to the issues set out in the provider's appeal letter.

(d) There shall be no appeal from a determination by the office certifying any issues for summary review by the secretary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-3; filed Oct 31, 1994, 3:30 p.m.: 18 IR 863; 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)

405 IAC 1-1.5-4 Decision on summary review

Authority: IC 12-15-21
Affected: IC 4-21.5-3-28

Sec. 4. (a) Upon a determination of the office of Medicaid policy and planning (office) that any or all of the issues in the provider's statement of issues concern issues in section 3(a) of this rule, the office will certify to the secretary of family and social services administration (secretary) those issues for summary review by the secretary or the secretary's designee. With respect to each issue certified by the office, the secretary or the secretary's designee will issue a decision:

(1) affirming the determination of the office;

(2) dissolving the determination of the office; or

(3) remanding the determination of the office for an evidentiary hearing before an administrative law judge.

(b) The decision of the secretary or the secretary's designee on summary review shall be rendered within forty-five (45) calendar days after certification by the office to the secretary.

(c) The secretary shall send a notice of the decision on summary review to the provider. The decision on summary review of the secretary or the secretary's designee is interlocutory unless it adjudicates all the issues in the provider's appeal. It is not a final order until all issues in the provider's statement of issues are adjudicated by the secretary or the secretary's designee under IC 4-21.5-3-28. A provider may not seek judicial review of an adverse determination of the secretary on summary review until such time as a final order on all the issues in the provider's statement of issues is rendered. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-4; filed Oct 31, 1994, 3:30 p.m.: 18 IR 864; 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)*

405 IAC 1-1.5-5 Repayment of overpayment to office

Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 5. (a) The office of Medicaid policy and planning (office) may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to 405 IAC 1-1-5(d)(3). The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current Medicaid payments to a provider.

(2) In the case of an institutional provider, offset the amount of the overpayment to any or all of the Medicaid facilities owned by the provider until the overpayment has been satisfied.

(3) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(4) Enter into an agreement with the provider in accordance with 405 IAC 1-1-5.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. Interest on overpayments shall not exceed the percentage set out in IC 12-15-13-3(f)(1) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*.

(c) Notwithstanding any other rule in this article, for hospitals who receive a notice that the provider has been underpaid by the office as a result of the cost settlement process, the office will pay interest to the hospital on the amount of the underpayment. Such interest will accrue from the date of the underpayment at the rate of interest set out in IC 12-15-13-3(f)(2) *[IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011.]*. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-5; filed Oct 31, 1994, 3:30 p.m.: 18 IR 864; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3374; 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)*

Rule 1.6. Managed Care Provider Reimbursement Dispute Resolution

405 IAC 1-1.6-1 Scope

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

Sec. 1. (a) This rule applies to disputes relating to claims submitted to risk-based managed care organizations (MCOs) contracted with the office by providers who are not contracted with the MCO and who provide services to a Medicaid member enrolled in a risk-based managed care plan.

(b) This rule governs the procedures for a provider's objection to a determination by the MCO involving the provider's claim, including a provider's objection to:

(1) any determination by the MCO regarding payment for a claim submitted by the provider, including the amount of such payment; or

(2) the MCO's determination that a claim submitted by the provider lacks sufficient supporting information, records, or other materials.

(c) The procedures in this rule may, at the election of a provider, be utilized to determine the payment due for a claim in the event the MCO fails, within thirty (30) days after the provider submits the claim, to notify the provider of its determination:

(1) regarding payment for the provider's claim; or

(2) that the provider's claim lacked sufficient supporting information, records, or other materials.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-1; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816; 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)

405 IAC 1-1.6-2 Informal objection

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

Sec. 2. (a) The provider may make verbal inquiries at any time to resolve a claim matter. Before the provider may submit a formal claim appeal under section 3 of this rule, the provider shall attempt to informally resolve the matter as described in this section.

(b) The informal dispute process shall be commenced by a provider submitting a written objection to the MCO, within the following time limits:

(1) If the provider disagrees with the MCO's determination regarding the provider's claim, the informal process must be commenced within sixty (60) days after the provider's receipt of written notification of the MCO's determination.

(2) If the MCO fails to make a determination within thirty (30) days of the date the claim was submitted, the informal process must be commenced within ninety (90) days of the date the claim was submitted to the MCO.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-2; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816; errata filed Nov 15, 2004, 10:20 a.m.: 28 IR 970; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-1.6-3 Formal appeal to managed care organization

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

Sec. 3. (a) In the event the matter is not resolved to the provider's satisfaction within thirty (30) days after the provider commenced the informal process set out in section 2 of this rule, the provider shall have sixty (60) days after the end of the thirty (30) day period to submit a formal appeal notice to the MCO.

(b) The provider's claim appeal notice must be in writing and specify the basis of the provider's dispute with the MCO.

(c) The formal claim appeal procedure is commenced by the MCO's receipt of the provider's written claim appeal notice. The

appeal review is conducted by a panel of one (1) or more individuals selected by the MCO. The panel shall:

(1) be knowledgeable about the policy, legal, and clinical issues involved in the matter subject to the appeal;

(2) not include an individual who has been involved in any previous consideration of the matter; and

(3) consider all information and material submitted to it by the provider that bears directly upon an issue involved in the matter.

(d) The MCO shall allow the provider an opportunity to appear in person before the panel or to communicate with the panel through appropriate other means if the provider is unable to appear in person.

(e) The provider may be represented by an attorney or other representative during the formal claim appeal procedure.

(f) The MCO's medical director, or other licensed physician designated by the medical director, shall serve as a consultant to the panel in the event the matter involves a question of medical necessity or medical appropriateness.

(g) The panel shall make a written determination of the matter that is the subject of the provider's appeal. The panel's written determination of the matter shall:

(1) be the MCO's final position in regard to the matter;

(2) include, as applicable, a detailed explanation of the factual, legal, policy, and clinical basis of the panel's determination; and

(3) include notice to the provider of the provider's right to submit to binding arbitration, or other binding resolution procedure to which the MCO and provider mutually agree, the matter that was the subject of the formal claim resolution procedure.

(h) The panel's written determination shall be issued to the provider within forty-five (45) days after the commencement of the formal claim appeal process. In the event the panel fails to issue the panel's written determination within forty-five (45) days after the commencement of the formal claim appeal process, the failure on the part of the panel shall have the effect of an approval by the panel of the provider's claim. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-3; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-1.6-4 Arbitration

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 34-57-2

Sec. 4. (a) If the provider is dissatisfied with the decision of the MCO panel, the provider may submit the matter to binding arbitration. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at IC 34-57-2, unless:

(1) the provider and MCO mutually agree to some other binding resolution procedure; or

(2) the MCO or providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.

(b) The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving the MCO and the provider.

(c) The fees and expenses of arbitration or other binding resolution procedure shall be borne by the nonprevailing party. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-4; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-1.6-5 Supporting documentation for claims; final determination

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

Sec. 5. (a) A claim that is finally determined through the claim resolution procedure not to lack sufficient supporting documentation shall be processed by the MCO within thirty (30) days after such final determination.

(b) If it is finally determined that a claim lacks sufficient supporting documentation, the provider shall have thirty (30) days after receipt of written notice of the final determination to submit the requisite supporting documentation. The claim shall be

processed by the MCO within thirty (30) days after the provider submits to the MCO the required supporting documentation. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-5; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-1.6-6 Record keeping and reporting requirements

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

Sec. 6. The MCO shall maintain a log of all written informal provider objections to determinations and formal provider appeals involving claims. The logged information shall include the:

(1) provider's name;
(2) date of objection;
(3) nature of the objection; and
(4) disposition.

The MCO shall submit quarterly reports to the office regarding the number and type of provider objections and appeals. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-6; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

Rule 2. Inspection of Care in Long Term Care Facilities

405 IAC 1-2-1 Inspection (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Oct 12, 1995, 1:30 p.m.: 19 IR 350)*

Rule 3. Criteria for Level of Care in Long Term Care Facilities

405 IAC 1-3-1 Skilled nursing services; unskilled services

Authority: IC 12-15-1-1; IC 12-15-1-10
Affected: IC 12-15-5-1

Sec. 1. (a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially seven (7) days a week.

(b) Rehabilitation services for an acute rehabilitative condition may be provided at either skilled or intermediate level of care, depending upon the resident's overall condition and nursing care needs. To qualify to skilled rehabilitation services, the following conditions shall be met:

(1) The services are ordered by a physician and must be required and provided at least five (5) days a week.
(2) The therapy must be of such complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required.
(3) The overall condition of the patient must be such that the judgment, knowledge, and skills of a licensed therapist are required.

(c) If the patient's condition is such that it requires observation and assessment by licensed professional nursing staff to identify or evaluate the patient's need for modification of treatment and the initiation of additional medical procedures until the patient's condition is stabilized, the service is at the skilled level. These services must be documented by physician's orders, progress notes, and nurse's notes. Routine or prophylactic monitoring of a stable condition is considered intermediate level.

(d) When licensed professional nursing staff is required to teach a skilled procedure in order to facilitate discharge to self-care, skilled level of care can be considered short term. This could include teaching self-injection, self-catheterization, catheter care, ostomy care, dressing changes, or suctioning. Nursing care plan and documentation of overall condition must substantiate that discharge to self-care following a training program is a realistic goal. Training programs of longer than thirty (30) days, when no other skilled services are required, will be considered appropriate for the intermediate level of care.

(e) The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan and supervision of personal care does not in itself require skilled level of care. Skilled level of care is appropriate where the sum total of unskilled services that are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the significant involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety. The need for significant skilled personnel involvement must be documented within the patient's medical record.

(f) Based upon the principles in subsections (a) through (e), examples of skilled nursing services include, but are not limited to, the following:

(1) Intravenous infusions or intravenous and intramuscular injections. However, injections which can usually be self-administered, such as the well-regulated diabetic who receives daily insulin injections, would not require skilled services. The occasional or PRN (as needed) intramuscular injection would qualify as a skilled service only if the patient's medical condition is unstable as supported by documentation in the patient's medical records.

(2) Nasogastric tube and gastrostomy feedings.

(3) Nasopharyngeal and tracheotomy aspiration. However, patients with tracheotomy tubes which have been used over a long period of time and where the patient is mentally able to perform this care with little, if any, supervision would not qualify for skilled level of care.

(4) Insertion and sterile irrigation or replacement of catheters. Skilled care may be required for patients in whom catheter obstructions frequently occur necessitating the intervention of professional personnel. The sterile irrigation of catheters must be ordered by the physician specifying the type of irrigation and length of time which the sterile irrigations are to continue. Routine sterile irrigations continuing longer than fourteen (14) days will be considered appropriate for intermediate level of care.

(5) Complex wound care involving sterile dressings, prescription medications, and aseptic techniques. Justification for these procedures must be fully documented, and the duration of these treatments must be specified by the physician. The necessity for the treatments continuing longer than thirty (30) days must be documented on the patient's record by fully describing the patient's condition.

(6) Care of extensive decubitus ulcers. The size and stage of the decubitus must be documented. The treatment must be specifically ordered by the physician. Appropriate documentation to monitor the progress of the decubitus is also required.

(7) Initial phases of a regimen involving administration of oxygen. Patients requiring the administration of oxygen on a daily basis for a new or recent medical condition would qualify for skilled level care. However, patients receiving oxygen either continuously or PRN for a chronic, stable medical condition would not qualify for skilled level care.

(g) In order to qualify for skilled level of care, documentation of the medical necessity for increased intensity of nursing services must be noted in physician's orders, progress notes, and nurse's notes. When this intensity of nursing services is no longer required, it is the responsibility of the nursing facility and physician to transfer the resident to the intermediate level of care. The office may initiate an independent evaluation and level of care assessment to determine whether continued reimbursement at the skilled level is justified. *(Office of the Secretary of Family and Social Services; Long Term Care Facilities II; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 269; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2852; filed Mar 10, 1993, 5:00 p.m.: 16 IR 1792; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-3-2 Intermediate level of care criteria

Authority: IC 12-15-1-1; IC 12-15-1-10
Affected: IC 12-15-5-1

Sec. 2. (a) Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing

supervision and attention. Intermediate care services encompass a range of services from those below skilled level services to those above room and board level services. The determination of the differences between the skilled and intermediate level of care is based upon the patient's condition, along with the complexity and range of medical services required by the patient on a daily basis. The provision of room, food, laundry, and supervision of activities of daily living do not, in and of themselves, qualify as intermediate care.

(b) Intermediate care includes room, food, laundry, and professional supervision of activities for protection and safety, along with combinations of the following:

(1) Assistance with ambulation.

(2) Assistance with transfers and positioning.

(3) Assistance with general bathing and hygiene.

(4) Assistance with eating.

(5) Assistance with dressing.

(6) Assistance with toileting/incontinence care.

(c) Intermediate services require some professional supervision, but may be performed by properly trained nonprofessional personnel. The following illustrated services are generally of a supportive nature and are less than skilled level services:

(1) Administration of routine oral medications, eye drops, ointment, or any combination of all of these.

(2) Injections which usually can be self-administered, such as the well-regulated diabetic who receives daily insulin injections. The administration of an occasional or PRN (as needed) intramuscular injection would be considered appropriate for intermediate level of care.

(3) General maintenance care of colostomy or ileostomy, including cleaning colostomy, changing colostomy bags, or routine use of equipment.

(4) Routine insertion and maintenance for patency of indwelling catheters.

(5) Changes of dressings in noninfected, postoperative, or chronic conditions.

(6) Prophylactic and palliative skin care, including bathing and application of medical creams or treatment of minor skin conditions.

(7) Administration of oxygen, after initial phases for a stable, chronic condition.

(8) Routine care of plaster cast and brace patients, including hip spica or body casts.

(9) Heat as palliative treatment.

(10) Provision and supervision of restorative measures.

(11) Provision of skilled services or procedures when the resident's overall condition does not require the intensity of professional nursing services necessary for skilled level of care.

(12) Twenty-four (24) hour a day supervision or direct assistance to maintain safety due to confusion or disorientation that is not related to, or a result of, mental illness.

(d) Medicaid does not make reimbursement for services below the intermediate level of care. *(Office of the Secretary of Family and Social Services; Long Term Care Facilities III; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 272; filed Mar 15, 1988, 1:59 p.m.: 11 IR 2854; filed Mar 10, 1993, 5:00 p.m.: 16 IR 1794; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-3) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 1-3-3 Examples illustrating criteria for level of care; differentiation between skilled and intermediate care

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

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

Sec. 3. The following examples illustrate some of the considerations involved in the differentiation between Skilled and Intermediate care.

SKILLED CARE	INTERMEDIATE CARE
Anemia	

Rapid breakdown of red blood cells which may produce a hemolytic crisis. Treatment – intravenous solutions or transfusions.	Frequently present in the elderly. Oral medication or infrequent injections usually sufficient for routine treatment.
Arteriosclerosic Heart Disease	
Severe vascular heart disease requiring powerful antihypertensive drugs. There may be symptoms of heart failure requiring accurate digitalization and diuretics.	Minimal or moderate amounts of medication without adjustment to medications.
Arthritis	
Drugs used in large doses and over a prolonged period of time that may produce metabolic or toxic symptoms.	Long history of chronic arthritis. Routine medication and physical therapy.
Brain Syndromes (Psychoses)	
Must receive active treatment. (1) Treatment developed by a physician in conjunction with staff members. (2) Services are expected to improve the patient's condition and level of functioning. (3) Services are supervised and evaluated by a physician and documented in the medical record.	Therapy not planned for the particular patient. Activities are diversional in nature, i.e., to provide social or recreational outlet for the patient. Non-energetic treatment with medications.
Bronchitis (chronic) and Bronchiectasis	
Limited pulmonary reserve with changes in oxygen requirements. Intractable congestive heart failure.	Standard oral medication. Patient has been taught to manage own inhalation equipment.
Cataract	
Skilled care required for 14 days because of very recent surgery or complications.	Usually cataract extractions are followed by a normal uncomplicated convalescence in the hospital and discharge to the patient's home.
Cancer	
Recent major surgery. Current treatment with radium, radioactive isotopes, X-ray, and anti-neoplastic agents. Active treatment for serious complications such as severe pain, acute infections, decubiti, fractures, special training while patient learns to handle appliances or surgical wounds, including colostomy.	No specific treatment. Considered arrested. If metastasis, the cancer is not being actively treated.
Cerebrovascular Accident	
Hemiplegia and/or speech disturbance. Less than six months since cerebrovascular accident. Active speech or physical therapy.	Small cerebral vessel involved with minor paralysis (Ischemia Attacks). Patient can ambulate. More than six months since C.V.A.
Cirrhosis of Liver	
Persistent ascites being treated by diuretics, by paracentesis or both.	Bed rest and diet. Moderate use of diuretic drugs.
Congestive Heart Failure	
Patient requires vigorous and comprehensive treatment. Severe shortness of breath, requiring tourniquets on limbs, phlebotomy, or oxygen therapy.	Incipient or mild failure with exertional shortness of breath, fatigue, and perhaps edema of the ankles, which usually subside readily with diuretic and digitalis therapy.
Convulsions	
Frequent attacks due to serious brain diseases, such as tumors, cerebral edema, and cerebrovascular accidents. Difficult to control.	Infrequent attacks that can be controlled or alleviated by medication. Frequency of once a month will be considered skilled care.

Decubitus Ulcer

Energetic treatment by debridement of necrotic tissue, medications, and bandages. Tissue necrosis and infection must be actively treated.	Minor healing decubiti or skin care to prevent decubiti.

Diabetes Mellitus

Severe or "brittle" diabetes. Variations in insulin requirements. Also for the juvenile diabetic.	Diabetes easily controlled by diet and oral medication or insulin.

Emotional Disturbances

To control severe agitation or depression for short period of time, large doses of tranquilizers or anti-depressives are required. Close supervision is required (when IM medications are being given daily).	Anxiety and depression are not severe. Mental condition does not require close continuous supervision.

Emphysema

"Respiratory cripple" may show symptoms of respiratory infection, severe bronchial secretion, carbon dioxide retention, and cardiac failure. These symptoms require energetic medical treatment.	Symptoms of wheezing, chronic cough, and mild dyspnea which do not require special treatment by skilled personnel. Patient may require IPPB treatment for a period.

Fractures

Many factors are involved in the amount of skilled care patient requires. Care depends upon the location of the fracture, the degree of healing, the type of treatment, and the severity of any complications.	The healing process is almost complete. Restorative physical therapy may be necessary.

Hypertensive Heart Disease

Vigorous and diligent treatment for patient showing cerebral signs (encephalopathy) strokes, transient hemiparesis, cardiac insufficiency, coronary ischemia, and severe headaches not controlled by routine analgesics.	Patient has been on long-term antihypertensive therapy or alarming symptoms are absent and the patient is not under vigorous treatment.

Malnutrition

Condition is so serious that patient requires frequent visits by his physician. I.V. or tube feedings generally required.	Patient's poor eating habits are corrected by special diets.

Myocardial Infarction

Recent infarction. Relative rest for the injured heart. Possible congestive heart failure.	Attack over 2 – 3 months ago. Routine prophylaxis (anti-coagulants) against thromboembolic complications. Heart compensating.

Nephritis, Nephrosclerosis, Nephroses

Acute phase of these conditions requires active therapy. In the chronic state they may require special treatment for heart failure, electrolyte abnormalities, acidosis and uremia.	Many elderly patients suffer from renal diseases. Treatment often is a dietary regimen and diuretic drugs.

Osteoporosis

Collapse and wedging of the atrophic vertebral bones may appear under minimal stress. Skilled care will be required to treat the fracture or alleviate the pain.	This condition is found in many elderly people. Oral medications may be administered.

(Office of the Secretary of Family and Social Services; Long Term Care Facilities IV; filed Feb 10, 1978, 11:20 am: Rules and Regs. 1979, p. 273; 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) NOTE: Transferred from the Division of Family and Children (470 IAC 5-3-4) to the Office of the Secretary of Family and Social Services (405 IAC 1-3-3) by P.L.9-

1991, SECTION 131, effective January 1, 1992.

Rule 4. Rate-Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded

405 IAC 1-4-1 Policy; scope (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-2 Definitions (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-4 Financial report to department; annual schedule; prescribed form; extensions; penalty for untimely filing (Repealed)

Sec. 4. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-5 New provider; initial financial report to department; criteria for establishing initial interim rates; supplemental report; base rate setting (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-6 Active providers; rate review; annual request; additional requests; requests due to change in law; request concerning capital return factor; computation of factor (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-9 Criteria limiting rate adjustment granted by department (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-10 Computation of rate; allowable costs; review of cost reasonableness (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-11 Allowable costs; services provided by parties related to provider (Repealed)

Sec. 11. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-12 Allowable costs; capital return factor (Repealed)

Sec. 12. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-13 Allowable cost; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties (Repealed)

Sec. 13. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-14 Allowable costs; capital return factor; computation of return on equity component (Repealed)

Sec. 14. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-15 Allowable costs; capital return factor; use fee; depreciable life; property basis (Repealed)

Sec. 15. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation (Repealed)

Sec. 16. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members (Repealed)

Sec. 17. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses (Repealed)

Sec. 18. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation (Repealed)

Sec. 19. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits (Repealed)

Sec. 20. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-21 Nursing facilities providing intermediate or skilled care; staffing costs; incentive for cost efficiency (Repealed)

Sec. 21. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-22 Routine medical or nonmedical supplies and equipment (Repealed)

Sec. 22. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-23 Nursing facilities providing intermediate and skilled care; reimbursement for therapy services (Repealed)

Sec. 23. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-24 Nursing facilities providing intermediate care and skilled care; allocation of intermediate and skilled care costs (Repealed)

Sec. 24. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-25 State-owned intermediate care facilities for the mentally retarded; allowable costs; compensation; per diem rate (Repealed)

Sec. 25. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-26 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate; incentive payment rate (Repealed)

Sec. 26. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 12, 1993, 5:00 p.m.: 16 IR 1789)*

405 IAC 1-4-26.1 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate; incentive payment rate (Repealed)

Sec. 26.1. *(Repealed by Office of the Secretary of Family and Social Services; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331)*

405 IAC 1-4-27 Administrative reconsideration; appeal (Repealed)

Sec. 27. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-28 Nursing facilities; separate reimbursement for ventilator units in nursing homes (Repealed)

Sec. 28. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-29 Skilled nursing facilities; separate reimbursement for brain and high spinal cord trauma and major progressive neuromuscular disorders (Repealed)

Sec. 29. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-30 Skilled nursing facilities; separate reimbursement for "chronically medically dependent" people infected by the human immunodeficiency virus (HIV) (Repealed)

Sec. 30. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

405 IAC 1-4-31 Skilled nursing facilities; separate reimbursement for "chronically medically dependent" people infected by the human immunodeficiency virus (HIV) (Repealed)

Sec. 31. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 1, 1998, 3:25 p.m.: 22 IR 91)*

Rule 4.1. Rate-Setting Criteria for Home Health Agencies (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 16, 2010, 3:34 p.m.: 20100915-IR-405100166FRA)

Rule 4.2. Home Health Services

405 IAC 1-4.2-1 Policy; scope

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

Sec. 1. (a) This rule provides general information regarding the criteria for providing home health services to Medicaid members and sets forth the criteria for reimbursement for services rendered to Medicaid members by home health agencies. The information and procedures contained in this rule apply to home health agencies. Continued participation in Medicaid and payment for services are contingent upon maintenance of state licensure and compliance with the Medicaid provider agreement.

(b) In accordance with federal law, reimbursement for home health services will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population in the geographic area. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-4.2-2 Definitions

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2

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

(b) "HHA" means a home health agency as defined in IC 12-15-34-1 that is licensed by ISDH to provide home health services and is enrolled as a provider.

(c) "Home health care" means health care provided to Medicaid members who are medically confined to the home as certified by the attending or primary physician.

(d) "Hours worked" means the number of total hours paid for HHA personnel, less the number of hours paid for vacation, holiday, and sick pay.

(e) "Overhead cost rate" means the flat, statewide rate for all allowable costs not reimbursed through the staffing rate.

(f) "Semivariable cost" means that portion of the overhead cost that is reallocated from the overhead cost to the staffing cost. It consists of the following:

(1) Direct supervision.

(2) Routine medical supplies.

(3) Transportation.

(4) Any other semivariable expenses that must be covered by Medicaid under federal law.

(g) "Staffing cost rate" means the service-specific wage and benefit rate paid per billable hour and based upon standard personnel-related costs that are a function of staff time spent in the performance of patient care activities.

(h) "Telehealth services" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-2; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3375; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1116; filed Oct 8, 1998, 12:23 p.m.: 22 IR 433; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016,*

3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

405 IAC 1-4.2-3 Home health care services; general information

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2

Sec. 3. (a) Medicaid will reimburse HHAs for the following home health services:
(1) Skilled nursing performed by a registered nurse or licensed practical nurse.
(2) Home health aide services.
(3) Physical and occupational therapies.
(4) Speech pathology services.
(5) Renal dialysis.
(6) Telehealth services.

The services in this subsection must be performed in the home and provided within the limitations set forth in 405 IAC 5-16.

(b) Except as provided in subsection (c), all home health services require prior authorization by submitting a properly completed written request to the office. Prior authorization procedures for home health care are set forth in 405 IAC 5-16-3 and 405 IAC 5-16-3.1.

(c) Prior authorization may be obtained by telephone under the circumstances and subject to the limitations set forth in 405 IAC 5-3-2(b)(3). Services ordered in writing by a physician prior to the patient's discharge from a hospital within the limitations set forth in 405 IAC 5-3-12(2) do not need prior authorization. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-4.2-3.1 Financial report to office; annual schedule; extensions; penalty for untimely filing

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 3.1. (a) Each HHA shall submit an annual financial report to the office not later than one hundred fifty (150) days after the close of the HHA's reporting year. The annual financial report shall coincide with the fiscal year used by the HHA to report federal income taxes for the operation unless the HHA requests in writing that a different reporting period be used. Such a request shall be submitted within six (6) days after the initial certification of a HHA. This option may be exercised only one (1) time by a HHA. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the HHA's records and the annual financial report.

(b) Extension of the one hundred fifty (150) day filing period shall not be granted unless the HHA substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the HHA of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(c) When an annual financial report is thirty (30) days past due and an extension has not been granted, payment for all Medicaid claims filed by the HHA shall be withheld effective on the first day of the month following the thirtieth day the annual financial report is past due. Payment shall continue to be withheld until the first day of the month after the delinquent annual financial report is received by the office. After receipt of the delinquent annual financial report, the dollar amount paid to the HHA for the claims that were withheld shall be reduced by ten percent (10%). Reimbursement lost because of the ten percent (10%) penalty cannot be recovered by the HHA.

(d) When an annual financial report is sixty (60) days past due and an extension has not been granted, the office shall notify the HHA that the HHA's participation in Medicaid shall be terminated. The termination shall be effective on the first day of the month following the ninetieth day the annual financial report is past due unless the HHA submits the delinquent annual financial

report before that date. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-3.1; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; 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; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-4.2-4 Home health care services; reimbursement methodology

Authority: IC 12-15
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 4. (a) HHAs will be reimbursed for covered services provided to Medicaid members through standard, statewide rates, computed as:

(1) one (1) overhead cost rate per HHA, per member, per day; plus

(2) the staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

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

(1) Determine for each HHA total patient-related costs submitted by HHAs on forms prescribed by the office, less direct staffing and benefit costs, divided by the total number of HHA visits during the Medicaid reporting period for that HHA. The result of this calculation is an overhead cost per visit for each HHA.

(2) Array all HHAs in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.

(3) The statewide median overhead cost per visit is the cost of the agency at the point in the overhead cost array at which one-half (1/2) of the overhead cost observations are from higher-cost agencies and one-half (1/2) are from lower-cost agencies.

(c) The staffing cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median direct staffing and benefit costs per hour for each of the following disciplines:

(1) Registered nurse.

(2) Licensed practical nurse.

(3) Home health aide.

(4) Physical therapist.

(5) Occupational therapist.

(6) Speech pathologist.

(d) The statewide median direct staffing and benefit costs per hour is derived in the following manner:

(1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHAs on forms prescribed by the office, divided by the total number of HHA hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each HHA and discipline.

(2) Array all HHAs in the state in accordance with their staffing cost rate per hour for each discipline, from the highest to the lowest.

(3) The statewide median staffing cost rate per hour for each discipline is the cost of the agency at the point in the staffing cost array in which one-half (1/2) of the cost observations are from agencies with higher staffing rates per hour and one-half (1/2) are from agencies with lower staffing rates per hour.

(e) All HHAs must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all HHA personnel.

(f) Medicare-certified HHAs are required to submit a Medicaid cost report on forms prescribed by the office and the most recently filed Medicare cost report. Non-Medicare-certified HHAs are required to submit a Medicaid cost report on forms prescribed by the office and the latest fiscal year end financial statements.

(g) Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each HHA's cost from the most recent completed year will be adjusted for inflation using the Center for Medicare & Medicaid Services Home Health Agency Market Basket index as published quarterly by Global Insight. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the

next expected rate period.

(h) The semivariable cost will be removed from the overhead cost calculated in accordance with subsection (b) and added to the staffing cost calculated in accordance with subsection (c), based on hours worked.

(i) Field audits will be conducted yearly on a selected number of HHAs. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.

(j) Financial and statistical documentation may be requested by the office. This documentation may include, but is not limited to, the following:

(1) Medicaid cost reports.

(2) Medicare cost reports.

(3) Statistical data.

(4) Financial statements.

(5) Other supporting documents deemed necessary by the office.

Failure to submit requested documentation within thirty (30) days of the date of the request may result in the imposition of the sanctions described in section 3.1(c) and 3.1(d) of this rule and sanctions set forth in IC 12-15-22-1.

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

(1) A field audit identifies overpayment by Medicaid.

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

(A) complete appropriate Medicaid billing adjustment forms; and

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

(l) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by three percent (3%) for home health services that have been calculated under this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-4.2-5 Home health care services; annual adjustments

Authority: IC 12-15-21-1; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 5. New rates set on July 1, 2008, shall be:

(1) effective on July 1; and

(2) annually adjusted thereafter based upon the most recently submitted financial and statistical documentation as filed by all HHAs who billed Medicaid for services provided during the cost report period.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-5; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3377; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1119; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

405 IAC 1-4.2-6 Telehealth services

Authority: IC 12-15-5-11; IC 12-15-21
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 6. (a) Approved telehealth services are reimbursed separately from other home health services. The unit of reimbursement for telehealth services provided by an HHA is one (1) calendar day.

(b) Reimbursement is available for telehealth services as follows:

(1) One-time amount per client of fourteen dollars and forty-five cents ($14.45) related to an initial face-to-face visit

necessary to train the member to appropriately operate the telehealth equipment.

(2) One (1) payment of nine dollars and eighty-four cents ($9.84) for each day the telehealth equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

(c) Rates for telehealth services shall not be adjusted annually.

(d) All equipment and software cost associated with the telehealth services must be separately identified on the HHA's annual cost report so that it may be removed from the calculation of overhead costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-6; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

Rule 4.3. Additional Rate-Setting Criteria for Nursing Facilities, Community Residential Facilities for the Developmentally Disabled, and Intermediate Care Facilities for the Mentally Retarded

405 IAC 1-4.3-1 Limitations or qualifications to Medicaid reimbursement; litigation expenses

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-14-2

Sec. 1. (a) Notwithstanding any other sections of this article, the criteria in this section apply to litigation expenses for nursing facilities, ICFs/IID, and CRFs/DD.

(b) Legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the office as reasonably related medical expenses under Medicaid if the expenses are incurred as the result of an administrative or judicial action or proceeding against any agency of the state or the federal government. *(Office of the Secretary of Family and Social Services; 405 IAC 1-4.3-1; filed Jul 28, 1994, 4:00 p.m.: 17 IR 2853; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 5. Provider Records

405 IAC 1-5-1 Medical records; contents and retention

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

Sec. 1. (a) Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program.

(b) All providers participating in the Indiana Medicaid program shall maintain, for a period of seven (7) years from the date Medicaid services are provided, such medical or other records, or both, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. A copy of a claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement. Such medical or other records, or both, shall include, at the minimum, the following information and documentation:

(1) The identity of the individual to whom service was rendered.

(2) The identity of the provider rendering the service.

(3) The identity and position of the provider employee rendering the service, if applicable.

(4) The date on which the service was rendered.

(5) The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.

(6) A detailed statement describing services rendered.

(7) The location at which services were rendered.

(8) The amount claimed through the Indiana Medicaid program for each specific service rendered.

(9) Written evidence of physician involvement and personal patient evaluation will be required to document the acute

medical needs. A current plan of treatment and progress notes, as to the necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.

(10) When a recipient is enrolled in therapy, and when required under Medicaid program rules, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy program.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-110; filed Aug 16, 1979, 3:30 p.m.: 2 IR 1383; filed Sep 23, 1982, 9:55 a.m.: 5 IR 2351; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3298; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:15 a.m.: 28 IR 2134; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-5-1) to the Office of the Secretary of Family and Social Services (405 IAC 1-5-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 1-5-2 Disclosure of medical records

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-22

Sec. 2. Records maintained by providers under section 1 of this rule shall be openly and fully disclosed and produced to the office of Medicaid policy and planning or any authorized representative, designee, or agent thereof, forthwith, upon reasonable notice and request. Such notice and request may be made in person, in writing, or by telephonic means. Failure on the part of any provider to comply with this section shall constitute an abuse of the Medicaid program under IC 12-15-22 and applicable federal law. *(Office of the Secretary of Family and Social Services; 405 IAC 1-5-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; 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)*

405 IAC 1-5-3 Provider financial records used in rate setting; retention

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

Sec. 3. Providers whose reimbursement is determined by the office of Medicaid policy and planning must maintain financial records for a period of not less than three (3) years following submission of financial data to the office. A provider must disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings. *(Office of the Secretary of Family and Social Services; 405 IAC 1-5-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; 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)*

Rule 6. Medicaid Covered Services and Limitations (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365)

Rule 7. Medicaid Medical Policy (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3365)

Rule 8. Hospital and Ambulatory Surgical Center Reimbursement for Outpatient Services

405 IAC 1-8-1 Prospective reimbursement methodology (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Dec 2, 1993, 2:00 p.m.: 17 IR 737)*

405 IAC 1-8-2 Policy; scope

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

Sec. 2. (a) Reimbursement for outpatient hospital services as defined by 42 CFR 440.20(a) and to ambulatory surgical centers is available to providers enrolled by the office as providers who are in good standing. Continued participation in Medicaid and payment for outpatient hospital services and ambulatory surgical centers are contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) The methodology for the reimbursement described in subsection (a) shall be based on set fee schedule allowances for each procedure or occurrence as established by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-2; filed Dec 2, 1993, 2:00 p.m.: 17 IR 735; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-8-3 Reimbursement methodology

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

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

(b) Surgical procedures shall be:

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

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

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

(c) Payments for emergent care that:

(1) do not include surgery; and

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

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

(d) Payments for nonemergent care that:

(1) do not include surgery; and

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

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

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

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

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

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

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

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

(k) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by three percent (3%) for outpatient hospital services (excluding ambulatory surgical center reimbursement) that have been calculated under this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted*

filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 16, 2010, 3:35 p.m.: 20100915-IR-405100167FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

405 IAC 1-8-4 Client copayment

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-6-3; IC 12-15-6-4

Sec. 4. (a) Except for those categories of individuals and services specifically exempted in subsection (e), Medicaid members shall be responsible for paying directly to providers a set portion of the payment for nonemergency services provided in an emergency room setting. Services defined as nonemergency shall be determined by the office.

(b) The amount of copayment to be charged shall be three dollars ($3) for nonemergency services provided in emergency room settings.

(c) The provider shall be responsible for collecting the appropriate copayment amount from the member.

(d) Participating providers may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. This services guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate the individual's liability for the copayment.

(e) The following categories of members and services are exempt from the copayment requirements:

(1) Services provided to children under eighteen (18) years of age.

(2) Services provided to pregnant women.

(3) Family planning services.

(4) Services provided by a health maintenance organization (HMO) to members enrolled in an HMO.

(5) Medicaid members residing in participating long term care facilities.

(f) The copayment shall be made by the members and collected by the provider. Medicaid reimbursement shall be adjusted to reflect the copayment amount. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-4; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-8-5 Outpatient hospital assessment fee

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

Sec. 5. (a) Effective through June 30, 2017, the office shall collect an outpatient hospital assessment fee (HAF) from each outpatient hospital that:

(1) meets the definition set forth in IC 16-18-2-179(b); and

(2) is licensed under either:

(A) IC 16-21-2 as an acute care hospital; or

(B) IC 12-25 as a private psychiatric hospital.

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

et seq.) and that do not have a cost report on file, information for computing the assessment fee will be obtained from the hospital by the office or its designee.

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

(d) The following hospitals are excluded from the assessment fee:

(1) Long term care hospitals.

(2) State-owned hospitals.

(3) Hospitals operated by the federal government.

(4) Freestanding rehabilitation hospitals.

(5) Freestanding psychiatric hospitals with:

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

(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging. A freestanding psychiatric hospital that was certified as part of a community mental health center at any time during the HAF period is subject to the assessment fee.

(6) Out-of-state hospitals.

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

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

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

(B) acute care hospitals that:

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

(ii) did not have LIUR status in 2010.

(2) Fifty percent (50%) of the full rate for acute hospitals that:

(A) qualify for DSH payments during each HAF period through meeting LIUR criteria; and

(B) met LIUR status in 2010.

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

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

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

(1) Be in writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

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

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

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

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

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

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

(A) A Medicaid payment to the hospital.

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

(2) In another manner determined by the office.

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

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

(2) submitted to the office or its designee.

If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. The installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and shall include provisions for the collection of interest. The interest shall not exceed the percentage determined in IC 12-15-21-3(6)(A).

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

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

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

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

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

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

(1) The initial outpatient hospital adjustment factor is three and twenty-hundredths (3.20) for the following:

(A) Acute care hospitals licensed under IC 16-21, except for those specified in subdivision (2).

(B) Psychiatric institutions licensed under IC 12-25.

(2) For the period through June 30, 2015, the outpatient hospital adjustment factor is ninety-seven hundredths (0.97), and thereafter is one (1.0), for the following:

(A) Long term care hospitals.

(B) Freestanding rehabilitation hospitals.

(C) Out-of-state hospitals.

(D) Clinical laboratory services.

(o) For the period through June 30, 2017, the limitation on payments for an individual claim to the lesser of the amount computed or billed charges shall not apply. *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-5; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)*

Rule 9. Reimbursement for Inpatient Psychiatric Services (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 10. Reimbursement for Inpatient Hospital Services (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 10.5. Reimbursement for Inpatient Hospital Services

405 IAC 1-10.5-1 Policy; scope

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

Sec. 1. Reimbursement for inpatient hospital services, as defined by 42 CFR 440.10, is available to providers enrolled by the office as Medicaid providers and who are in good standing. Continued participation in the Medicaid program and payment of inpatient hospital services are contingent upon maintenance of state licensure and conformance with the office's provider agreement. 405 IAC 5-17 and 405 IAC 5-28 establish criteria for providing inpatient hospital services to Medicaid members and set forth the types of services for which Medicaid reimbursement may be available. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-1; filed Oct 5, 1994, 11:10 a.m.: 18 IR 243; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55; 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)*

405 IAC 1-10.5-2 Definitions

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1; IC 12-24-1-3; IC 12-25; IC 16-21

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

(b) "All patient refined diagnosis-related group (DRG) grouper" refers to a classification system used to assign inpatient stays to DRGs.

(c) "Base amount" means the rate per Medicaid stay that is multiplied by the relative weight to determine the DRG rate.

(d) "Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

(e) "Capital costs" are costs associated with the capital costs of the facility. The term includes, but is not limited to, the following:

(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

(f) "Children's hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a children's hospital; or
(2) furnishes services to inpatients who are predominantly individuals under eighteen (18) years of age, as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under eighteen (18) years of age.

(g) "Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold, defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. This amount may be changed at the time the relative weights are adjusted.

(h) "Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays utilizing similar hospital resources. Classification is made through the use of the all patient refined (APR) DRG grouper.

(i) "Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge unless one (1) of the units is paid according to the level-of-care approach.

(j) "DRG daily rate" means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the average length of stay for all stays classified into the DRG.

(k) "DRG rate" means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse

hospitals for routine and ancillary costs of providing care for an inpatient stay.

(l) "Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(n) "Inpatient" means a patient who was admitted to a medical facility on the recommendation of a physician and who received room, board, and professional services in the facility.

(n) "Inpatient hospital facility" means:

(1) a general acute hospital licensed under IC 16-21;

(2) a mental health institution licensed under IC 12-25;

(3) a state mental health institution under IC 12-24-1-3; or

(4) a rehabilitation inpatient facility.

(o) "Intestinal transplant" means the grafting of either the small or large intestines from a donor into a recipient.

(p) "Less than one-day stay" means a medical stay of less than twenty-four (24) hours.

(q) "Level-of-care case" means a medical stay, as defined by the office, that includes psychiatric cases, rehabilitation cases, long term care hospital admissions, and certain burn cases.

(r) "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure subject to subsection (r).

(s) "Long term care hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a long term hospital; or

(2) has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.

(t) "Marginal cost factor" means a percentage applied to the difference between the cost per stay and the outlier threshold for purposes of the cost outlier computation.

(u) "Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day. The term does not include any portion of an outpatient service under 405 IAC 1-8-3 that precedes an admission as an inpatient subject to subsection (n).

(v) "Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by Medicaid.

(w) "Medical education costs" means the direct costs associated with the salaries and benefits of medical interns and residents and paramedical education programs.

(x) "Multivisceral transplant" means the grafting of either the small or large intestines and one (1) or more of the following organs from a donor into a member:

(1) Liver.

(2) Stomach.

(3) Pancreas.

(y) "Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

(z) "Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

(aa) "Principal diagnosis" means the diagnosis, as described by the International Classifications of Diseases, 10th revision, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

(bb) "Readmission" means that a patient is admitted into the hospital following a previous hospital admission and discharge for a related condition as defined by the office.

(cc) "Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

(dd) "Relative weight" means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

(ee) "Routine and ancillary costs" means costs that are incurred in providing services exclusive of medical education and capital costs.

(ff) "Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit to another unit within the same hospital will not

constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

(gg) "Transferee hospital" means that hospital that accepts a transfer from another hospital.

(hh) "Transferring hospital" means the hospital that initially admits and then discharges the patient to another hospital. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-2; filed Oct 5, 1994, 11:10 a.m.: 18 IR 244; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1514; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2248; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2482; 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; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-10.5-3 Prospective reimbursement methodology

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

Sec. 3. (a) The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by inpatient hospital facilities that are covered by Medicaid. The methodology for reimbursement described in this section shall be a prospective system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology or, in the case of intestinal or multivisceral transplants, as described under subsection (j). Prospective payment shall constitute full reimbursement unless otherwise indicated herein or as indicated in provider manuals and update bulletins. There shall be no year-end cost settlement payments.

(b) Rebasing of the DRG and level-of-care methodologies will apply information from the most recent available cost report that has been filed and audited by the office.

(c) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the lower of billed charges or the sum of the DRG rate, the capital rate, the medical education rate, and, if applicable, the outlier payment amount.

(d) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the lower of billed charges or the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate, and, if applicable, the outlier payment amount (burn cases only).

(e) Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient refined DRG grouper.

(f) The DRG rate is equal to the product of the relative weight and the base amount.

(g) Relative weights will be reviewed periodically by the office and adjusted no more often than annually by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine whether an adjustment to the relative weights will be made. DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted. The office shall include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission will not be eligible for outpatient reimbursement under 405 IAC 1-8-3. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

(h) Base amounts will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.

(i) The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one (1) standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred twenty percent (120%) of the statewide base amount for DRG services.

(j) The reimbursement methodology for all covered intestinal and multivisceral transplants shall be equal to ninety percent (90%) of reasonable cost, until such time an appropriate DRG as determined by the office can be assigned. The office will use the

most recent cost report data that has been filed and audited by the office to determine reasonable costs.

(k) Level-of-care rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. The office shall not set separate level-of-care rates for different categories of facilities except as specifically noted in this section.

(l) Level-of-care cases are categorized as DRG numbers 740, 750–756, 757 (excluding diagnosis codes for intellectual disabilities-mild, moderate, severe, and profound or not otherwise specified classifiable to F70–F79), 758–760, 841–844, and 860, as defined and grouped using the all patient refined DRG grouper, version 30. These DRG numbers represent burn, psychiatric, and rehabilitative care.

(m) In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must offer a burn intensive care unit.

(n) The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one (1) standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

(o) The office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of long term hospital set forth in this rule to be eligible for the separate level-of-care rate.

(p) Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital per diem rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. Capital payment rates shall be adjusted to reflect a minimum occupancy level for nonnursery beds of eighty percent (80%).

(q) The capital payment amount for Medicaid stays reimbursed under the DRG methodology shall be equal to the product of the per diem capital rate and the average length of stay for all cases within the particular DRG. Medicaid stays reimbursed under the level-of-care methodology will be paid the per diem capital rate for each covered day of care. The office shall not set separate capital per diem rates for different categories of facilities except as specifically noted in this rule.

(r) Medical education rates shall be prospective, hospital-specific per diem amounts. The medical education payment amount for stays reimbursed under the DRG methodology shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Payment amounts for medical education for stays reimbursed under the level-of-care methodology shall be equal to the medical education per diem rate for each covered day of care.

(s) Facility-specific, per diem medical education rates shall be based on medical education costs per day multiplied by the number of residents reported by the facility. In subsequent years, but no more often than every second year, the office will use the most recent cost report data that has been filed and audited by the office to determine a medical education cost per day that more accurately reflects the cost of efficiently providing hospital services. For hospitals with approved graduate medical education programs, the number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor. Indirect medical education costs shall not be reimbursed.

(t) Medical education payments will only be available to hospitals that continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program.

(u) For hospitals with new medical education programs, the corresponding medical education per diem will not be effective prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data and cost report data.

(v) Cost outlier cases are determined according to a threshold established by the office. For purposes of establishing outlier payment amounts, prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio by submitted and approved charges. Outlier payment amounts shall be equal to the marginal cost factor multiplied by the difference between the prospective cost per stay and the outlier threshold amount. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology except for burn cases that exceed the established threshold.

(w) Readmissions for the same or related diagnoses within three (3) calendar days after discharge will be treated as the same admission for payment purposes. Readmissions that occur after three (3) calendar days will be treated as separate stays for payment purposes but will be subject to medical review.

(x) Special payment policies shall apply to certain transfer cases. The transferee, or receiving, hospital is paid according to the DRG methodology or level-of-care methodology. The transferring hospital is paid the sum of the following:

(1) A DRG daily rate for each Medicaid day of the member's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided.

(2) The capital per diem rate.

(3) The medical education per diem rate. Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate.

(y) Hospitals will not receive separate DRG payments for Medicaid patients subsequent to their return from a transferee hospital. Additional costs incurred as a result of a patient's return from a transferee hospital are eligible for cost outlier reimbursement subject to subsection (v). The office may establish a separate outlier threshold or marginal cost factor for such cases.

(z) Special payment policies shall apply to less than twenty-four (24) hour stays. For less than twenty-four (24) hour stays, hospitals will be paid under the outpatient reimbursement methodology as described in 405 IAC 1-8-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-3; filed Oct 5, 1994, 11:10 a.m.: 18 IR 245; filed Nov 16, 1995, 3:00 p.m.: 19 IR 664; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1083; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1515; errata filed Mar 21, 1997, 9:45 a.m.: 20 IR 2116; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 57; errata filed Jan 25, 2002, 2:27 p.m.: 25 IR 1906; filed Oct 20, 2003, 10:00 a.m.: 27 IR 863; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2249; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2484; errata filed Jun 16, 2004, 9:35 a.m.: 27 IR 3580; 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)*

405 IAC 1-10.5-4 Reimbursement for new providers and out-of-state providers

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

Sec. 4. (a) The purpose of this section is to establish payment rates for inpatient hospital facilities that commenced participation in the state Medicaid program after fiscal year 1990 and for out-of-state hospital providers participating in the Indiana Medicaid program.

(b) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate calculated using the statewide median capital rate, the medical education rate, and, if applicable, the outlier payment calculated using the statewide median cost-to-charge ratio.

(c) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate calculated using the statewide median capital rate, and the medical education rate.

(d) Outlier payments for inpatient stays reimbursed under subsection (b) shall be determined according to the methodology described in section 3 of this rule. Each out-of-state hospital that submits a Medicaid hospital cost report will receive a cost-to-charge ratio. All other out-of-state facilities must use the statewide median cost-to-charge ratio to determine applicable cost outlier payments.

(e) To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) and 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Medicaid inpatient days. Providers must submit annually a Medicaid hospital cost report to be eligible for this reimbursement. The facility-specific per diem medical education rate for an out-of-state provider shall not exceed the highest in-state medical education per diem rate.

(f) To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) and 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Medicaid inpatient days. Providers must submit annually a Medicaid hospital cost report to be eligible for a separate base amount. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-4; filed Oct 5, 1994, 11:10 a.m.: 18 IR 246; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1084; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1517; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.:*

20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-10.5-5 Health care-acquired conditions and other provider-preventable conditions

Authority: IC 12-15
Affected: IC 12-15-15-1

Sec. 5. (a) This section applies to the following:

(1) Payment for inpatient stays reimbursed according to the DRG and level-of-care methodologies.

(2) All inpatient hospital facility reimbursement provisions, including the following:

(A) Medicaid supplemental payments.

(B) Medicaid enhanced payments.

(C) Medicaid disproportionate share hospital payments.

(b) The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a health care-acquired condition that was not present on the date of admission. If a health care-acquired condition is not present on the date of admission, the discharge will be assigned to a DRG as though the health care-acquired condition was not present.

(c) Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

(d) For purposes of this section, a "health care-acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and 42 CFR 447.26(b) and in effect on the date of admission.

(e) The state shall not pay for other provider-preventable conditions, as defined at 42 CFR 447.26(b). *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-5; filed Aug 28, 2009, 3:38 p.m.: 20090923-IR-405090202FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA)*

405 IAC 1-10.5-6 Rate reduction

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

Sec. 6. Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, 2017, by three percent (3%) for inpatient hospital services that have been calculated under this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-6; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA)*

405 IAC 1-10.5-7 Inpatient hospital assessment fee

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

Sec. 7. (a) Effective through June 30, 2017, the office shall collect an inpatient hospital assessment fee (HAF) from each inpatient hospital that:

(1) meets the definition set forth in IC 16-18-2-179(b); and

(2) is licensed under either:

(A) IC 16-21-2 as an acute care hospital; or

(B) IC 12-25 as a private psychiatric hospital.

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

adjusted as follows:

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

(2) To exclude hospitals that have closed.

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

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

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

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

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

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

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

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

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

(1) Long term care hospitals.

(2) State-owned hospitals.

(3) Hospitals operated by the federal government.

(4) Freestanding rehabilitation hospitals.

(5) Freestanding psychiatric hospitals with:

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

(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging. A freestanding psychiatric hospital that was certified as part of a community mental health center at any time during the HAF period is subject to the assessment fee.

(6) Out-of-state hospitals.

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

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

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

(B) acute care hospitals that:

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

(ii) did not have LIUR status in 2010.

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

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

through meeting LIUR criteria.

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

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

(1) Be in writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

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

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

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

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

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

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

(A) A Medicaid payment to the hospital.

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

(2) In another manner determined by the office.

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

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

(2) submitted to the office or its designee.

If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage determined under IC 12-15-21-3(6)(A).

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

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

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

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

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

(o) For the fee period, as defined at IC 16-21-10-3, inpatient hospital rates are subject to an inpatient hospital adjustment factor that may be changed but not more frequently than every six (6) months. The inpatient hospital adjustment factors shall result

in aggregate payments that reasonably approximate the federal Medicare upper payment limit under 42 CFR 447.272, but shall not result in payments in excess of the federal Medicare upper payment limit. The initial inpatient hospital adjustment factors are as follows:

(1) The initial hospital adjustment factor for the DRG base rate is three (3.00).

(2) The initial hospital adjustment factor for psychiatric level of care rates is two and twenty-hundredths (2.20).

(3) The initial hospital adjustment factor for acute care hospital rehabilitation level of care rates is three (3.00).

(4) The initial hospital adjustment factor for burn level of care rates is one (1.00).

(p) The inpatient hospital adjustment factors in subsection (o) apply to the following:

(1) Acute care hospitals licensed under IC 16-21, except for those specified in subsection (q).

(2) Psychiatric institutions licensed under IC 12-25.

(q) For the period through June 30, 2015, the inpatient hospital adjustment factor is ninety-seven hundredths (.97), and thereafter is one (1.0), for the following:

(1) Long term care hospitals.

(2) Freestanding rehabilitation hospitals.

(3) Out-of-state hospitals.

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

(s) Following the close of each state fiscal year, the office or its contractor shall perform a test to ensure that annual aggregate inpatient payments to a hospital do not exceed the hospital's total inpatient billed charges for the fiscal year. Annual aggregate inpatient payments to a hospital in excess of the hospital's billed charges for the fiscal year shall be recovered by the office or its designee. As permitted by 42 CFR 447.271(b), payments to nominal charge hospitals identified in IC 12-15-15-11 are not subject to this inpatient billed charge limitation. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-7; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)*

Rule 11. Reimbursement for Services Performed by Physicians, Limited License Practitioners, and Nonphysician Practitioners (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59)

Rule 11.5. Reimbursement for Services Performed by Physicians, Limited License Practitioners, and Nonphysician Practitioners

405 IAC 1-11.5-1 Policy; scope

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

Sec. 1. (a) Reimbursement for physician services, limited license practitioner services, and nonphysician practitioner services as defined by 42 CFR 440.50 and 42 CFR 440.60(a) is available to providers licensed by the professional licensing agency and enrolled by the office as providers who are in good standing. Continued participation in Medicaid and payment for services is contingent upon maintenance of state licensure and conformance with the office's provider agreement.

(b) As used in this rule, "physician and limited license practitioner" or "LLP" means any of the following:

(1) A doctor of medicine.

(2) A doctor of osteopathy.

(3) A physician group practice.

(4) A primary care group practice.

(5) An optometrist.

(6) A podiatrist.

(7) A dentist who is an oral surgeon.

(8) A chiropractor.

(9) A health service provider in psychology.

(c) As used in this rule, "nonphysician practitioner" or "NPP" means any of the following:
(1) A physical therapist.
(2) An occupational therapist.
(3) A respiratory therapist.
(4) An audiologist.
(5) A speech therapist.
(6) A licensed psychologist.
(7) An independent laboratory or radiology provider.
(8) A dentist who is not an oral surgeon.
(9) A social worker certified through the American Academy of Certified Social Workers (ACSW) or who has a master of social work (MSW) degree, a psychologist with a basic certificate, or a licensed psychologist providing outpatient mental health services in a physician-directed outpatient mental health facility.
(10) An advance practice nurse.
(11) A physician's assistant.
(12) A mental health professional listed in 405 IAC 5-21.5-1(c), or an individual who has documented education, training, or experience, comparable or equivalent to those listed in this subsection, as approved by the supervising physician or HSPP, under the supervision of a psychiatrist, a physician, or a licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(13) An inpatient hospital facility as defined in 405 IAC 1-10.5-2.

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-1; filed Sep 6, 1994, 3:25 p.m.: 18 IR 87; 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 Sep 12, 2008, 12:34 p.m.: 20081008-IR-405080186FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

405 IAC 1-11.5-2 Reimbursement methodology

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

Sec. 2. (a) The office shall establish fee schedules with maximum allowable payment amounts for services and procedures:
(1) covered under Medicaid; and
(2) provided by eligible physicians, LLPs, and other NPPs.
(b) The reimbursement for services of physicians and LLPs shall be determined as follows:
(1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10), shall be equal to the lower of the following:
(A) The submitted charges for the procedure.
(B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office.
(2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:
(A) Relative value units may be:
(i) obtained from other state Medicaid programs; or
(ii) developed specifically for Medicaid subject to review by the office.
(B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.
(3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.
(4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as

established by the office.
(5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).
(7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by CMS for the Medicare Part B fee schedule for physician services.
(8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by CMS for the Medicare Part B fee schedule for physician services.
(9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections, if it is used for patients who meet the criteria established by the office.
(10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.
(c) Reimbursement for services of NPPs shall be in accordance with the following:
(1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be not lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.
(2) Reimbursement for services of:
(A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;
(B) psychologists with basic certificates; and
(C) licensed psychologists;
providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with 405 IAC 5-20-8 shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.
(3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).
(4) Reimbursement for services provided by certified physical therapists' assistants shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must be billed through the supervising licensed physical therapist or physician.
(5) Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. The state MAC rate for blood factor products is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The office will review the state MAC rates for blood factor products on an ongoing basis and adjust the rates as necessary to:
(A) reflect the prevailing market conditions; and
(B) ensure reasonable access by inpatient hospital providers to blood factor products at or below the applicable state MAC rate.
Inpatient hospitals shall submit claims for reimbursement in accordance with the instructions set forth in the provider manual or update bulletins.
(6) Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services

as established under subsection (b)(1).

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

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

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

(g) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b). *(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2; filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1901; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Sep 12, 2008, 12:34 p.m.: 20081008-IR-405080186FRA; filed Aug 19, 2010, 3:32 p.m.: 20100915-IR-405100250FRA; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100793FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-11.5-3 Additional provisions

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

Sec. 3. (a) Physician reimbursement is subject to all other Medicaid rules not otherwise specifically covered by this section. As an example, the provider of service may not develop or bill Medicaid for charges that are in excess of the usual and customary charges billed for similar services to non-Medicaid payers.

(b) In the event that the provider is dissatisfied with rates issued in accordance with this section and has exhausted all interim review procedures provided in this article, it may seek an administrative appeal under IC 4-21.5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-3; filed Sep 6, 1994, 3:25 p.m.: 18 IR 89; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled

405 IAC 1-12-1 Policy; scope

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

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

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid

expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

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

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

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-1; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-2 Definitions

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

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

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

(1) care;

(2) room and board;

(3) supplies; and

(4) ancillary services;

within a single, comprehensive amount.

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

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

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

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

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

(h) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and

January 1 and shall be computed on a statewide basis for like levels of care, with the exceptions noted in this subsection, as follows:

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

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

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

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

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

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

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

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

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

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

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

(p) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(q) "Forms prescribed by the office" means:

(1) forms provided by the office; or

(2) substitute forms that have received prior written approval by the office.

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

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

(t) "Like levels of care" means care:

(1) within the same level of licensure provided in a CRF/DD;

(2) provided in a nonstate-operated ICF/IID; or

(3) provided in a nonstate-operated ICF/IID licensed as a CRMNF.

(u) "Non-rebasing year" means the year during which nonstate-operated ICFs/IID and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:

October 1, 2011, through September 30, 2012

October 1, 2013, through September 30, 2014

October 1, 2015, through September 30, 2016
October 1, 2017, through September 30, 2018
And every second year thereafter.

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

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

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

(y) "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's length transaction, not to exceed the limitations set out in this rule.

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

October 1, 2012, through September 30, 2013
October 1, 2014, through September 30, 2015
October 1, 2016, through September 30, 2017
October 1, 2018, through September 30, 2019
And every second year thereafter.

(aa) "Related party/organization" means that the provider:

(1) is associated or affiliated with; or

(2) has the ability to control or be controlled by;

the organization furnishing the service, facilities, or supplies.

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

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

(dd) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-2; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2314; filed Aug 15, 1997, 8:47 a.m.: 21 IR 76; filed Oct 31, 1997, 8:45 a.m.: 21 IR 949; filed Aug 14, 1998, 4:27 p.m.: 22 IR 63; errata filed Dec 14, 1998, 11:37 a.m.: 22 IR 1526; filed Sep 3, 1999, 4:35 p.m.: 23 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3121; filed Oct 10, 2002, 10:52 a.m.: 26 IR 718; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchical order listed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care. The burden of demonstrating that costs are patient or resident related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-3; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2316; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR- 405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

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

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

(1) Patient or resident census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and customary charge.

(8) Certification statement signed by the provider that:

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

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

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

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

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

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

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

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the enrollment date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or

(2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the enrollment date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/IID providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) Until the identified threshold number of homes is obtained, the fiftieth percentile rates shall be determined as follows:

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

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

(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental homes multiplied by one hundred fifty-nine percent (159%).

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences for adults, the fiftieth percentile rate for extensive support needs residences for adults shall be the fiftieth percentile rate for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

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

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

(1) Patient or resident census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and customary charge.

(8) Certification by the provider that:

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

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

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

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

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

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-5; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2317; filed Aug 21, 1996, 2:00 p.m.: 20 IR 12; filed Aug 15, 1997, 8:47 a.m.: 21 IR 78; filed Oct 31, 1997, 8:45 a.m.: 21 IR 950; filed Sep 3, 1999, 4:35 p.m.: 23 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3123; filed Oct 10, 2002, 10:52 a.m.: 26 IR 721; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-6 Active providers; rate review; annual request

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

Sec. 6. (a) The rate effective date of the annual rate review established during rebasing years and nonrebasing years shall be the first day of the fourth month following the provider's reporting year-end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The annual rate review that shall become effective during a rebasing year shall be established using the annual financial report as the basis of the review.

(c) The annual rate review that shall become effective during a nonrebasing year shall be established by applying an inflation adjustment to the previous year's annual or base Medicaid rate that excludes the rate reduction amount specified in section 24(d) of this rule. The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual or base Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-6; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 722; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jul 31, 2008, 4:12 p.m.: 20080827-IR-405070647FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

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

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

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

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

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

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

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

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

Median Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-7; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; filed Sep 3, 1999, 4:35 p.m.: 23 IR 21; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 723; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-12-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient or resident utilization.

(b) Each facility and distinct home office location shall be allowed:

(1) one (1) patient or resident care-related automobile; and

(2) one (1) vehicle that can be utilized for facility maintenance or patient or resident support or for both uses;

to be included in the vehicle basis for purposes of cost reimbursement under this rule. Vehicle basis means the purchase price of the vehicle used for facility or home office operations. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office location(s) are responsible for maintaining records to substantiate operational and personal use for all allowable vehicles. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-8; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 723; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office

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

Sec. 9. During rebasing years and for base rate reviews, the Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate established during rebasing years and for base rate reviews is subject to the following limitations:

(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the DDRS.

(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.

(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I

Profit Add-On

The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.

Level of Care	(A) Percent	(B) Ceiling	(C) Cap
Sheltered living	40%	105%	10%
Intensive training	40%	120%	10%
Child rearing	40%	130%	12%
Nonstate-operated ICF/IID	40%	125%	12%
Developmental training	40%	110%	10%
Child rearing with a specialized program	40%	120%	12%
Small behavior management residences for children	40%	120%	12%
Basic developmental	40%	110%	10%
Small extensive medical needs residences for adults	40%	110%	10%
Extensive support needs residences for adults	40%	110%	10%

TABLE II
Overall Rate Limit

Level of Care	(A) Percent
Sheltered living	115%
Intensive training	120%
Child rearing	130%
Developmental training	120%
Child rearing with a specialized program	120%
Small behavior management residences for children	120%
Basic developmental	120%
Small extensive medical needs residences for adults	120%
Extensive support needs residences for adults	120%
Nonstate-operated ICF/IID	107%

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-9; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2320; filed Aug 15, 1997, 8:47 a.m.: 21 IR 79; filed Oct 31, 1997, 8:45 a.m.: 21 IR 951; filed Aug 14, 1998, 4:27 p.m.: 22 IR 65; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Oct 10, 2002, 10:52 a.m.: 26 IR 724; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-12-10 Computation of rate; allowable costs; review of cost reasonableness

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

Sec. 10. (a) The per diem rate shall be an all-inclusive rate. The office shall not set a rate for more than one (1) level of care for each CRF/DD provider.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient or resident care costs shall be clearly identified.

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

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

(e) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-10; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2321; 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)*

405 IAC 1-12-11 Allowable costs; services provided by parties related to provider

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

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction in an open competitive market.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own

the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

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

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.

(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

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

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.

(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.

(4) The organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(f) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-11; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-12 Allowable costs; capital return factor

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

Sec. 12. (a) Providers, other than extensive support needs residences for adults, shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient or resident care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate during rebasing years is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient or resident care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-12; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 724; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

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

Sec. 13. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years. If facility payments toward the principal loan amount are less than the amount derived from a standard loan amortization during the reporting period, the computation of the use fee shall be limited to the principal and interest amounts actually paid during the reporting period, unless the financing arrangement specifically requires that amortized payments to be made to a sinking fund, or its equivalent, for future principal payments and the provider can demonstrate that payments from the sinking fund are actually made.

(c) The use fee component of the capital return factor shall be limited by the lesser of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall be recognized only when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the

period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall be recognized only if the provider can demonstrate that such loans were reasonable and necessary in providing patient or resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient or resident care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-13; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2322; filed Sep 1, 2000, 2:10 p.m.: 24 IR 16; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 725; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-12-14 Allowable costs; capital return factor; computation of return on equity component

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

Sec. 14. (a) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment or actual equity in allowable facilities and equipment up to sixty percent (60%) of allowable historical cost of facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical costs of facilities and equipment, or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, ten (10) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations of section 15(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-14; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2323; filed Sep 1, 2000, 2:10*

p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 726; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

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

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition, for all providers, except for providers of extensive support needs residences for adults, shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700

3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

The schedule shall be updated semiannually effective on March 1 and September 1 by the office and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate, for all providers, except for providers of extensive support needs residences for adults, that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor, which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on the following:

(A) The maximum property basis per bed at the time of acquisition of each bed, plus one-half (1/2) of the difference between that amount and the maximum property basis per bed at the rate effective date.

(B) The term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983.

(C) The allowable interest rate is the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on the following:

(A) The allowable equity as established under section 14 of this rule.

(B) The rate of return on equity is the greater of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be not greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under Medicaid shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-15; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2324; filed Sep 1, 2000, 2:10 p.m.: 24 IR 17; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 726; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-12-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

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

Sec. 16. (a) The basis used in computing the capital return factor and the average historical cost of property of the median

bed shall be the historical cost of all assets used to deliver patient or resident-related services, provided they are:

(1) in use;

(2) identifiable to patient or resident care;

(3) available for physical inspection; and

(4) recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost and any associated property financing or financings or capital lease or leases shall not be included in computing the capital return factor or the average historical cost of property of the median bed.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor and the average historical cost of property of the median bed shall include only items currently used in providing services customarily provided to patients or residents.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's length sale or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-16; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 727; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

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

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

Sec. 17. (a) If a facility is sold or leased within eight (8) years of the seller's or lessor's acquisition date and this transaction is recognized as a change of provider status, the buyer's or lessee's property basis in facilities and equipment shall be the seller's or lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's or lessor's historical cost basis, for each month the seller or lessor has owned or leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.

(2) Inception date of the initial agreement between lessee and lessor.

(3) Imputed or stated interest rate.

(4) Duration of payments.

(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized only if the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:

(1) There is no spousal relationship between parties.

(2) The following persons are considered family members:

(A) Natural parents, 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, and daughter-in-law.

(E) Grandparent and grandchild.

(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.

(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

(5) The seller and all parties with an ownership interest in the previous provider are not associated with the facility in any way after the sale other than as a passive creditor.

(6) 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.

(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.

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

(9) If any of the entities involved are corporations, they must 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.

(g) In order to establish an historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines issued in November 1976 by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members, for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-17; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2325; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 728; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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

Sec. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not

be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients or nonresidents shall be offset against the total cost of such service to determine the allowable patient or resident related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-18; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2326; 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)*

405 IAC 1-12-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided the:

(1) employees are engaged in patient or resident care-related functions; and

(2) compensation amounts are reasonable and allowable under this section and sections 20 through 22 of this rule.

(b) The provider shall report using the forms or in a format prescribed by the office all patient and resident-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when the services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. For all providers, except for providers of extensive support needs residences for adults:

(1) hours for laundry services in CRF/DD or ICF/IID facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility; and

(2) hours associated with the provision of day services and other ancillary services, except as specified in subsection (d), shall be excluded from the staffing limitation.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and 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.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-19; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 729; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Sec. 20. (a) Compensation for owner, related party, individuals within management, consultants who perform management

functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, individuals within management, contractors, and consultants who perform management functions, as well as any other individual or entity performing such tasks.

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

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

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

Owner and Management Compensation		Owner's Expense
Beds	Allowance	(12% × bed allowance)
10	$18,527	$2,223
20	$24,717	$2,966
30	$30,887	$3,706
40	$37,049	$4,446
50	$43,241	$5,189
60	$46,948	$5,634
70	$50,657	$6,079
80	$54,362	$6,523
90	$58,055	$6,967
100	$61,763	$7,412
110	$66,731	$8,007
120	$71,663	$8,600
130	$76,628	$9,195
140	$81,546	$9,786
150	$86,496	$10,380
160	$91,427	$10,971
170	$96,378	$11,565
180	$101,313	$12,157
190	$106,262	$12,751
200	$111,196	$13,343
200 and over	$111,196 plus $225 per bed over 200	$13,343 plus $27 per bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1)

operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-20; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-12-20.5 Extensive support needs residences for adults; fair rental value allowance

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

Sec. 20.5. Providers of extensive support needs residences for adults shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility. The fair rental value allowance shall be calculated as follows:

(1) The fair rental value allowance for extensive support needs residences for adults is calculated during rebasing years and base rate reviews by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including the following:

(A) Land.
(B) Building.
(C) Improvements.
(D) Vehicles.
(E) Equipment.

The original historical cost of allowable resident related land, buildings, and improvements as of the provider's date of initial Medicaid certification shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the calendar quarter that includes the rate effective date. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(5) If there are fewer than six (6) nonleased homes with rates established that are licensed as extensive support needs residences for adults, then the historical cost of property per bed used in the fair rental value calculation shall be one hundred eighteen thousand seven hundred fifty dollars ($118,750).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-20.5; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; errata filed Dec 12, 2007, 11:58 a.m.: 20080102-IR-405060157ACA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for individuals with intellectual disabilities; allowable costs; compensation; per diem rate

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

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

(b) The per diem rate for ICFs/IID is an all-inclusive rate. The per diem rate includes all services provided to patients by the

facility.

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

(d) Any ICFs/IID that is licensed as a CRMNF will be paid at a rate of six hundred twenty-six dollars and twenty-six cents ($626.26) per resident day. This per diem rate is available only upon certification as a Medicaid ICF/IID and licensure by the division of disability and rehabilitative services. ICFs/IID that are licensed as CRMNFs are not subject to other rate adjustments identified in this rule except for 405 IAC 1-12-27 *[405 IAC 1-12-27 was voided by P.L.12-2016, SECTION 10, effective July 1, 2016.]* and will not receive a base rate nor be subject to the base rate reporting requirements at section 5 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-21; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-22 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate

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

Sec. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20.5 of this rule, the procedures described in this section apply to ICFs/IID with eight (8) or fewer beds (CRFs/DD), except for ICFs/IID licensed as:

(1) small behavior management residences for children for which the procedures described in this section apply to facilities with six (6) or fewer beds;

(2) small extensive medical needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds; and

(3) extensive support needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds.

(b) Costs related to staffing shall be limited to the following:

Type of License	Staff Hours Per Resident Day
Sheltered living	4.5
Intensive training	6.0
Developmental training	8.0
Child rearing	8.0
Child rearing residences with specialized programs	10.0
Basic developmental	10.0
Small behavior management residences for children	12.0
Small extensive medical needs residences for adults	12.0
Extensive support needs residences for adults	24.0

(c) Any change in staffing that exceeds the current limitations of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children will require approval on a case-by-case basis, upon application by the facility. This approval will be determined in the following manner:

(1) A new or current provider of service that seeks staffing above four and one-half (4.5) hours per resident day for adults or eight (8) hours per resident day for children must first obtain approval from the DDRS, based upon the DDRS assessment of the program needs of the residents. The DDRS will establish the maximum number of staff hours per resident day for each facility, which may be less than but may not be more than the ceiling for each type of license. If a change in type of license is required to permit the staffing limitation determined by the DDRS, then the DDRS will make its recommendation to the licensing authority and convey to the office the decision of the licensing authority. The office shall:

(A) conduct a complete and independent review of a request for increased staffing; and

(B) retain final authority to determine whether a rate change will be granted as a result of a change in licensure type.

(2) If a provider of services holds a current license that would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDRS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each CRF/DD provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2328; filed Aug 15, 1997, 8:47 a.m.: 21 IR 81; filed Oct 31, 1997, 8:45 a.m.: 21 IR 953; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:24 p.m.: 25 IR 3124; filed Aug 7, 2007, 10:27 a.m.: 20070905-IR-405060157FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-23 Medical or nonmedical supplies and equipment; personal care items

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

Sec. 23. (a) Routine medical and nonmedical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill Medicaid for such items in addition to the established rate. Under no circumstances shall the routine medical and nonmedical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:

(1) Hairbrushes and combs.
(2) Dental adhesives and caps.
(3) Toothpaste.
(4) Shower caps.
(5) Nail files.
(6) Lemon glycerine swabs.
(7) Mouthwashes.
(8) Toothbrushes.
(9) Deodorants.
(10) Shampoos.
(11) Disposable tissues.
(12) Razor.
(13) Any other items or equipment covered by Medicaid and specifically requested by a resident and not routinely provided by the provider.

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-23; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-12-24 Assessment methodology

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) CRF/DD and ICF/IID facilities that are not operated by the state will be assessed an amount that is based on total

annual facility revenue. In determining total annual revenue when the financial report period is other than three hundred sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period. The assessment percentage applied to total annual revenue shall be six percent (6%). In no event shall the assessment percentage exceed the percentage determined to be eligible for federal financial participation under federal law.

(b) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:

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

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

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

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

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

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2329; filed Aug 14, 1998, 4:27 p.m.: 22 IR 67; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:40 a.m.: 25 IR 381; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jul 31, 2008, 4:12 p.m.: 20080827-IR-405070647FRA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-12-25 Reimbursement for day services

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

Sec. 25. For ICF/IID and CRF/DD facilities, the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-25; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2330; filed Aug 14, 1998, 4:27 p.m.: 22 IR 68; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 28, 2013, 10:20 a.m.: 20130925-IR-405120637FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-26 Administrative reconsideration; appeal

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

Sec. 26. (a) The office shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider may request an administrative reconsideration by the office. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the office not later than forty-five (45) days after release of the rate or allowable cost determinations as computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The office shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

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

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

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-26; filed Jun 1, 1994, 5:00 p.m.: 17 IR 2331; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:52 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-12-27 Rate reduction (Voided)

Sec. 27. *(Voided by P.L.12-2016, SECTION 10, effective July 1, 2016.)*

Rule 13. Disproportionate Share Hospital Payments

405 IAC 1-13-1 Eligibility

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-6

Sec. 1. (a) Eligibility for basic and enhanced disproportionate share hospital payments for hospital providers that are not owned or operated by the state will be determined using a provider's Medicaid inpatient utilization rate and low income utilization

rate based on utilization and revenue data from the cost reporting period used to determine that provider's eligibility for disproportionate share payments as of July 1, 1992.

(b) Hospital providers that are owned or operated by the state are eligible for disproportionate share hospital payments for a fiscal year if:

(1) for any portion of that fiscal year, the provider meets CMS's conditions of participation for the Medicare program;

(2) for any portion of that fiscal year, the provider is eligible for Medicaid payments;

(3) the hospital's low income utilization rate for that fiscal year exceeds twenty-five percent (25%); and

(4) the hospital's Medicaid utilization rate exceeds one percent (1%).

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-1; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-13-2 Basic disproportionate share payments

Authority: IC 12-15-21-1; IC 12-15-21-3
Affected: IC 12-15-6

Sec. 2. (a) For purposes of determining the proportional distribution to be made from the disproportionate share pool for basic disproportionate share payments to hospital providers eligible under section 1(a) of this rule, the provider's utilization and revenue data shall be for the same cost reporting period as in section 1(a) of this rule.

(b) Basic disproportionate share distributions from the disproportionate share pool to hospital providers eligible under section 1(b) of this rule shall be based on the hospital's costs during the fiscal year for services furnished to individuals who are either of the following:

(1) Eligible for Medicaid under the state plan.

(2) Have no health insurance or other source of third party coverage for services provided during the fiscal year and whose personal resources are inadequate to cover the cost of the services furnished. For purposes of this subdivision, payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered a source of third party payment.

(Office of the Secretary of Family and Social Services; 405 IAC 1-13-2; filed Jan 27, 1994, 5:00 p.m.: 17 IR 1090; filed May 25, 1995, 3:00 p.m.: 18 IR 2409; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 14. Rate-Setting Criteria for Nursing Facilities (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Dec 27, 1994, 3:45 p.m.: 18 IR 1260)

Rule 14.1. Rate-Setting Criteria for Nursing Facilities (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed May 30, 1997, 4:25 p.m.: 20 IR 2774)

Rule 14.2. Rate-Setting Criteria for Nursing Facilities (Voided)

NOTE: Voided by P.L.130-1998, SECTION 3, retroactively effective July 1, 1997.

Rule 14.5. Rate-Setting Criteria for HIV Nursing Facilities

405 IAC 1-14.5-1 Policy; scope

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

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nursing

facilities (NF) that provide skilled and intermediate nursing care for chronically medically dependent people infected by the human immunodeficiency virus (HIV). All payments referred to within this rule for the provider group and levels of care are contingent upon the following:

(1) Proper and current certification.

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

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

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-1; filed Aug 12, 1998, 2:32 p.m.: 22 IR 48; 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)*

405 IAC 1-14.5-2 Definitions

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

Sec. 2. (a) As used in this rule, "allowable per patient day cost" means a ratio between total allowable cost and patient days.

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

(c) As used in this rule, the "Medicaid cost per patient day" means the sum of the direct care, indirect care, administrative and capital component medians calculated in accordance with 405 IAC 1-14.3 *[sic.]*. For providers of skilled nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of 1.27;

(2) the indirect care median;

(3) the administrative median; and

(4) the capital component median.

For providers of intermediate nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of .69;

(2) the indirect care median;

(3) the administrative median; and

(4) the capital component median.

The Medicaid cost per patient day shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective April 1, July 1, October 1, and January 1.

(d) As used in this rule, "change of provider status" means a bona fide sale or capital lease that, for reimbursement purposes, is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board

Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.

(e) As used in this rule, "chronically medically dependent" means a medical condition of a person who is infected by the human immunodeficiency virus (HIV) and has been certified by a physician as, because of the HIV infection, requiring a skilled or intermediate level of care as specified under 405 IAC 1-3-1 and 1-3-2 *[sic., 405 IAC 1-3-2]*.

(f) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(g) As used in this rule, "debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(h) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(i) As used in this rule, "equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(j) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(k) As used in this rule, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(l) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(m) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(n) As used in this rule, "like levels of care" means:

(1) skilled care provided in a nursing facility;

(2) intermediate care provided in a nursing facility;

(3) special skilled or intermediate services provided to persons who are chronically medically dependent because of HIV.

(o) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients by providers of like levels of care.

(p) As used in this rule, "office" means the office of Medicaid policy and planning.

(q) As used in this rule, "ordinary patient related costs" means costs of services and supplies that are necessary in delivery of patient care by similar providers within the state.

(r) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(s) As used in this rule, "profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(t) As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(u) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

(v) As used in this rule, "special skilled or intermediate services" means medical and health care services that are provided to a patient who is:

(1) chronically medically dependent; and

(2) in need of a level of care that is less intensive than the care provided in a hospital licensed under IC 16-10-1 *[IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30, 1993.]*.

(w) As used in this rule, "unit of service" means all patient care at the appropriate level of care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(x) As used in this rule, "use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-2; filed Aug 12, 1998, 2:32 p.m.: 22 IR 49; 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)*

405 IAC 1-14.5-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider status transactions unless otherwise prescribed by this rule.

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

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

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

(d) Each provider shall submit, upon request, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

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

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-3; filed Aug 12, 1998, 2:32 p.m.: 22 IR 50; 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)*

405 IAC 1-14.5-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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

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

reconciliation statements between the provider's records and the annual financial report.

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

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

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

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

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

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

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-4; filed Aug 12, 1998, 2:32 p.m.: 22 IR 51; 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)

405 IAC 1-14.5-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

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

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date that a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.

(b) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule shall apply. For purposes

of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

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

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

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

(d) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

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

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

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

(h) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted by the American Institute of Certified Public Accountants. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-5; filed Aug 12, 1998, 2:32 p.m.: 22 IR 51; 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)*

405 IAC 1-14.5-6 Active providers; rate review; annual request; additional requests; requests due to change in law; requests concerning capital return factor; computation of factor

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

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a

significant rate increase is mandated. This review will be considered separately by the office.

(c) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using minimum occupancy levels specified in section 7(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-6; filed Aug 12, 1998, 2:32 p.m.: 22 IR 52; 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)*

405 IAC 1-14.5-7 Request for rate review; occupancy level assumptions; effect of inflation

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

Sec. 7. (a) Rate setting shall be prospective, based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For nursing facilities, allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-7; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; 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)*

405 IAC 1-14.5-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of cost reimbursement under this rule. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-8; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; 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)*

405 IAC 1-14.5-9 Criteria limiting rate adjustment granted by office

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

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs, plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:

(1) The Medicaid cost per patient day times one hundred fifteen percent (115%). This subdivision does not apply to private room rates.

(2) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services.

(3) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(4) Inflated allowable per patient day cost plus the allowed profit add-on payment. The profit add-on is equal to fifty percent (50%) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient day cost, and one hundred ten percent (110%) of the Medicaid cost per patient day, calculated on a statewide basis. Under no circumstances shall a provider's profit add-on exceed ten percent (10%) of the Medicaid cost per patient day, calculated on a statewide basis.

(b) The rate for private rooms and the rate for rooms with three (3) beds or more shall be calculated using the ratio or percentage spread of the proposed private pay rates for those types of beds times the rate for rooms with two (2) beds, subject to the other limitations of this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-9; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; 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)*

405 IAC 1-14.5-10 Computation of rate; allowable costs; review of cost reasonableness

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

Sec. 10. (a) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

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

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

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-10; filed Aug 12, 1998, 2:32 p.m.: 22 IR 53; 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)*

405 IAC 1-14.5-11 Allowable costs; services provided by parties related to provider

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

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply.

(e) The office shall grant an exception when a related organization meets all of the following conditions:
(1) The supplying organization is a bona fide separate organization.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.
(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-11; filed Aug 12, 1998, 2:32 p.m.: 22 IR 54; 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)

405 IAC 1-14.5-12 Allowable costs; capital return factor

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

Sec. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land, and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-12; filed Aug 12, 1998, 2:32 p.m.: 22 IR 54; 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)*

405 IAC 1-14.5-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

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

Sec. 13. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall only be recognized when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-13; filed Aug 12, 1998, 2:32 p.m.: 22 IR 55; filed Sep 1,

2000, 2:10 p.m.: 24 IR 19; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 3, 2002, 3:15 p.m.: 26 IR 1080; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-14.5-14 Allowable costs; capital return factor; computation of return on equity component

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

Sec. 14. (a) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment, or actual equity in allowable facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical cost of facilities and equipment or the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:
(1) a change of provider status; or
(2) a new operation;
on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, ten (10) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations under section 15(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-14; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 3, 2002, 3:15 p.m.: 26 IR 1081; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-14.5-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

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

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080

10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700
3/1/94	$26,000
9/1/94	$26,300
3/1/95	$26,500
9/1/95	$27,300
3/1/96	$27,700
9/1/96	$28,000
3/1/97	$28,300
9/1/97	$28,600

The schedule shall be updated semiannually, effective on March 1 and September 1 by the office, and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference

between that amount and the maximum property basis per bed at the rate effective date times eighty percent (80%);

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) a rate of return on equity that is the greater of United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-15; filed Aug 12, 1998, 2:32 p.m.: 22 IR 56; filed Sep 1, 2000, 2:10 p.m.: 24 IR 20; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 3, 2002, 3:15 p.m.: 26 IR 1081; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-14.5-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

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

Sec. 16. (a) The basis used in computing the capital return factor shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.

(2) They are identifiable to patient care.

(3) They are available for physical inspection.

(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the capital return factor.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and an *[sic., a]* historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-16; filed Aug 12, 1998, 2:32 p.m.: 22 IR 57; 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)*

405 IAC 1-14.5-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

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

Sec. 17. (a) If a facility is sold or leased within eight (8) years of the seller's/lessor's acquisition date, and this transaction is recognized as a change of provider status, the buyer's/lessee's property basis in facilities and equipment shall be the seller's/lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's/lessor's historical cost basis for each month the seller/lessor has owned/leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.
(2) Inception date of the initial agreement between lessee and lessor.
(3) Imputed or stated interest rate.
(4) Duration of payments.
(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized provided the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:

(1) There is no spousal relationship between parties.
(2) The following persons 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.

(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.

(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

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

(6) 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.

(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.

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

(9) If any of the entities involved are corporations, they must 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.

(g) In order to establish an *[sic., a]* historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines established by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-17; filed Aug 12, 1998, 2:32 p.m.: 22 IR 58; 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)*

405 IAC 1-14.5-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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

Sec. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-18; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; 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)*

405 IAC 1-14.5-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and sections 20 through 26 of this rule.

(b) The provider shall report on the financial report form, in the manner prescribed using the forms prescribed by the office, all patient related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by personnel. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported. Hours for laundry and therapy services in nursing facilities, whether paid in-house or contracted, shall not be included in calculating the staffing limitation, but shall be reported on the financial report form using the forms or in the format prescribed by the office.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and 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.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 20 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-19; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; 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)*

405 IAC 1-14.5-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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

Sec. 20. (a) Compensation for owner, related party, management, consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks.

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

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

(d) The owner, related party, and management compensation and expense limitation per operation effective July 1, 1997,

shall be as follows:

Owner and Management Compensation		Owner's Expense
Beds	Allowance	(12% × Bed Allowance)
10	$22,500	$2,700
20	$30,019	$3,602
30	$37,513	$4,502
40	$44,998	$5,400
50	$52,517	$6,302
60	$57,019	$6,842
70	$61,524	$7,383
80	$66,023	$7,923
90	$70,510	$8,461
100	$75,013	$9,002
110	$81,046	$9,726
120	$87,037	$10,444
130	$93,066	$11,168
140	$99,040	$11,885
150	$105,052	$12,606
160	$111,040	$13,325
170	$117,054	$14,046
180	$123,048	$14,766
190	$129,058	$15,487
200	$135,050	$16,206
200 and over	$135,050 + $250/bed over 200	$16,206 + $30/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-20; filed Aug 12, 1998, 2:32 p.m.: 22 IR 59; 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)*

405 IAC 1-14.5-21 Staffing costs in nursing facilities

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

Sec. 21. Subject to the exclusions specified in section 19(b) of this rule, recognition of the costs related to total staffing requirements will be limited to five and one-half (5½) hours worked per patient day in nursing facilities providing skilled care and four and one-fourth (4¼) hours worked per patient day in nursing facilities providing intermediate care. Hours worked exclude vacation, sick, and holiday pay. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-21; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; 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)*

405 IAC 1-14.5-22 Medical or nonmedical supplies and equipment

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

Sec. 22. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-22; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; 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)*

405 IAC 1-14.5-23 Nursing facilities providing intermediate and skilled care; reimbursement for therapy services

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

Sec. 23. (a) Therapy services provided to Medicaid recipients by nursing facilities providing intermediate care or skilled care are to be included in the established rate. Under no circumstances shall therapies be billed to Medicaid through any provider. Services which may be reported in the cost report used to determine the established rate include the following:

(1) Audiology.
(2) Physical therapy.
(3) Speech therapy.
(4) Occupational therapy.
(5) Respiratory therapy.

All such services shall be provided and reimbursed only if they meet the conditions as prescribed in the Indiana Medicaid provider manual for nursing facilities providing intermediate care or skilled care.

(b) A nursing facility providing intermediate care or skilled care may elect to provide therapy services if either of the following conditions are met:

(1) The facility employs licensed/certified therapists as members of its staff.
(2) The facility has a contract with a licensed/certified therapist or therapy agency to provide services to residents of the facility.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-23; filed Aug 12, 1998, 2:32 p.m.: 22 IR 60; 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)

405 IAC 1-14.5-24 Nursing facilities providing intermediate care and skilled care; allocation of intermediate and skilled care costs

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

Sec. 24. (a) The detailed basis for allocation of expenses between different levels of care and special services (HIV) in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) Any change in the allocations must be approved by the department prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the department for approval at least ninety (90) days prior to the provider's reporting year end. If a change in allocation basis has not been approved by the department, the provider shall not submit cost reports using a new allocation basis.
(4) The allocation basis for the capital return factor calculated under sections 12 through 17 of this rule shall be patient days, unless a different allocation methodology was approved prior to October 1, 1990, and the provider has not changed the number of beds in either level of care since October 1, 1990. In those instances, the previously approved allocation methodology may be continued.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-24; filed Aug 12, 1998, 2:32 p.m.: 22 IR 61; 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)

405 IAC 1-14.5-25 Administrative reconsideration; appeal

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

Sec. 25. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

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

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5-3.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-25; filed Aug 12, 1998, 2:32 p.m.: 22 IR 61; 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)*

405 IAC 1-14.5-26 Nursing facilities; separate add-on reimbursement for chronically medically dependent people infected by the human immunodeficiency virus

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

Sec. 26. (a) Care for a chronically medically dependent person may be reimbursed under this section to those providers of skilled or intermediate nursing services who provide the required level of care.

(b) Costs that are reimbursed under this rate must meet the following conditions:

(1) Be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, rules, regulations, and quality and safety standards.

(2) Include, to the extent permitted by federal laws and regulations, increased costs for:

(A) respiratory therapy;
(B) intensive case management;
(C) medically-related social services;
(D) physician and nursing care;
(E) linens; and
(F) dietary supplements.

(c) Recognition of the costs related to total staffing will be limited to an overall staffing limit for all personnel of not more than eight (8) hours per patient day for skilled level of care, and not more than six (6) hours per patient day for intermediate level of care.

(d) No cost recognition will be included in the per diem for those services provided by a health care provider which are being separately reimbursed by the Medicaid program.

(e) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.

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

(g) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation, and an extension had not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after receipt of the report by the office.

(h) Providers of special skilled and intermediate services licensed under IC 16-10-4 *[IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30,1993.]* that have been approved by the office must have more than eight (8) beds but less than forty (40) beds approved for this type of service. Bed allocation will be based upon locality and reasonableness on a first come first served basis.

(i) The office may not approve more than one hundred (100) beds for special skilled or intermediate services without the agreement of the secretary of Indiana family and social services administration, the commissioner of the Indiana state department of health, and the assistant secretary of the office.

(j) Allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy based on beds available to the program. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-26; filed Aug 12, 1998, 2:32 p.m.: 22 IR 62; 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)*

405 IAC 1-14.5-27 Limitation to Medicaid rate increases for HIV nursing facilities

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

Sec. 27. Notwithstanding all other provisions of this rule, for the period January 1, 2006, through June 30, 2007, HIV nursing facility rates that have been calculated under this rule shall be reduced by five dollars ($5) per resident per day. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.5-27; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

Rule 14.6. Rate-Setting Criteria for Nursing Facilities

405 IAC 1-14.6-1 Policy; scope

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

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid members by nursing facilities. All payments referred to within this rule are contingent upon the following:

(1) Proper and current certification.

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

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

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

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

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

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

(2) apply to the net outstanding overpayment during the periods in which such overpayment exists.

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

405 IAC 1-14.6-2 Definitions

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

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

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.

(2) Services and supplies of a home office that are:

(A) allowable and patient-related; and

(B) appropriately allocated to the nursing facility.

(3) Office and clerical staff.

(4) Legal and accounting fees.

(5) Advertising.

(6) All staff travel and mileage.

(7) Telephone.

(8) License dues and subscriptions.

(9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.

(10) Working capital interest.

(11) State gross receipts taxes.

(12) Utilization review costs.

(13) Liability insurance.

(14) Management and other consultant fees.

(15) Qualified intellectual disability professional.

(16) Educational seminars for administrative staff.

(17) Support and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.

(c) "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is based on the facility's total quality score.

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

(f) "Average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) "Average historical cost of property of the median bed" means the allowable patient-related property cost per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

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

(i) "Capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(j) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups under the resource utilization group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

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

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and

(2) received written approval from the office to be designated as a children's nursing facility.

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

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

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

(o) "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.

(2) Nurse consulting services.

(3) Pharmacy consultants.

(4) Medical director services.

(5) Nurse aide training.

(6) Medical supplies.

(7) Oxygen.

(8) Medical records costs.

(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental costs for these items are limited to one dollar and fifty cents ($1.50) per resident day.

(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.

(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.

(12) Legend and nonlegend sterile water products used for irrigation or humidification.

(13) Educational seminars for direct care staff.

(14) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis by the member, nursing facility care staff, or by prescriber's order as a part of routine care as defined in subsection (ff).

(p) "Fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%

Capital	100%

(s) "Forms prescribed by the office" means either of the following:

(1) Cost reporting forms provided by the office.

(2) Substitute forms that have received prior written approval by the office.

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

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

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

(w) "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Dietary services and supplies.

(2) Raw food.

(3) Patient laundry services and supplies.

(4) Patient housekeeping services and supplies.

(5) Plant operations services and supplies.

(6) Utilities.

(7) Social services.

(8) Activities supplies and services.

(9) Recreational supplies and services.

(10) Repairs and maintenance.

(11) Cable or satellite television throughout the nursing facility, including residents' rooms.

(12) Pets, pet supplies and maintenance, and veterinary expenses.

(13) Educational seminars for indirect care staff.

(14) All costs related to nonambulance travel and transportation of residents.

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

(y) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (9/2000) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by CMS.

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

(aa) "Nursing home report card score" means a numerical score developed and published by ISDH that quantifies each facility's key survey results.

(bb) "Ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

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

(dd) "Reasonable allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(ee) "Related party/organization" means that the provider:

(1) is associated or affiliated with; or

(2) has the ability to control or be controlled by;

the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

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

condition.

(gg) "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI for all residents and facility-average CMI for Medicaid residents.

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

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

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

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

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

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

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

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

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

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

(ii) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's total quality score.

(jj) "Therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

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

(ll) "Unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(mm) "Unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system:

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

(2) result in the assessment being classified into a different RUG-III category.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

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

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

Sec. 3. (a) The basis of accounting under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent

between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care. The burden of demonstrating that costs are patient-related lies with the provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-3; filed Aug 12, 1998, 2:27 p.m.: 22 IR 71, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

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

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

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

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

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

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

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

(6) Complete balance sheet data.

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

(8) Certification by the provider that:

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

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

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

(10) A copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.

(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting

the cost report schedule, line number, and column where each general ledger account is reported on the cost report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The office:

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

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

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

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

(B) no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on the initial and expanded sample of residents assessments, the office

will determine the percent of all assessments audited that are unsupported.

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

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

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

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

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

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

(A) the office shall conclude the MDS audit; and

(B) no corrective remedy shall apply.

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

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

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(m) The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates

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

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

provider's CMI for Medicaid residents. Initial interim rates shall be effective on the:

(1) enrollment date; or

(2) date that a service is established;

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

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

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

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

(e) For a new operation, the interim quality assessment and Medicaid rate add-on shall be based on projected patient days. A retroactive settlement of the quality assessment and Medicaid rate add-on will be determined, based on actual patient days, for the time period from the first day of operation until the first annual rate effective date associated with the provider's first fiscal year end with a minimum of six (6) months of actual historical data. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-5; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2242; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2467; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Sec. 6. (a) The:

(1) normalized average allowable cost of the median patient day for the direct care component; and

(2) average allowable cost of the median patient day for the indirect, administrative, and capital components;

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

(b) The:

(1) normalized allowable per patient day cost for the direct care component; and

(2) allowable per patient day costs for the therapy, indirect care, administrative, and capital components;

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

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

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

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

(1) updated each calendar quarter; and

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

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

(g) When the number of nursing facility beds licensed by ISDH is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate-setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-6; filed Aug 12, 1998, 2:27 p.m.: 22 IR 73, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3872; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Oct 4, 2007, 2:05 p.m.: 20071031-IR-405070150FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, 2017, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual

financial report used to establish a Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on the following minimum occupancy levels:

(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.

(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the applicable minimum occupancy requirement described in subsection (d), if both of the following conditions can be established to the satisfaction of the office:

(1) The provider demonstrates that its current resident census has:

(A) increased to the applicable minimum occupancy level described in subsection (d), or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed and desk reviewed cost report period; and

(B) remained at such level for not fewer than ninety (90) days.

(2) The provider demonstrates that its resident census has:

(A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and

(B) remained at such level for not fewer than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) Except as provided for in subsection (h), the CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85
Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77

Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC2	0.83
Reduced Physical Functions	PC1	0.76
Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

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

(1) The resident classifies into one (1) of the following RUG-III groups:

(A) PB2.

(B) PB1.

(C) PA2.

(D) PA1.

(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then a cognitive performance score (CPS) of:

(A) zero (0) – Intact;

(B) one (1) – Borderline Intact; or

(C) two (2) – Mild Impairment.

(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence.

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

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

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

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

(1) A preliminary CMI report that will:

(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and

(B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(j) The office will increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents

($11.50) per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning October 1, 2011, through June 30, 2013, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on the office shall determine each nursing facility's report card score based on the latest published data as of the end of the state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	$14.30
83 – 265	$14.30 – ((Nursing Home Report Card Score – 82) × $0.0777)
266 and above	$0

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

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

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

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 – 18	$0
19 – 83	$14.30 – ((84 - Nursing Facility Total Quality Score) × 0.216667)
84 – 100	$14.30

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

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

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

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

(2) Normalized weighted average nursing hours per resident day. The office shall determine each nursing facility's

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

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

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

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

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

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

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

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

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

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

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

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

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

Nursing Facility Annual CNA Turnover Rates	Quality Points Awarded
Less than or equal to 39.4%	2
Greater than 39.4% and less than 96.2%	Proportional quality points awarded as follows: 2 – [39.4% – facility's annual CNA turnover rate) × (-3.521127)]
Equal to or greater than 96.2%	0

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

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

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

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

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

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

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 3, 2009, 1:44 p.m.: 20090429-IR-405080602FRA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-14.6-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of computing the average historical cost of property of the median bed. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-8; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 2				
Non-Children's Nursing Facilities				
Effective Date	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.

Table 3	
Total Quality Score	Percentage
84 - 100	100%
19 - 83	100% + ((Total Quality Score – 84) / 66)
18 and below	0%

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.

(3) The tentative indirect care component profit add-on payment is equal to the profit add-on percentage contained in Table 4, times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus

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

Table 4				
Effective Date	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2017	July 1, 2017, and after	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	60%	52%	105%	100%

(C) The allowed indirect care component profit add-on payment is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.

(4) The tentative capital component profit add-on payment is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:

(A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 5; minus

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

Table 5		
Capital Component Profit Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	100%	80%

(C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's total quality score.

(5) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ceiling defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in Table 6.

Table 6		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	July 1, 2003, through June 30, 2017	July 1, 2017, and after
Percentage	120%	110%

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in Table 7.

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

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

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

(4) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office shall determine each facility's CMI for all residents on a time-weighted basis.

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

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

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

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-9; filed Aug 12, 1998, 2:27 p.m.: 22 IR 75, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2244; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; filed Oct 10, 2002, 10:47 a.m.: 26 IR 714; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3874; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2980; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report

forms. Allowable patient care costs shall be clearly identified.

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

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

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

(e) The following costs are not considered allowable costs and shall not be included in the established rate:

(1) All over-the-counter, legend, and nonlegend drugs.

(2) Cost of replacement hearing aids and eyeglasses.

(3) All costs associated with pastoral care.

(4) All costs associated with resident and family gifts, including, but not limited to, flowers, Bibles, and memory books.

(5) All costs associated with collection fees.

(6) All costs, fees, and dues associated with lobbying activities.

(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities.

(8) All costs associated with barber and beauty shop activities.

(9) All costs associated with marketing.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-10; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

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

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

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

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

(c) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

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

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.

(6) Grandparent and grandchild.

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

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

(f) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for a NSGO provider shall not be considered an arm's-length business activity transacted in an open competitive market.

(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.

(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and

(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(g) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-11; filed Aug 12, 1998, 2:27 p.m.: 22 IR 76, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2245; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

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

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

Sec. 12. (a) Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property, except that rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators shall be reimbursed in the direct care component. The fair rental value allowance includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease

expense is appropriately allocated to the facility.

(b) The fair rental value allowance is calculated as follows:

(1) Determine, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

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

405 IAC 1-14.6-13 Reporting of financing arrangements; working capital; interest; allocation of loans

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

Sec. 13. (a) All patient-related property financing arrangements shall be fully and completely disclosed on the forms prescribed by the office.

(b) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities that are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(c) Interest on working capital loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient-related services. Working capital interest must be reduced by investment income from any related party. Working capital loans from a related party must be identified and reported separately on the annual financial report. Interest costs on related party working capital loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid at least annually for a minimum of thirty (30) days. Failure to document the existence of, or adhere to such repayment schedule, shall result in the related party working capital interest costs being disallowed.

(d) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-13; filed Aug 12, 1998, 2:27 p.m.: 22 IR 77, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-14.6-14 Property; basis; historical cost; mandatory record keeping; valuation

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

Sec. 14. (a) The basis used in computing the average historical cost of property of the median bed shall be the historical cost

of all assets used to deliver patient-related services that meet the following conditions:

(1) The assets are in use.

(2) The assets are identifiable to patient care.

(3) The assets are available for physical inspection.

(4) The assets are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the average historical cost of property of the median bed.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the average historical cost of property of the median bed shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least one thousand dollars ($1,000), the cost shall be capitalized and included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-14; filed Aug 12, 1998, 2:27 p.m.: 22 IR 78, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-14.6-15 Valuation; sale or lease among family members

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

Sec. 15. (a) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized 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.

(b) 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 in accordance with this rule as a bona fide sale arising from an arm's-length transaction, subject to the limitations of subsection (c):

(1) There is no spousal relationship between parties.

(2) The following persons 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.

(3) The transfer is recognized and reported by all parties 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) This family sale exception has not been utilized 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 must 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.

(c) In order to establish a historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to 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.

(d) If a lease of facilities between family members under subsection (b)(2) qualifies as a capitalized lease under guidelines established by the American Institute of Certified Public Accountants, 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 1-14.6-15; filed Aug 12, 1998, 2:27 p.m.: 22 IR 78, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-14.6-16 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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

Sec. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office shall calculate a ratio of indirect cost to direct cost based on the direct and total therapy and nonallowable ancillary costs reported on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and nonallowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office shall remove the indirect and administrative costs reimbursed by other payers based on a statewide average ratio, excluding hospital based facilities, of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports. The statewide average ratio shall be computed on a statewide basis from the most recently completed desk reviewed annual financial report and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-16; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3875; 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)*

405 IAC 1-14.6-17 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 17. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and section 18 of this rule.

(b) The provider shall report on the forms prescribed by the office, all patient-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported for all employees.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and 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.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 18 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-17; filed Aug 12, 1998, 2:27 p.m.: 22 IR 79, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2246; 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)*

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

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

Sec. 18. (a) Compensation for:

(1) an owner, a related party, management, general line personnel, and consultants who perform management functions; or

(2) any individual or entity rendering services above the department head level;

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

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

(c) Beginning July 1, 2017, the maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:

(1) under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or

(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.

If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

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

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 and over	$129,298 + $262/bed over 200

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

405 IAC 1-14.6-19 Medical or nonmedical supplies and equipment

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

Sec. 19. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill Medicaid for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment for nursing facility residents be billed through a pharmacy or other provider. Medical and nonmedical supply items for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-19; filed Aug 12, 1998, 2:27 p.m.: 22 IR 80, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-14.6-20 Nursing facilities reimbursement for therapy services

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

Sec. 20. (a) Therapy services provided to Medicaid members by nursing facilities are included in the established rate. Under no circumstances shall therapies for nursing facility residents be billed to Medicaid through any provider. Therapy services for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid.

(b) For purposes of determining allowable therapy costs, the office shall adjust each provider's cost of therapy services reported on the Nursing Facility Financial Report, including any employee benefits prorated based on total salaries and wages, to account for non-Medicaid payers, including Medicare, of therapy services provided to nursing facility residents. Such adjustment shall be applied to each cost report in order to remove reported costs attributable to therapy services reimbursed by other payers. The adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-20; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2470; 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)*

405 IAC 1-14.6-21 Allocation of expenses

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

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

(b) The following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) No allocation of costs between annual financial report line items shall be permitted.

(4) Any changes in the allocation or classification of costs must be approved by the office prior to the changes being implemented. Proposed changes in allocation or classification methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

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

405 IAC 1-14.6-22 Administrative reconsideration; appeal

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

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

of its final decision in writing, not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

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

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

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

(e) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-22; filed Aug 12, 1998, 2:27 p.m.: 22 IR 81, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2247; errata filed Jul 28, 1999, 3:10 p.m.: 22 IR 3937; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:47 a.m.: 26 IR 716; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3876; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-14.6-23 Limitation to Medicaid rate increases for nursing facilities (Repealed)

Sec. 23. *(Repealed by Office of the Secretary of Family and Social Services; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)*

405 IAC 1-14.6-24 Nursing facility quality assessment

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

Sec. 24. (a) Through June 30, 2017, the office shall collect a quality assessment from each nursing facility licensed under IC 16-28 as a comprehensive care facility based on the most recently completed annual financial report or quality assessment data collection form, as follows:

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

(2) Privately owned or operated and nonstate government owned or operated nursing facilities with total annual nursing facility census days equal to or greater than sixty-two thousand (62,000), four dollars and nine cents ($4.09) per non-Medicare day.

(3) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated before July 1, 2003, four dollars and nine cents ($4.09) per non-Medicare day.

(4) Nonstate government owned or operated nursing facilities that became nonstate government owned or operated on or after July 1, 2003, with total annual nursing facility census fewer than sixty-two thousand (62,000), sixteen dollars and thirty-seven cents ($16.37) per non-Medicare day.

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

(1) A continuing care retirement community that meets one (1) of the following:

(A) A continuing care retirement community that was registered with the securities commissioner as a continuing care retirement community on or before January 1, 2007, and that has continuously maintained at least one (1) continuing care agreement since on or before January 1, 2007, with an individual residing in the continuing care retirement community.

(B) A continuing care retirement community that for the entire period from January 1, 2007, through June 30, 2009, operated independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).

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

(D) A continuing care retirement community that meets the definition set forth in IC 16-28-15-2.

(2) A hospital-based nursing facility licensed under IC 16-21.

(3) The Indiana Veterans' Home.

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

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

(e) The office shall notify each nursing facility of the amount of the facility's assessment after the amount of the assessment has been computed. If the facility disagrees with the computation of the assessment, the facility shall request an administrative reconsideration by the office. The reconsideration request shall be as follows:

(1) In writing.

(2) Contain the following:

(A) Specific issues to be reconsidered.

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

(3) Signed by the authorized representative of the facility and must be received by the office not later than forty-five (45) days after the notice of the assessment is mailed.

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

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

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

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

(2) Submitted to the office.

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

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

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

(1) Against a Medicaid payment to the facility.

(2) Against a Medicaid payment to another health facility that is related to the facility through common ownership or control.

(3) In another manner determined by the office.

(j) If a facility:

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

(2) fails to pay the quality assessment fee;

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

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-24; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2983; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA; filed Nov 1, 2010, 11:45 a.m.: 20101201-IR-405100065FRA; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-14.6-25 Additional reimbursement for closing or converting nursing facilities (Repealed)

Sec. 25. *(Repealed by Office of the Secretary of Family and Social Services; filed May 31, 2013, 8:52 a.m.: 20130626-IR-405120279FRA)*

405 IAC 1-14.6-26 Rate reduction

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

Sec. 26. Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced by three percent (3%) per resident day, through June 30, 2017, for nursing facility services that have been calculated under this rule except for the following:

(1) The difference between:

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

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

(2) The difference between:

(A) the quality assessment rate add-on, as described in section 24(a) of this rule; and

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

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

Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set

405 IAC 1-15-1 Scope

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

Sec. 1. This section requires nursing facilities certified to provide nursing facility care to Medicaid members to electronically transmit minimum data set (MDS) information for all residents, including residents in a noncertified bed, to the office for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes. *(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)*

405 IAC 1-15-2 Definitions

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

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

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

(c) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. Version 2.0 (9/2000) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by CMS. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-2; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-15-3 General requirements

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

Sec. 3. (a) The office shall provide nursing facilities with technical support in preparing MDS transmission to the office, including, but not limited to, the following:

(1) Providing training on the transmission of MDS data.

(2) Any other support that the office deems necessary for successful transmission of MDS data.

(b) Allowable costs incurred by nursing facilities relating to transmission of MDS data to the office shall be reimbursed through the cost reporting mechanism established under 405 IAC 1-14.6. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-3; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; 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)*

405 IAC 1-15-4 MDS supporting documentation requirements

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

Sec. 4. (a) The office shall publish supporting documentation guidelines for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system. The guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

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

405 IAC 1-15-5 MDS audit requirements

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

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

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

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

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

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments have been transmitted, shall be referred to the IMFCU for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-5; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-15-6 MDS assessment requirements

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

Sec. 6. Nursing facilities shall complete and transmit the resident's room number on all full or quarterly MDS assessments. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-6; 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)*

405 IAC 1-15-7 Nursing restorative programs (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Nov 1, 2010, 11:37 a.m.: 20101201-IR-405100183FRA)*

Rule 16. Reimbursement for Hospice Services

405 IAC 1-16-1 Policy

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid members by duly certified hospice providers that provide hospice care. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, and compensate providers for reasonable, allowable costs that must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-16-2 Levels of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 2. (a) Reimbursement for hospice care shall be made according to the methodology and amounts calculated by CMS. Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the hospice wage index published by CMS.

(b) Medicaid reimbursement for hospice services will be made at one (1) of five (5) all-inclusive per diem rates for each day in which a Medicaid member is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine home care: Days one (1) - sixty (60).

(2) Routine home care: Days over sixty (60).

(3) Continuous home care.

(4) Inpatient respite care.

(5) General inpatient hospice care.

(c) The routine home care daily rate is eligible for a service intensity add-on (SIA) payment for services provided during the last seven (7) days of a Medicaid member's life. The SIA Medicaid reimbursement will be equal to the continuous home care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by a registered nurse or social worker for up to four (4) hours total, per day, and adjusted by the hospice wage index published by CMS. The following conditions must be met to qualify for the SIA payment:

(1) The day is a routine home care level of care day.

(2) The day occurs during the last seven (7) days of life and the Medicaid member is discharged deceased.

(3) Direct patient care is provided by a registered nurse or a social worker that day.

(d) The hospice will be paid at one (1) of the routine home care rates for each day the member is at home, under the care of the hospice provider, and not receiving continuous home care. Medicaid reimbursement for routine home care will be made at one (1) of two (2) all-inclusive per diem rates as follows:

(1) Higher base payment for the first sixty (60) days of hospice care.

(2) Reduced base payment for days sixty-one (61) and over of hospice care.

(e) Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse, and a nurse must provide care for over half the

total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty-four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty-four (24) hours a day.

(f) The hospice provider will be paid at the inpatient respite care rate for each day that the member is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(g) Subject to the limitations in section 3 of this rule, the hospice provider will be paid at the general inpatient hospice rate for each day the member is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The member must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the member's record must clearly explain the reason for admission and the member's condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.

(h) When routine home care or continuous home care is furnished to a member who resides in a nursing facility, the nursing facility is considered the member's home.

(i) Reimbursement for inpatient respite care is available only for a member who resides in a private home. Reimbursement for inpatient respite care is not available for a member who resides in a nursing facility.

(j) Reimbursement for the SIA is available only for routine home care provided in a member's home or in a nursing facility.

(k) When a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3634; 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 Sep 14, 2016, 9:51 a.m.: 20161012-IR-405150449FRA)*

405 IAC 1-16-3 Limitation on payments for inpatient care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 3. (a) Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period by the designated hospice provider or its contracted agent or agents. For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days.

(b) The limitations on payment for inpatient days are as follows:

(1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).

(2) If the total number of days of inpatient care to Medicaid hospice members is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.

(3) If the total number of days of inpatient care to Medicaid hospice members is greater than the maximum number of

inpatient days computed in subdivision (1), then the payment limitation will be determined by the following method:

(A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.

(B) Multiplying excess inpatient care days by the routine home care rate.

(C) Adding together the amounts calculated in clauses (A) and (B).

(D) Comparing the amount in clause (C) with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid members exceeds the amount calculated in clause (C) is due from the hospice provider.

(Office of the Secretary of Family and Social Services; 405 IAC 1-16-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-16-4 Additional amount for nursing facility residents

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services, when the office has determined that the member requires nursing facility level of care. Medicaid reimbursement is available for hospice services rendered to a nursing facility resident only if, prior to services being rendered, the hospice and the nursing facility enter into a written agreement under which the hospice takes full responsibility for the professional care management of the resident's hospice care and the nursing facility agrees to provide room and board to the individual. In this context, "room and board" includes all assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(b) The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Medicaid would have paid to the nursing facility for any resident for those dates of service on which the member was a resident of that facility.

(c) Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

(d) The additional amount for room and board is not available for members receiving inpatient respite care or general inpatient care. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; 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)*

405 IAC 1-16-5 Reimbursement for physician services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 5. (a) The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for hospice care.

(b) Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the

hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

(c) Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to Medicaid when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

(d) Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for nonvolunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 17. Rate-Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded

405 IAC 1-17-1 Policy; scope

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-3.5; IC 12-15-13-4; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid members by duly certified state-owned ICFs/IID, state-owned nursing facilities, and state-owned psychiatric hospitals. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

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

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures:

(1) recognize level and quality of care;

(2) establish effective accountability over Medicaid expenditures;

(3) provide for a regular review mechanism for rate changes;

(4) compensate providers for reasonable, allowable costs incurred by a prudent businessperson; and

(5) allow incentives to encourage efficient and economic operations.

The system of payment outlined in this rule is a retrospective system using interim rates predicated on a reasonable, cost-related basis, in conjunction with a final settlement process. Cost limitations are contained in this rule that establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data that caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must:

(1) complete the appropriate Medicaid billing adjustment form; and

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

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-3-3.5(g) for a noninstitutional provider or IC 12-15-13-4(h) for an institutional provider. *(Office of the Secretary of Family and Social*

Services; 405 IAC 1-17-1; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 93; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 1-17-2 Definitions

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

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

(b) "All-inclusive rate" means a per diem rate which, at a minimum, reimburses for all:

(1) nursing care;

(2) room and board;

(3) supplies; and

(4) ancillary therapy services;

within a single, comprehensive amount.

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

(d) "Budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

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

(f) "Desk review" means a review and application of this rule to a provider submitted annual financial report including accompanying notes and supplemental information.

(g) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) "Forms prescribed by the office" means:

(1) forms provided by the office; or

(2) substitute forms that have received prior written approval by the office.

(i) "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) "Generally accepted accounting principles" means those accounting principles as established by the Governmental Accounting Standards Board (GASB).

(k) "Like levels of care" means ICF/IID level of care provided in a state-owned ICF/IID, nursing facility level of care provided in a state-owned nursing facility, or psychiatric hospital level of care provided in a state-owned psychiatric hospital.

(l) "Ordinary patient related costs" means costs of services and supplies that are necessary in the delivery of patient care by similar providers within the state.

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

(n) "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(o) "Unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours). *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-2; filed Sep 1, 1998, 3:25 p.m.: 22 IR 83; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 94; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 28, 2010, 2:21 p.m.: 20100728-IR-405090192FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-17-3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board pronouncements shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. State accounting records are maintained on a cash basis, which shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document the adjustments in a finalized exception report; and

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

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for the enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information:

(1) none of the commingled costs shall be recognized as Medicaid allowable costs; and

(2) the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-3; filed Sep 1, 1998, 3:25 p.m.: 22 IR 84; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 94; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 1-17-4 Financial report to office; annual schedule; prescribed form; extensions

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

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

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

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

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

(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and customary charge on the last day of the reporting period.

(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.

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

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-4; filed Sep 1, 1998, 3:25 p.m.: 22 IR 85; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 95; 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)*

405 IAC 1-17-5 New provider; initial financial report to office; criteria for establishing initial rates; supplemental report

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

Sec. 5. (a) Rate requests to establish initial rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this rule, used to compute rates for active providers shall be followed to compute initial rates for new providers, except that historical data are not available. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-5; filed Sep 1, 1998, 3:25 p.m.: 22 IR 85; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 96; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-17-6 Active providers; rate review; annual request; additional requests; requests due to change in law

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

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the interim rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional interim rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional interim rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional interim rate review shall be completed in the same manner as the annual interim rate review, using all other limitations in effect at the time the annual interim review took place.

(c) To request the additional interim review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional interim review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an

additional interim rate review. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-6; filed Sep 1, 1998, 3:25 p.m.: 22 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 96; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-17-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

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

Sec. 7. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each interim rate review request shall include a budget financial report. If a budget financial report is not submitted, the interim rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Patient census data.

(B) Statistical data.

(C) Ownership and related party information.

(D) Statement of all expenses and all income.

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

(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and customary charge on the rate effective date of the rate review.

(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.

(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) The provider shall adjust patient census data based on the highest of the following:

(A) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.

(B) Forecasted patient days for the twelve (12) month budget period.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-7; filed Sep 1, 1998, 3:25 p.m.: 22 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 97; 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)*

405 IAC 1-17-8 Limitations or qualifications to Medicaid reimbursement; advertising

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

Sec. 8. Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-8; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; 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)

405 IAC 1-17-9 Criteria limiting rate adjustment granted by office

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

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. Providers reimbursed under this rule will be reimbursed with a retrospective payment system. The annual financial reports filed by the providers will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the annual financial report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the interim per diem rates based on the projected budget and paid during the report period will be multiplied by the paid client days to arrive at the annual settlement. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-9; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2003, 10:45 a.m.: 27 IR 98; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-17-10 Computation of rate; allowable costs; review of cost reasonableness

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

Sec. 10. (a) The rate for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

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

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-10; filed Sep 1, 1998, 3:25 p.m.: 22 IR 87; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-17-11 Allowable costs; capital reimbursement; depreciable life

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

Sec. 11. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years

Vehicles	4 years
Software	3 years

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-11; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; 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)

405 IAC 1-17-12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

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

Sec. 12. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donated asset are related parties, the net book value of the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-12; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; 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)*

405 IAC 1-17-13 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

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

Sec. 13. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-13; filed Sep 1, 1998, 3:25 p.m.: 22 IR 88; 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)*

405 IAC 1-17-14 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

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

Sec. 14. (a) Reasonable compensation of individuals employed or to be employed by a provider is an allowable cost, provided such employees are engaged in, or will be engaged in, patient care-related functions and that forecasted compensation amounts are reasonable in light of historical data under this section and section 15 of this rule.

(b) The provider shall report on the financial report form in the manner prescribed, using the forms prescribed by the office, all patient related staff costs and hours incurred, and forecasted to be incurred, to perform the function for which the provider was certified. Both total compensation and total hours worked, and forecasted to be worked, shall be reported. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. Said records shall indicate each employee's classification, hours worked, rate of pay, and 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. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-14; filed Sep 1, 1998, 3:25 p.m.: 22 IR 89; 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)*

405 IAC 1-17-15 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

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

Sec. 15. (a) Compensation for management, consultant, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management and consultant functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractor, and consultant as well as any other individual or entity performing such tasks.

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

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

within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

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

Owner and Management Compensation		Owner's Expenses
Beds	Allowance	(12% × bed allowance)
10	$21,542	$2,585
20	$28,741	$3,449
30	$35,915	$4,310
40	$43,081	$5,170
50	$50,281	$6,034
60	$54,590	$6,551
70	$58,904	$7,068
80	$63,211	$7,585
90	$67,507	$8,101
100	$71,818	$8,618
110	$77,594	$9,311
120	$83,330	$10,000
130	$89,103	$10,692
140	$94,822	$11,379
150	$100,578	$12,069
160	$106,311	$12,757
170	$112,068	$13,448
180	$117,807	$14,137
190	$123,562	$14,827
200	$129,298	$15,516
200 & over	$129,298+ $262/bed over 200	$15,516+ $31/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-15; filed Sep 1, 1998, 3:25 p.m.: 22 IR 89; 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)*

405 IAC 1-17-16 Allocation of costs

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

Sec. 16. (a) The detailed basis for allocation of expense between different levels of care in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Any change in the allocations must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

(Office of the Secretary of Family and Social Services; 405 IAC 1-17-16; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; 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)

405 IAC 1-17-17 State-owned facilities per diem rate

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

Sec. 17. (a) The per diem rate for providers reimbursed under this rule:

(1) is an all-inclusive rate; and

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

(b) Resources from health insurance plans available to the resident shall apply first to defraying the costs of medical services before Medicaid. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services, Veteran's Administration, and other health insurances. Services reimbursed through other sources shall be segregated and not claimed on the facility's cost report. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-17; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; 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)*

405 IAC 1-17-18 Administrative reconsideration; appeal

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

Sec. 18. (a) The office shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the office. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the office within forty-five (45) days after release of the rate computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The office shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from the office. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider and must be received by the office within forty-five (45) days after release of the rate computed by the office. Upon receipt of the request for reconsideration, the office shall evaluate the data. After review, the office may amend the audit adjustment or affirm the original adjustment. The office shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process. *(Office of the Secretary of Family and Social Services; 405 IAC 1-17-18; filed Sep 1, 1998, 3:25 p.m.: 22 IR 90; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 18. Reimbursement of Medicare Cross-Over Claims

405 IAC 1-18-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-13; IC 12-15-14

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "Cross-over claim" means a Medicaid claim filed on behalf of a Medicare beneficiary who is also eligible for Medicaid. The term includes claims filed on behalf of beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries (QMBs) and beneficiaries who are eligible for full Medicaid coverage.

(c) "Medicaid allowable amount" means the reimbursement rate for a Medicaid claim as determined under state and federal law and policies. This reimbursement rate shall be the most recent rate on file with the office of Medicaid policy and planning or its contractor at the time a cross-over claim is processed.

(d) "Medicare payment amount" means the amount of payment made by Medicare to the provider for a given claim. It does not include coinsurance amounts or deductibles. *(Office of the Secretary of Family and Social Services; 405 IAC 1-18-1; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2476; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-18-2 Reimbursement of cross-over claims

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-14

Sec. 2. (a) Cross-over claims filed by providers are reimbursed as set out in this section.

(b) If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero (0).

(c) If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

(1) the difference between the Medicaid allowable amount minus the Medicare payment amount; or

(2) the Medicare cost-sharing costs described in 42 U.S.C. 1396d(p)(3)(B) through 42 U.S.C. 1396d(p)(3)(D), if any, for the claim.

(Office of the Secretary of Family and Social Services; 405 IAC 1-18-2; filed Mar 18, 2002, 3:32 p.m.: 25 IR 2477; filed Nov 27, 2002, 4:30 p.m.: 26 IR 1079; 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; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)

405 IAC 1-18-3 Reimbursement of cross-over claims filed by providers other than nursing facilities (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Nov 27, 2002, 4:30 p.m.: 26 IR 1080)*

Rule 19. Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

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

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B, and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

(A) keep copies of all these requests and the responses to them;

(B) make them available to the office upon request; and

(C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) A long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) The office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5. *(Office of the Secretary of Family and Social Services; 405 IAC 1-19-1; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2865; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 1-19-2 Time and manner of disclosure

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

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

(b) Any disclosing entity must supply the information specified in this rule to the office at any time there is a change in ownership or control.

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

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

(e) Providers are required to notify the office upon such time as the information specified in this rule changes within thirty-five (35) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall also provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5. *(Office of the Secretary of Family and Social Services; 405 IAC 1-19-2; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2865; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 20. Change of Ownership for a Long Term Care Facility

405 IAC 1-20-1 General

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

Sec. 1. (a) As used in 405 IAC 1-19 and this rule, "long term care facility" means any of the following:

(1) A nursing facility.

(2) A CRF/DD.

(3) An ICF/IID.

(b) For Medicaid provider agreement purposes, the provider is the party directly or ultimately responsible for operating the business enterprise. This party is legally responsible for decisions and liabilities in a business management sense. The same party also bears the final responsibility for operational decisions made in the capacity of a governing body and for the consequences of

those decisions.

(c) Whether the owner of the provider enterprise (provider) owns the premises or rents or leases the premises from a landlord or lessor is immaterial. However, if the provider enters into an agreement, which allows the landlord to make or participate in decisions about the ongoing operation of the provider enterprise, this indicates that the provider has entered into either a partnership agreement or a management agency agreement instead of a property lease. A new partnership agreement constitutes a change of ownership. *(Office of the Secretary of Family and Social Services; 405 IAC 1-20-1; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2866; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-20-2 Notification requirements

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

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

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

(1) A copy of the agreement of sale or transfer.

(2) The expected date of transfer.

(3) If applicable, the name of any individual who has an ownership or control interest, is a managing employee, or an agent of the transferor, who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee.

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

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

(e) The effective date of the change of ownership will be determined by ISDH's certification and transmittal and amended by ISDH, if necessary, to correspond with the transferor/transferee agreement of sale or transfer. *(Office of the Secretary of Family and Social Services; 405 IAC 1-20-2; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2866; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 1-20-3 Change of ownership types

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

Sec. 3. A change of ownership in an existing long term care facility occurs under, but is not limited to, any of the following circumstances:

(1) For a sole proprietorship, if a provider of services is an entity owned by a single individual, a transfer of title and property to the enterprise to another person or firm, whether or not including a transfer of title to the real estate or if the former sole proprietor becomes one (1) of the members of a business entity succeeding him or her as the new owner.

(2) For a partnership, a new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement, that dissolves the old partnership and creates a new partnership.

(3) For a corporation, a new corporation, the merger of the applicant or provider corporation into another corporation, or the consolidation of two (2) or more corporations, or any other change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct

legal responsibility under state law for operation of the corporation's entity, whether that body is:

(A) a board of trustees;

(B) a board of directors;

(C) the entire membership of the corporation; or

(D) known by some other name.

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

405 IAC 1-20-4 Change of ownership effect

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

Sec. 4. When there is a change of ownership of a long term care facility, the office will transfer the provider agreement to the transferee subject to the terms and conditions under which it was originally issued and subject to any existing plan of correction and pending audit findings as follows:

(1) The transferor and transferee shall reach an agreement between themselves concerning Medicaid reimbursements, underpayments, overpayments, and civil monetary penalties.

(2) From the effective date of change of ownership and if all requirements are met, all reimbursements will be made to the transferee, regardless of whether the reimbursement was incurred by a current owner or previous owner.

(3) From the effective date of change of ownership, the transferee shall assume liability for repayment to the office of any amount due the office, regardless of whether liability was incurred by a current owner or operator or by a previous owner or operator.

(4) Liability of current and previous providers to the office shall be joint and several.

(5) A current or previous owner or lessee may request from the office a list of all known outstanding liabilities due the office by the facility and of any known pending office actions against a facility that may result in further liability.

(6) For purposes of this section, examples of reimbursements, overpayments, and penalties shall include, but not be limited to, the following:

(A) Outstanding claims.

(B) Any retro rate adjustment that results in an underpayment or overpayment based upon the transferor's cost report.

(C) Amounts identified during past, present, or future audits that pertain to an audit period prior to a change in ownership.

(D) Pending or completed surveillance utilization review (SUR) audit.

(E) Imposition of penalties due to failure of the provider to be in substantial compliance with applicable federal requirements for nursing facilities participation in the Medicare program or Medicaid.

(F) Civil monetary penalties.

(G) Amounts established by final administrative decisions.

(Office of the Secretary of Family and Social Services; 405 IAC 1-20-4; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2867; 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)

405 IAC 1-20-5 Record retention

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

Sec. 5. The transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three (3) years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer. *(Office of the Secretary of Family and Social Services; 405 IAC 1-20-5; filed Apr 17, 2003, 5:15 p.m.: 26 IR 2867; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

Rule 21. Payments for Psychiatric Residential Treatment Facility Services

405 IAC 1-21-1 Purpose; scope

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

Sec. 1. The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by psychiatric residential treatment facilities that are covered by Medicaid. Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475; 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)*

405 IAC 1-21-2 "Psychiatric residential treatment facility" or "PRTF" defined

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

Sec. 2. As used in this rule, "psychiatric residential treatment facility" or "PRTF" means a facility that is licensed under 465 IAC 2-11 as a private secure child caring institution and meets the requirements set forth in 405 IAC 5-20-3.1. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-2; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA)*

405 IAC 1-21-3 Reimbursement rates

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

Sec. 3. Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:

(1) The PRTFs shall be reimbursed for services provided to Medicaid members based upon the lower of:
  (A) the statewide PRTF prospective per diem rate calculated by the office; or
  (B) the usual and customary daily charges billed for the psychiatric treatment of eligible members.

(2) The applicable PRTF payment per diem rate determined in subdivision (1) shall provide reimbursement for all Medicaid covered services provided in the psychiatric residential treatment facility except for those costs described in subdivisions (3) and (6). Providers will include, and rates will be determined using, only those allowable costs as listed in Medicaid provider reimbursement manuals and update bulletins.

(3) The per diem rate determined in subdivision (1) shall exclude those costs incurred for the following:
  (A) Pharmaceutical supplies and services. Medicaid reimbursement for costs incurred for pharmaceutical supplies and services provided to eligible members shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in 405 IAC 5-24.
  (B) Physician services. Medicaid reimbursement for costs incurred for physician services provided to eligible members shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in 405 IAC 5-25.

(4) All costs utilized to determine the statewide prospective per diem rate in subdivision (1)(A) shall be subject to reasonability standards as set forth in the Medicare Provider Reimbursement Manual, CMS-Pub. 15-1, Chapter 25.

(5) The per diem rate determined in subdivision (1) shall exclude such costs unrelated to providing psychiatric residential services, including, but not limited to, the following:
  (A) Group education, including elementary and secondary education.
  (B) Advertising or marketing.
  (C) Nonpsychiatric specialty programs.

(6) Medicaid reimbursement for Medicaid covered psychiatric services provided to members residing in a psychiatric residential treatment facility shall be limited to the payments described in this rule. Costs for Medicaid covered services not related to the member's psychiatric condition but performed at the PRTF will be included in the PRTF per diem rate. Medicaid reimbursement for Medicaid covered services not related to the member's psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are unavailable at the PRTF and are performed at a location other than the PRTF.

(7) The established per diem rate for psychiatric residential treatment facilities shall be reviewed annually by the office by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.

(Office of the Secretary of Family and Social Services; 405 IAC 1-21-3; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475; 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)

405 IAC 1-21-4 Cost reports and audits

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

Sec. 4. PRTFs shall file a cost report annually using a uniform cost report form prescribed by the office. The office may audit or review the cost reports as it deems necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-4; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; errata filed Apr 8, 2004, 10:35 a.m.: 27 IR 2499; 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)*

*