



## **Provider Manual:**

# **Residential Treatment Services Providers Rates**

**Effective January 1, 2013**

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## **Chapter 1: General Information**

### ***Purpose of the Provider Manual***

This Provider Manual has been created to assist residential treatment services providers (“residential providers”) with understanding the mechanisms of rate setting as established by 465 IAC 2-16, with rates effective January 1, 2012. This Provider Manual will more thoroughly outline the procedures the Department of Child Services (“department”) will use for establishing the base rate, as defined in 465 IAC 2-16-4, and other cost based rates for children placed by the department or a probation department with a residential provider.

This Provider Manual will be updated once a year. If there are any changes made throughout the year, residential providers will be notified through a bulletin. A bulletin supersedes the information provided in the Provider Manual.

### ***General Contact Information for the Department***

Contact information for the department can be found on the department’s website, [www.in.gov/dcs](http://www.in.gov/dcs), click on Contact Us.

### ***Responsibilities of the Department***

The department is responsible for providing and administering child services (as defined in IC 31-25-2 et seq.). Child services include services specifically provided for children who are adjudicated to be children in need of services or delinquent children.

The department is solely responsible for licensing all residential providers in the State of Indiana.

The department is responsible for setting rates for and making payments to residential providers in accordance with 465 IAC 2-16. The relationship between the department and residential providers is governed by contract, which sets out additional responsibilities of the residential providers and the department.

### ***Responsibilities of the Residential Provider***

Each residential provider is responsible for knowing and adhering to the licensing rules as found in the Indiana Code, administrative rules promulgated by the department and department policies. Each residential provider is responsible for knowing and adhering to the terms and requirements of the promulgated residential provider rate setting rule as found at 465 IAC 2-16 (<http://www.in.gov/legislative/iac/T04650/A00020.PDF>).

Each residential provider is responsible for ensuring timely submission of requested information to the department. This includes timely submission of cost reports and follow-up information requested as part of the cost report audit process.

Each residential provider is responsible for knowing and adhering to the terms and conditions as found in its contract with the department and in any child specific placement referral issued by the department or a probation department. The residential providers’ programs and services must be consistent with terms of any Case Plan for the child.

Applicable laws and the department's practices and policies are subject to change. The department will provide notice to the residential provider of any new policies or changes in current policies that have been adopted by the Director of the department, and include such notice on its website at [www.in.gov/dcs](http://www.in.gov/dcs).

## **Chapter 2: The Annual Rate-Setting Process**

The department will set residential provider rates on a calendar year basis. At the beginning of each calendar year, the department will have a public comment period and a public hearing to discuss rate setting for that year. The public comment period and the public hearing will be held prior to cost report<sup>1</sup> training.

### ***Annual Public Comment Period***

The annual period of public comment will be open for at least thirty (30) days preceding the annual public hearing. The public comment time period will allow each residential provider and other interested persons or organizations to communicate ideas, suggestions, or other comments regarding the rate setting process.

The next public comment period will be December 17 – January 17, 2013. Send comments to the department at [RateRulePublicComments.Dcs@dcs.IN.gov](mailto:RateRulePublicComments.Dcs@dcs.IN.gov) or to:

**Indiana Department of Child Services  
Attention: General Counsel, Rate Rule Public Comments  
302 W. Washington Street, E306-MS47  
Indianapolis, IN 46204**

### ***Annual Public Hearing***

Each year, at least one public hearing regarding rate setting will be held on or about the third Friday in January at an address specified in a notice posted by the department on the department's website. Notice of a public hearing will be posted on the department's website for a period of at least thirty (30) consecutive days immediately before the date scheduled for the hearing. The department will also send electronic notice of the public hearing to residential providers currently under contract with the department.

The public hearing will be open to the public, and the department will accept comments, suggestions, and feedback related to annual review of the base rate and other cost based rates set by the department.

The next public hearing will be January 18, 2013, at the Indiana Government Center South, at 402 W. Washington Street, Indianapolis, Indiana, 46204.

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<sup>1</sup> The "cost report" is a report that the department requires each residential provider to complete for each program that it operates. The cost report includes actual costs incurred on behalf of the program in the most recently completed residential provider fiscal year, or in an alternative twelve (12) month period as specified by the department. The cost report also includes any other information relating to determination of the cost of operating or supervising the program that is specified by the department, or that the residential provider considers relevant to determination of its reasonable administrative costs relating to the program.

## Chapter 3: Base Rate and Other Cost Based Rates

### *General Information*

The department will pay a base rate to all residential providers for services provided to children placed by the department or a probation department. The department may also pay for educational and behavioral health services if applicable. See Chapter 4 and 5 for more information on those payments. Behavioral health, education, and physical health services must be unbundled from the base rate so that actual costs are identifiable and alternative funding sources can be accessed to enable the most efficient use of state funds to pay for child services.

The base rate is made up of the following components:

1. Maintenance payment;
2. Administrative payment; and,
3. Payment for costs that are not eligible for Title IV-E reimbursement, if such costs are related to licensing requirements as established by 465 IAC 2-9 through 465 IAC 2-13 or written agreement between the department and residential providers. Such costs shall include, but are not limited to on-site nursing staff or transportation to medical appointments for the child.

### *Establishment of the Base Rate and Other Cost Based Rates*

The department will set the residential provider's base rate (and other cost based rates the department may set) pursuant to **465 IAC 2-16** and will utilize the residential provider's cost report to do so.<sup>2</sup> The residential provider shall submit the cost report to the department on an annual basis. The department will provide notice to residential providers by February of each year as to when the cost report is due. Failure to submit the cost report timely may result in delay in payment or non-payment by the department for administrative costs incurred or services rendered by the residential provider.

The cost report will be based on a single year's costs, not multiple years. The cost report shall include actual costs incurred on behalf of each program in the most recently completed calendar year for the residential provider and shall be completed in accordance with the residential provider cost report instructions. Pursuant to 465 IAC 2-16, the department reserves the right to select an alternative reporting period. If an alternative reporting period is selected for future cost reports, the department will give all providers adequate advance notice of such a change. A copy of the residential provider cost report instructions can be found on the DCS website at [www.in.gov/dcs/2334.htm](http://www.in.gov/dcs/2334.htm).

If the residential provider has not been licensed, or operated a program for which a base rate is required, for a period of at least twelve (12) months in the reporting period before the cost report is due to the department, the residential provider shall submit a cost report utilizing a comprehensive twelve (12) month operating budget for the new program. The cost report shall be submitted at least ninety (90) days before the start of the program.

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<sup>2</sup> The cost report also will be used to set the residential provider's Title IV-E rate.

If the residential provider makes a substantial change in an existing program, the department has the ability to reevaluate the costs associated with the program, which may result in a new base rate or other cost based rate.

The department will review each cost report for reasonableness and eligibility under Title IV-E, OMB circulars and the CFR. The department may, in its discretion, adjust historical costs to reflect current costs by applying a cost of living adjustment. For costs that are not eligible under Title IV-E, the department will review the cost report for allowability as determined by the department. Based on that review, the department will submit to the residential provider a final approved cost report that the department will use in calculating the applicable rates.

Each cost report submitted by the residential provider is subject to further review or audit by the department. The department will perform annual desk audits on all cost reports and occasional field audits when appropriate. Such a review or audit may result in a rate adjustment as specified in a new rate letter issued and mailed to the residential provider.

### ***Allowable Costs***

To be an allowable cost on the cost report, a cost must relate to “administration” of the residential facility, “maintenance” of a child placed in the residential facility, and licensing requirements as established by 465 IAC 2-9 through 465 IAC 2-13 or written agreement between the department and residential providers if the costs are not eligible for Title IV-E reimbursement.

Costs related to the administration of the residential facility include, but are not limited to:

1. Case work;
2. Case management;
3. General administration and management;
4. Accounting and finance;
5. Human resources;
6. Management information systems;
7. Quality assurance procedures;
8. Legal expenses, other than fees and costs related to certain litigation;
9. Office supplies;
10. Professional fees and dues;
11. Subscriptions;
12. Printing and postage;
13. Medical examinations required as a condition of employment;
14. A reasonable profit margin for residential treatment services providers that are not tax-exempt entities<sup>3</sup>; and,

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<sup>3</sup> "Tax exempt entity" means a residential provider that has been determined to be exempt from federal income taxation by the Internal Revenue Service or otherwise operates under such an exemption pursuant to the Internal Revenue Code of 1986, as amended.

15. Independent living services as specified in written agreements with residential treatment service providers.<sup>4</sup>

Costs related to maintenance of a child in a residential facility are costs to cover the reasonable cost of, and the reasonable cost of providing, the following items:

1. Food;
2. Clothing<sup>5</sup>;
3. Shelter, including reasonable occupancy costs;
4. Daily supervision;
5. School supplies;
6. Personal incidentals for the child<sup>6</sup>;
7. Liability insurance with respect to a child placed in the residential treatment services provider's facility;
8. Reasonable travel expenses for the child to attend school where the child was enrolled before placement, to the extent that school transportation is not provided or required to be provided under applicable Indiana law by a public school corporation or other state or local agency; and,
9. Reasonable travel expenses for the child for family visitation to the extent required by, or consistent with, the child's individual case plan or court order.

Costs related to licensing requirements as established by 465 IAC 2-9 through 465 IAC 2-13 or written agreement between the department and residential providers that are not eligible for Title IV-E reimbursement include, but are not limited to, on-site nursing staff or transportation to medical appointments for the child.

In addition to the above, to be an allowable cost on the cost report, the costs must generally be reasonable, necessary, related to the care of children, and related to goods or services actually provided by the residential provider.

The department determines if costs are reasonable by determining if they are consistent with applicable guidelines as described in 2 CFR Part 225 (OMB Circular A-87 Cost Principles for State, Local, and Indian Tribal Governments)<sup>7</sup>, 2 CFR Part 230 (OMB Circular A-122 Cost Principles for Non-Profit Organizations)<sup>8</sup>, and 48 CFR Part 31, Section 201-3 (Determining Reasonableness).

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<sup>4</sup> The department's master contract with residential providers specifies the independent living services that must be provided as part of the base rate. This includes but is not limited to completion of Ansell-Casey Life Skills Assessment and adherence to the department's service standards with regard to independent living services residential facilities.

<sup>5</sup> This includes initial and ongoing clothing for the child.

<sup>6</sup> This includes a gift in an amount up to \$50 for the child's birthday and for the December holidays.

<sup>7</sup> OMB Circular A-87: [http://www.whitehouse.gov/omb/circulars/a087/a87\\_2004.pdf](http://www.whitehouse.gov/omb/circulars/a087/a87_2004.pdf)

<sup>8</sup> OMB Circular A-122: [http://www.whitehouse.gov/omb/circulars/a122/a122\\_2004.pdf](http://www.whitehouse.gov/omb/circulars/a122/a122_2004.pdf)

As discussed in 2 CFR Part 225 and 2 CFR Part 230:

A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. In determining reasonableness of a given cost, consideration shall be given to:

- a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
- b. The restraints or requirements imposed by such factors as: Sound business practices; arm's-length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
- c. Market prices for comparable goods or services.
- d. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government.
- e. Significant deviations from the established practices of the governmental unit which may unjustifiably increase the Federal award's cost.

As discussed in 48 CFR Part 31, Section 201-3:

- a. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business. Reasonableness of specific costs must be examined with particular care in connection with firms or their separate divisions that may not be subject to effective competitive restraints. No presumption of reasonableness shall be attached to the incurrence of costs by a contractor. If an initial review of the facts results in a challenge of a specific cost by the contracting officer or the contracting officer's representative, the burden of proof shall be upon the contractor to establish that such cost is reasonable.
- b. What is reasonable depends upon a variety of considerations and circumstances, including:
  1. Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance;
  2. Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations;
  3. The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and,
  4. Any significant deviations from the contractor's established practices.

### ***Offsetting Revenue and Netting***

Eligible cost reimbursement offsetting will be applied as a credit in accordance with federal regulations as identified by 2 CFR Part 230 (OMB Circular A-122 Cost Principles for Non-Profit Organizations). The resulting net cost will be used to establish the administrative payment.

“Applicable credits” refers to those receipts, or reduction of expenditures which operate to offset or reduce expense items that are allocable to awards as direct or indirect costs. Typical examples of such transactions include but are not limited to the following: purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds, other governmental funding sources (other than per diem payments), such as the U.S. Department of Education school lunch program and Medicaid funding, and adjustments of overpayments or erroneous charges.

To the extent that such credits accruing or received by the residential provider relate to allowable cost, they shall be credited to the department either as a cost reduction or cash refund, as appropriate.

### ***Unallowable Costs in the Base Rate and Other Cost Based Rates***

Expenditures for the below are ineligible costs under Title IV-E and are not included as an allowable cost as part of the Title IV-E portion of the base rate:

1. Counseling/Therapy;
2. Education (other than school supplies); and,
3. Health and medical services or treatment.

Consistent with Federal guidelines, the department will not pay any residential provider for the unallowable expenses and costs specified below. The unallowable costs and expenses will not be considered by the department in calculating the base rate and other cost based rates and must be paid with funds secured from a funding source other than the department.

1. Fines and penalties resulting from violations of, or failure of the organization to comply with federal, state, or local laws and regulations, except when incurred as a result of compliance with specific provisions a contract with the department or instructions in writing from the department;
2. Investment management counsel and staff and similar expenses incurred solely to enhance income from investments;
3. Lobbying as defined in 2 CFR Part 230 (OMB Circular A-122 Cost Principles for Non-Profit Organizations);
4. Organized fundraising, including financial campaigns, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions; a portion of administrative costs will be allocated to fundraising costs;
5. Donations and contributions, including cash, property, and services made by the organization, regardless of the recipient;
6. Donated goods or services received by the organization, except when donated services utilized in the performance of a direct cost activity are material in amount;

7. Bad debts including losses arising from uncollectible accounts and other claims, related collection costs, and related legal costs;
8. Compensation and special benefits to owners in excess of amounts reasonable for the services rendered;
9. Entertainment, including amusement, diversion, and social activities and any associated costs not directly related to reasonable entertainment and recreation for children placed with the residential provider, such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities;
10. Alcoholic beverages;
11. Litigation expenses and fees if they relate to a lawsuit or other legal proceeding that:
  - a. Relates to a violation of, or failure to comply with, a federal, state, local, or foreign statute or regulation by the organization (including its agents and employees); and, results in a conviction in a criminal proceeding, a determination of liability in a civil or administrative proceeding involving an allegation of fraud or similar misconduct, the imposition of a monetary penalty in any civil or administrative proceeding, termination of the contract with the department by reason of a violation or failure to comply with a law or regulation, or a disposition by consent or compromise if the action could have resulted in any of the proceeding dispositions;
  - b. Is initiated by the residential provider against the department for:
    - i. Administrative or judicial review of any final rate, payment, child assessment, or child program placement determination made by the department;
    - ii. Interpretation or application of this rule, any other rule of the department, or any department policy;
    - iii. Alleged noncompliance by the department with any provision of Title IV-E or any other federal or state law, rule, or regulation; or,
    - iv. Alleged breach of any contract between the department and the residential provider.
  - c. Names as a party defendant any other federal or state governmental agency; or,
  - d. Is initiated by, or on behalf of, a child, a child's parent or legal guardian against the residential provider, alleging a claim for damages, breach of contract, violation of a constitutional or statutory right, or any other basis for liability of the residential provider to the plaintiff or plaintiffs.
12. Mortgage and loan principal payments;
13. Contingency reserves or similar provisions made for events the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening;
14. Advertising and marketing except those which relate to the core mission of the residential provider or are solely for the recruitment of personnel, the procurement of goods or services necessary to support the program, and other specific purposes necessary to meet the requirements of the department;
15. Housing of non-clients except as specifically authorized by the department in licensing rules as established by 465 IAC 2-9 through 465 IAC 2-13, as amended;

16. Taxes from which exemptions are available to the residential provider directly, or which are available to the residential provider based on an exemption afforded by the federal government when the awarding agency makes available the necessary exemption certificates;
17. Federal income taxes;
18. Non straight line depreciation except where clear evidence indicates that the expected consumption of the asset will be significantly greater or lesser in the early portions of its useful life than in later portions of its useful life.

The following costs and expenses are considered by the department to be unallowable costs on the cost report and will not be considered in calculating the administrative payment:

1. Salaries: Amounts exceeding the maximum allowable variation established by the department from the median salary for the job category that is determined by the department using:
  - a. The most recent available Child Welfare League of America Salary Study published by CWLA Press, that contains a survey of applicable job category salaries; or,
  - b. Applicable job category salaries paid by all residential providers in Indiana, as determined by reports compiled by, or available to, the department.
2. Fringe benefits: Amounts exceeding the maximum allowable variation established by the department from the median fringe benefit rate (total fringe benefits as a percent of total wages) for all Indiana residential providers, as determined by reports compiled by, or available to, the department.
3. Client to direct care staff ratios: Costs associated with staff in significant excess of licensing requirements as established by 465 IAC 2-9 through 465 IAC 2-13, as amended, or services standards adopted by the department and incorporated in a written agreement with residential treatment services providers.
4. Direct care staff to supervisor ratios: Costs associated with supervisory staff in significant excess of licensing requirements as established by 465 IAC 2-9 through 465 IAC 2-13, as amended, or services standards adopted by the department and incorporated in a written agreement with residential treatment services providers.
5. Indirect cost allocations: Any indirect cost allocations as a percentage of total operating costs in excess of the maximum percentage of total costs established by the department for allowable indirect costs.
6. Total administrative costs: Any amount by which total administrative costs, as defined in the cost report, exceed a maximum percentage of total costs established by the department.
7. Occupancy costs associated with excess capacity.
  - a. Occupancy costs means facility related costs of a residential provider including, but not limited to depreciation, mortgage interest, rent, utilities, building repairs and maintenance, property taxes, and property insurance.
  - b. Excess capacity means, in cases where the actual average annual occupancy rate, as included in the cost report, is less than the minimum

acceptable average annual occupancy rate as established annually by the department, for a particular residential provider or program, the difference between the (1) actual average annual occupancy rate of the residential treatment services provider's program; and (2) minimum acceptable average annual occupancy rate of the residential provider's program as established annually by the department.<sup>9</sup> Minimum acceptable average occupancy will be based upon an analysis of the amount of open capacity reasonably necessary to accommodate fluctuations in placements. Any unused capacity in excess of this reasonable cushion will be deemed excess capacity and the portion of occupancy costs associated with this excess capacity will be disallowed. Note that the only costs that will be disallowed due to excess capacity will be occupancy costs such as rent, depreciation, and property taxes. The department will use the definitions of "idle capacity" as provided in OMB Circular A-87 as guidance when it determines the "minimum acceptable average annual occupancy rate" for a particular provider.

The cost limits for the above items will be reviewed on an annual basis. The current cost caps will be published in a bulletin on an annual basis prior to the effective date of the new base rates.

### ***Annual Review of Rate Setting Methodology***

An independent third party contractor, currently Public Consulting Group (PCG), will conduct an annual review of the department's rate setting methodology. PCG also currently provides the department with ongoing consulting services related to Federal IV-E requirements, rules, and guidance. This includes the following activities:

1. As-is process maps and process write-ups;
2. System review and assessment;
3. Policy development and improvement and support with compliance issues;
4. On-going technical assistance;
5. On-going review and assessment of federal policy development and changes; and,
6. On-going review and assessment.

The department, as the statutorily designated Title IV-E agency and not the contractor is ultimately responsible for ensuring compliance with IV-E requirements. The contractor is an agent of DCS for that purpose.

### ***Notification of Base Rate and Other Cost Based Rate***

The department will mail to the residential provider a letter stating the base rate (and any other cost based rates) that the department agrees to pay, for each applicable residential provider

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<sup>9</sup> If a unit/cottage is inactive/idle, the licensed beds within that unit/cottage will not be included in determining excess capacity if the costs for such are not included on the annual cost report. For a facility that is opened for a partial year, the partial year costs should be reported and the same percentage of the beds will be utilized in the calculation of excess capacity.

program. The letter will include the effective date of the rate(s). The effective date will be not less than forty-five (45) days after the date of the initial annual rate letter.

If the residential provider accepts the rate(s) offered by the department in the rate letter, any agreement between the residential provider and the department shall be amended to the new rate(s). If the residential provider does not accept the rate(s) offered by the department, the residential provider must comply with the Review and Appeal section in Chapter 8 below.

## **Chapter 4: Behavioral Health**

### ***General Information***

Pursuant to the residential provider rate rule, behavioral health services are unbundled from the base rate so that actual costs are identifiable and alternative funding sources can be accessed to enable the most efficient use of state funds to pay for child services.

The Individual Child Placement Referral (ICPR) generated to the residential provider at the time of placement authorizes the residential provider (or their subcontractor) to provide the behavioral health services that are approved in the contract with the department<sup>10</sup>. A separate referral is not required. Providers do not have to wait until Medicaid approves units to start performing the services. If the child is not Medicaid eligible or Medicaid denies the approved service, then DCS will pay based on the initial referral.

All behavioral health services must be completed in accordance with service standards set by the department. The services standards can be found on the department's website at [www.in.gov/dcs](http://www.in.gov/dcs).

### ***Children who are Eligible for Medicaid***

Effective January 1, 2012, for children who are Medicaid eligible, behavioral health costs shall be billed to Medicaid for services authorized by the department that are Medicaid eligible. Thus, all residential providers must have the ability to access Medicaid for behavioral health services<sup>11</sup>. Residential providers can collaborate with other providers to bill Medicaid for behavioral health services if they cannot bill Medicaid directly.

For services that are not covered by Medicaid but are authorized by the department, the department will pay through a contract with the provider. The department's contract with the provider will set the behavioral health units that are approved by the department for each of the residential provider's programs. The residential provider must first bill Medicaid. If Medicaid denies the units after prior authorization is requested, the residential provider can bill the department under the contract up to the approved units. The total number of approved units is inclusive of Medicaid paid units and DCS paid units. However, the total number of approved units should not be construed to limit the amount of service billed to Medicaid. This cap is only to be utilized if Medicaid does not reimburse for services up to the total units. If a child's needs

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<sup>10</sup> If the residential provider is subcontracting behavioral health service to a Medicaid provider, the ICPR will be issued to the residential provider.

<sup>11</sup> If a residential provider does not provide behavioral health services or pays for behavioral health services through a source other than the department, then this section does not apply.

warrant additional medically necessary services, the provider should seek to provide that service under Medicaid coverage. For information on invoicing and billing, see Chapter 7.

The below behavioral health service category definitions apply to the DCS behavioral health packages. To bill DCS, the below services must be physician or HSPP-directed services provided by a practitioner who is eligible to bill Medicaid Clinic Option.

- Individual Therapy – structured, goal-oriented individual therapy for children affected by physical abuse, sexual abuse, emotional abuse, or neglect and/or to address family or youth issues that resulted in the involvement of juvenile probation. This is paid by DCS at an hourly rate of \$63.90 after a Medicaid denial.
- Family Therapy – structured, goal-oriented therapy for families affected by physical abuse, sexual abuse, emotional abuse, or neglect and/or to address family or youth issues that resulted in the involvement of juvenile probation. This is paid by DCS at an hourly rate of \$63.90 after a Medicaid denial. If the family therapy is conducted in the family home by an agency other than a Community Mental Health Center, a Medicaid denial is not required. Instead, this would be billed as a non-Medicaid eligible behavioral health service pursuant to the residential service package and marked as such in Area 15 of the standard invoice.
- Group Therapy – structured, goal-oriented group therapy for children affected by physical abuse, sexual abuse, emotional abuse, or neglect and/or to address family or youth issues that resulted in the involvement of juvenile probation. This is paid by DCS at an hourly rate of \$14.42 after a Medicaid denial.
- Diagnostic and Evaluation: The provider should complete a comprehensive diagnostic evaluation which incorporates and integrates information from multiple disciplines, including the nursing assessment, psychiatric evaluation, educational assessment, biopsychosocial assessment and psychological testing, as appropriate. Collateral data is also collected, and includes but is not limited to interviews with service providers, treatment records of inpatient and outpatient care, and information with family members. Neuropsychological tests and medication evaluation should also be completed as necessary. The diagnostic evaluation will integrate all data into a summary of the issues creating barriers to reunification, explain the psychological diagnosis, and will provide recommendations for treatment. This is paid by DCS at an hourly rate of \$87.30.
- Court Attendance – paid by DCS per appearance rate of \$127.80. Can only be billed if the therapist is requested in writing by DCS or probation to attend.
- Travel to and from Court – actual therapist’s time traveling to and from court; paid by DCS at an hourly rate of \$63.90.
- Other behavioral health services - these are:
  - Crisis Intervention: An unscheduled, immediate, short-term treatment intervention provided by a master’s- level therapist to a client who is experiencing a psychiatric or behavioral crisis. Crisis intervention services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. Paid by DCS at an hourly rate of \$63.90.

- Therapeutic Visitation: A planned, structured visitation between the child and his/her parent/guardian, family member or alternate caretaker, as outlined in the DCS case plan or ordered by the court. Therapeutic visitations are supervised by a master's-level therapist and are designed to a) assist children and their families in maintaining or reestablishing relationships that are healthy and safe for the child or b) assist children in the transition to different family structures, while providing for the safety of the child. Paid by DCS at an hourly rate of \$63.90.
- Periodic Reassessment: Completion of an updated bio-psychosocial assessment, or other specialized assessment, by a master's-level therapist, as requested by DCS or required by state licensure and/or accreditation standards. Paid by DCS at an hourly rate of \$63.90.
- CFT Meeting Attendance: Participation by a master's-level therapist in the Child and Family Team Meeting, as scheduled by DCS or the lead service agency. CFT Meetings are designed to develop a plan for assessment and delivery of ongoing services to families and children under the care and supervision of DCS. Paid by DCS at an hourly rate of \$63.90.
- Intensive MR/DD Behavioral Intervention: Behavioral intervention, facilitated by a master's-level therapist, designed to eliminate maladaptive behavior and develop adaptive behavior. Behavior interventions include antecedent manipulations, positive reinforcement of target behaviors, compliance training, simple correction, teaching specific adaptive skills, over-correction, planned ignoring, and other client-specific interventions based on behavioral principles. Paid by DCS at an hourly rate of \$63.90.
- Polygraphs for SMY youth: Paid by DCS per polygraph at actual charge up to a rate of \$350.00.
- Drug screens for drug and alcohol programs: Paid by DCS per drug screen at actual charge up to a rate of \$15.00.

In the rare circumstance when the below behavioral health packages are not sufficient for a particular child, the residential provider should contact the family case manager. The family case manager will staff the request with the DCS Clinical Resource Team.

### **Medicaid Clinic Option (MCO)**

DCS has developed **monthly** caps in each behavioral health service category for residential providers billing MCO and DCS. The monthly caps differ per residential program category and include total hours that would be billed to MCO and DCS.

The MCO behavioral health service packages by program are below:

- Emergency Shelter: This program provides emergency services to meet basic needs for safety, food, clothing, shelter, education, and recreation on a short-term basis, and allows access and admission on a 24-hour basis. This program can only be operated by facilities with an emergency shelter care child caring institution or group home license.
  - Individual Therapy: up to 2 hours per month

- Family Therapy: up to 2 hours per month
  - Group Therapy: None
  - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
  - Travel to and from court: bill actual time traveling to court
  - Other Behavioral Health Services: None
- Open Residential: This program provides a full range of therapeutic, educational, recreational, and support services by a professional, interdisciplinary team either on or off the campus of the facility. This program can only be operated by a facility with a child caring institution or group home license.
    - Individual Therapy: up to 5 hours per month
    - Family Therapy: up to 4 hours per month
    - Group Therapy: up to 16 hours per month
    - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
    - Travel to and from court: bill actual time traveling to court
    - Other Behavioral Health Services: up to 8 hours per month
    - Drug Screens: up to 2 screens a month
- Staff Secure / Intensive Residential: This program provides more intensive and frequent services and more intensive staffing patterns than open residential. The staffing, structure, and environment make possible more intensive child supervision and higher degree of safety. This program can only be operated by a facility with a child caring institution license.
    - Individual Therapy: up to 5 hours per month
    - Family Therapy: up to 4 hours per month
    - Group Therapy: up to 16 hours per month
    - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
    - Travel to and from court: bill actual time traveling to court
    - Other Behavioral Health Services: up to 8 hours per month
    - Drug Screens: up to 2 screens a month
- Secure Treatment: This program provides treatment within a locked, secure facility to gravely disabled children with chronic behavior that harms themselves or others. This program can only be operated by a facility with a private secure license.
    - Individual Therapy: up to 5 hours per month
    - Family Therapy: up to 4 hours per month
    - Group Therapy: up to 20 hours per month
    - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
    - Travel to and from court: bill actual time traveling to court
    - Other Behavioral Health Services: up to 10 hours per month
    - Drug Screens: up to 2 screens a month

- Short-Term Diagnostic and Evaluation: This program includes a time-limited diagnostic and assessment process that evaluates each child's and family's needs.
  - Individual Therapy: up to 2 hours per month
  - Family Therapy: up to 4 hours per month
  - Group Therapy: up to 8 hours per month
  - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
  - Travel to and from court: bill actual time traveling to court
  - Other Behavioral Health Services: up to 4 hours per month
  - Drug Screens: up to 2 screens a month
  - Diagnostic and Evaluation: up to 16 units
  
- Youth with Sexually Maladaptive Behaviors: This program provides highly structured, intensive sex offender specific treatment designed to improve public safety by reducing the risk of reoccurring sexually based offenses.
  - Individual Therapy: up to 5 hours per month
  - Family Therapy: up to 4 hours per month
  - Group Therapy: up to 20 hours per month
  - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
  - Travel to and from court: bill actual time traveling to court
  - Other Behavioral Health Services: up to 8 hours per month
  - Polygraph: up to 3 total
  - Drug Screens: up to 2 screens a month
  
- Developmental and Intellectual Disabilities: This program provides highly structured, intensive services to children with developmental and emotional disabilities, including autism spectrum disorders.
  - Individual Therapy: up to 5 hours per month
  - Family Therapy: up to 4 hours per month
  - Group Therapy: up to 4 hours per month
  - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
  - Travel to and from court: bill actual time traveling to court
  - Other Behavioral Health Services: up to 20 hours per month
  - Drug Screens: up to 2 screens a month
  
- Drug and Alcohol: This program provides highly structured, intensive substance abuse treatment designed to focus on behaviors that have attributed to high risk behavior.
  - Individual Therapy: up to 5 hours per month
  - Family Therapy: up to 4 hours per month
  - Group Therapy: up to 20 hours per month
  - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)

- Travel to and from court: bill actual time traveling to court
  - Other Behavioral Health Services: up to 8 hours per month
  - Drug Screens: up to 2 screens a month
- **Teen Mom and Baby:** This program provides comprehensive, specialized services for pregnant and parenting teen mothers. This program can only be operated within a group home or child caring institution.
    - Individual Therapy: up to 5 hours per month
    - Family Therapy: up to 4 hours per month
    - Group Therapy: up to 8 hours per month
    - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
    - Travel to and from court: bill actual time traveling to court
    - Other Behavioral Health Services: up to 8 hours per month
    - Drug Screens: up to 2 screens a month
- **Independent Living / Residential Step Down:** This program assists young people in gaining the skills required to live healthy, productive, and responsible lives as self-sufficient adults while still providing needed daily supervision. It addresses all of the preparatory requirements for independent adulthood and recognizes the evolving and changing developmental needs of the adolescent. This program can only be operated by a facility with a group home or child caring institution license.
    - Individual Therapy: up to 5 hours per month
    - Family Therapy: up to 4 hours per month
    - Group Therapy: up to 8 hours per month
    - Court Attendance: bill appearance in court (documentation of DCS or probation request for therapist to attend court)
    - Travel to and from court: bill actual time traveling to court
    - Other Behavioral Health Services: up to 8 hours per month
    - Drug Screens: up to 2 screens a month

### **Medicaid Rehabilitation Option**<sup>12</sup>

Because the MRO service packages are sufficient to cover the majority of behavioral health services that are currently being provided by residential providers billing through MRO, the behavioral health package for MRO is up to 8 hours per month of other behavioral health services as defined previously.

### ***Children Who are not Eligible for Medicaid***

If the child is not Medicaid eligible and if private insurance is not available or does not cover the costs of services or treatment, behavioral health costs that are referred by the department shall be

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<sup>12</sup> The department will pay the state match for MRO services paid by Medicaid on behalf of department and probation youth placed in a residential facility. Any state match related to Medicaid-eligible services will be paid directly to the community mental health center (CMHC) if the CMHC is providing services on behalf of a residential provider that has a residential master contract with the department. There is no match for services paid with state dollars.

billed to the department through a contract with the department. The department will pay up to total units per program noted above. The residential provider must include evidence that the child is not Medicaid eligible with the invoice.

### ***Medicaid Enrollment for DCS and Probation Wards***

When a child enters out of home placement, the DCS Central Eligibility Unit (CEU) determines the child's IV-E eligibility a minimum of 30 days after removal, or once all information is entered into the appropriate data system by the FCM or probation officer, whichever is later. If the child is determined to be IV-E eligible and child does not currently have Medicaid, the DCS Medicaid Enrollment Unit enrolls the child in MA4 (a type of Medicaid). If the child is IV-E eligible and already has Medicaid, MEU sends a transmittal to the Division of Family Resources (DFR) to have the child's Medicaid changed to MA4. This process can take DFR up to 4 weeks. If the child is not IV-E eligible, MEU sends a Medicaid application to DFR for processing. This application can take up to 45 days for processing by DFR. Thus, the entire Medicaid enrollment process can take up to 75 days.

When there are changes in placement or IV-E eligibility or a reunification, Trial Home Visit or case closure, MEU receives a report and notifies DFR as appropriate so that appropriate Medicaid changes can be made. For DFR redeterminations, MEU receives the notices from DFR, requests information from the family case manager or probation officer and communicates eligibility information back to DFR, so there are no lapses in Medicaid coverage. For issues with Medicaid eligibility, contact the FCM or probation officer assigned to the child's case. They will then contact MEU for assistance.

## **Chapter 5: Education**

Pursuant to the residential provider rate rule, the costs of education services are unbundled from other costs and will have a separate cost based rate that is established through the IV-E cost report. The residential provider must submit educational services cost information with the cost report or as such information is reasonably requested by the department. The education rate will then be added to the base rate to determine the daily per diem for each residential program. To be reimbursed, this rate must be part of the residential provider's contract with the department.

Any payments made by the department for educational services that are provided directly by a residential provider shall be based on the reasonable costs contained in the cost report. As to costs to comply with an Individualized Education Plan (IEP), those will be included on the cost report based on costs from the previous year in complying with IEPs.

## **Chapter 6: Health and Medical Services or Treatment**

The department will pay for health and medical services or treatment, including prescription medication, directly to the service provider, on behalf of children within the department or probation's system of care who are placed with a residential provider if Medicaid denies a claim. The department will also pay if the child is not Medicaid eligible and private insurance is not available or does not cover the costs of services or treatment.

The department will pay on a reimbursement basis for services that are authorized but not otherwise covered. The provider should submit documentation with the invoice that shows that Medicaid or private insurance denied the claim or is not available.

This does not include on-site nursing services and medical transportation that are built into the base rate.

## Chapter 7: Invoicing and Billing

### *General Information on Submission of Invoices*

Any payments to a residential provider for the placement of a child or for behavioral health services while the child is placed in the residential facility will be made pursuant to an ICPR that is generated by the department (or by the Probation Department when appropriate) at the time the child is placed with the residential provider. A new ICPR is required for any change in the payment rate. The department requires each provider to submit an invoice for services. All providers must submit a completed State Form 28808 to receive payment, a copy of which can be found at [www.in.gov/dcs](http://www.in.gov/dcs) (click on forms, then finance) The following are important items to remember when submitting invoices:

- A claim cannot be submitted prior to the last day of placement or service claimed.
- Only days that ended with an overnight stay are billable; the last day of placement is not claimable.
- You must bill within 90 days from the last day of the month the service/placement occurred.
- An original signature is required for submission of a claim; submission via fax or e-mail cannot be accepted.
- The invoice must be received within 10 business days (including Saturday) from the Date of Invoice.
- New vendors (that have not previously received payments for services rendered to the State of Indiana) must submit a Vendor Information form prior to submitting an invoice which can be found on the DCS website at [www.in.gov/dcs](http://www.in.gov/dcs) (click on forms, then finance).. For questions contact the DCS Resource Unit at [DCSResourceUnit@dcs.in.gov](mailto:DCSResourceUnit@dcs.in.gov) or 877-340-0309 and select Option 2.

The following are instructions for completion of your claim form (line numbers below coincide with item numbers on the claim form):

1. **Name of Vendor** must match the name listed on the submitted Vendor Information form.
2. **Tax ID Number** must match the Tax ID listed on the submitted Vendor Information form.
3. **ST Number** is your unique identifier assigned by the KidTraks payment system. DCS Payment Research Unit (contact below) will provide the ST# if needed.
4. **Invoice Number** can be any combination of numbers and letters you assign, but must be different for each claim (e.g. Jan-2011, Feb-2011, etc.).

**\*\*INVOICE NUMBER MUST BE NO MORE THAN 8 CHARACTERS (including letters, numbers, spaces, dashes, slashes, etc.)\*\***

5. **Date of Invoice** is the date the claim is completed. The date cannot be prior to the last date of service provided and also cannot be more than 10 days after the signature date (item 23).
6. **Address** must match the address previously submitted on the Vendor Information form.
7. **Invoice Type** – **first submission, re-bill** due to denial of past invoice lines or **appeal** after multiple denials.
8. **Claim Pages** will generally be 1 of 1 for expediting the processing and approval of the invoice, unless multiple pages are needed
9. **Invoice Service Type** – **RESIDENTIAL** for placement services or **Medicaid** for Behavioral Health services. Please note that Behavioral Health services should be billed on a separate invoice from placement services.
10. **Claim Period** will be from the first of the month thru the last day of the month, unless the placement ended sooner.
11. **Total of Claim** must equal the sum of the total cost column (box 21).
12. **County** of wardship for each child.
13. **Billable Unit Referral ID** from the ICPR.
14. **Case ID** from the ICPR.
15. **Name/Comments/Documentation - Name** of the child in placement and/or any documentation that helps to explain the expense (especially useful for Behavioral Health expenses).
16. **Billing Code** – Service & Component code that matches the appropriate RESIDENTIAL program or Behavioral Health service
17. **Begin Date** is generally the first day of the month, unless placement started later.
18. **End Date** is generally the last day of the month, unless placement ended sooner.
19. **Unit** reflects the number of days in placement during the month or appropriate Behavioral Health unit.
20. **Rate**. The per diem listed on the ICPR or appropriate Behavioral Health rate.
21. **Total cost** = days x rate.
22. **Signature** -- Claim must be signed; signature should be in BLUE ink.
23. **Telephone number** – contact number of the person completing/responsible for the Claim for Support of Children Invoice.
24. **E-mail address**. – e-mail address of the person completing/responsible for the Claim for Support of Children Invoice.
25. **Signature Date** is the date the claim is signed. The date cannot be prior to the last date of service provided and also cannot be more than 10 days after the invoice date (item 5).

Failure to follow the above guidelines could result in the claim being denied and/or returned for correction. Invoices must be mailed to:

**DCS KidTraks Invoicing  
Room W364, Mail Stop 54  
402 W. Washington Street**

## **Indianapolis, IN 46204-2739**

If you are re-billing, mail the invoice to KidTraks and follow the below guidelines:

1. Complete a new invoice and re-date to the current date.
2. Assign a new invoice number (No more than 8 characters).
3. Use blue ink when signing and a current signature date.
4. Ensure all corrections on the invoice have been made.
5. Remember that the 90-day filing rule begins at the original invoice submission date or from the denial date, whichever is later.
6. Please write "Re-Bill" at the top of the returned invoice.

For an appeal of a denied invoice, an appeal must be submitted no later than twelve (12) months after the service was provided. Mail the appeal information directly to the attention of the Assistant Deputy Director of KidTraks, using the same address as above. You must include the following when you submit an appeal:

1. An Appeal letter clearly explaining the situation leading up to the appeal and including why you think this expense should be paid.
2. A copy of the denial letter(s).
3. A copy of the originally submitted invoice(s).
4. A new invoice with a current invoice date.
5. Any supporting documentation (referrals, Medicaid denials, etc.)

All appeals will be reviewed by a DCS Invoicing Appeals committee made up of fiscal, program and legal staff.

### ***Invoicing the Per Diem***

When invoicing the per diem, you can utilize one invoice for multiple children but you must invoice each child on a separate line. Ensure that you invoice the amount that is stated on the ICPR. The amount represents the appropriate rate and program. If there is a discrepancy between the ICPR and the program the child is actually placed in, contact the local office prior to submitting your invoice.

A new ICPR is needed any time the child moves to a new program.

### ***Invoicing Behavioral Health***

To invoice for behavioral health, the residential provider must have a residential contract with the department that contains a behavioral health component. The behavioral health component will set the approved maximum units that a residential provider can seek reimbursement. If the residential provider has a subcontractor that is providing behavioral health services, the department will pay the residential provider through the contract and not the subcontractor.

The residential provider must first bill Medicaid and receive a denial before billing the department. The residential provider must include the Medicaid denial, including denial codes, with the invoice. The only exceptions to needing a Medicaid denial are court attendance, travel

to and from court, the services listed in “other behavioral health services” on the contract. Also, a denial is not needed if the child is not Medicaid eligible.

The residential provider will have 90 days from the date of the Medicaid denial to invoice the department for the services.

### ***Invoice/Billing Questions***

Residential providers should contact the following with questions:

- For questions involving the placement, please contact the local DCS or probation office.
- For questions involving payments as well as completion of a claim form, contact DCS Payment Research Unit at [DCSPaymentResearchUnit@dcs.in.gov](mailto:DCSPaymentResearchUnit@dcs.in.gov) or 877-340-0309 and select Option 1.
- For a name change, change of address or change of bank accounts, contact DCS Resource Unit at [DCSResourceUnit@dcs.in.gov](mailto:DCSResourceUnit@dcs.in.gov) or 877-340-0309 and select Option 2.

## **Chapter 8: Review and Appeal of Rates**

### ***General Information***

A residential provider may request an administrative review of the base rate and other cost based rate approved by the department as stated in a letter issued to the residential provider. See 465 IAC 2-16-26. After the department issues a decision on the administrative review, the residential provider can request an administrative appeal. See 465 IAC 2-16-27. Below is information on both processes.

### ***Process for Requesting Administrative Review***

A residential provider may request an administrative review of the base rate and other cost based rates when it believes that:

- Errors have been made in the cost report submitted to the department, calculation of the rate, or the determination by the department of the reasonableness of any cost; or,
- The determination of the rate by the department has an adverse impact on child welfare in Indiana and no other residential provider in the State of Indiana, or other licensed provider, can adequately address the adverse impact to child welfare in the State of Indiana.

A request for administrative review of the base rate and other cost based rates approved by the department must be submitted in writing to the department no later than thirty (30) days after the written notice of the approved rate has been sent by the department. Notice is effective upon mailing of the letter notifying the residential provider of the rate to the residential provider’s address. A request for administrative review submitted more than thirty (30) days after the notice of the rate was mailed will not be considered.

The request for administrative review shall be submitted on the department form titled “Residential Treatment Services Provider (RTSP) and Child Placing Agency (CPA) Rates Administrative Review Request,” with the required documentation attached. The form can be found on the DCS website at [www.in.gov/dcs](http://www.in.gov/dcs) (click on forms, then finance). As required by the rule, the residential provider shall include in the request for review but not be limited to the following items:

- Identification of the current rate and approved new rate, as applicable to a specific program or service offered by the residential provider;
- An updated or revised cost report for the applicable program or service, including an itemized statement of administrative and indirect costs that the residential provider considers allowable under the provisions of this rule;
- A clear, concise statement of the reasons for the requested change; and,
- A detailed statement of related information in support of the change.

The residential provider shall send the completed form and all required attachments to the department via email or U.S. Mail at:

**Indiana Department of Child Services**  
**Attention: General Counsel, Rate Review**  
**302 West Washington Street, Room E306, MS 47**  
**Indianapolis, IN 46204**  
**[DCS.RateReviewAndAppeals@dcs.in.gov](mailto:DCS.RateReviewAndAppeals@dcs.in.gov)**

The department cannot accept or process an incomplete request for review that does not include at least the items specified in this subsection. No request for review of the base rate and other cost based rates can be acted upon if the residential provider has a current license that is in the process of being revoked by the department.

### ***The Department’s Administrative Review***

The department’s review will be conducted by at least three (3) representatives from the department, with at least one (1) representatives each from Fiscal, Programs and Services and Legal/Licensing. The review will consist of a review of the documentation submitted by the residential provider as well as other documentation that the department has relating to the reason for appeal. The residential provider can only submit documentation for review and does not have the right to be present or present witnesses. The department will mail notice of the review decision to the residential provider within thirty (30) days of the department’s receipt of the Administrative Review Request form.

### ***Process for Appealing the Base Rate and Other Cost Based Rates***

Before requesting an Administrative Appeal, a residential provider must have requested an Administrative Review and received a review decision from the department. A residential provider may request an appeal of the department administrative review decision by submitting a written request within fifteen (15) days of receipt of the Department’s notice of the administrative review decision. See 465 IAC 2-17-28.

The request for Administrative Appeal shall be submitted on the department form titled “Residential Treatment Services Provider (RTSP) and Child Placing Agency (CPA) Rates Administrative Appeal Request,” with any documentation attached. The form can be found on the DCS website at [www.in.gov/dcs](http://www.in.gov/dcs) (click on forms, then finance). When an administrative hearing is requested, the administrative appeal case file will contain only information that is filed with the Hearings and Appeals office for a specific case. It will not contain the file from the Administrative Review.

The residential provider shall send the completed form and any attachments to the department via mail at:

**Indiana Department of Child Services  
Attention: Office of the General Counsel, Hearings and Appeals  
302 W. Washington Street, Room E 306, MS 47  
Indianapolis, IN 46204**

### ***The Appeal***

The appeal will be heard under the applicable provisions of the Administrative Orders and Procedures Act (AOPA). See IC 4-21.5-3-7(a); see also 465 IAC 2-17-28 for a listing of AOPA provisions that do not apply. In the appeal, the residential provider has the burden of proof and the burden of persuasion to establish, by a preponderance of the evidence, that the department's decision following the administrative review is erroneous. The administrative law judge may, with the consent of the parties, consolidate two (2) or more pending appeals that involve the same or substantially similar facts or issues, for purposes of a hearing and decision under this section.

Unless a continuance is granted, the assigned administrative law judge (ALJ) will hold an administrative hearing not more than sixty (60) days after the department receives the written request. The (ALJ) may grant a continuance of the date for a hearing for any of the following reasons:

1. The residential provider files a written motion for continuance specifying the reasons for the request and alternate dates when the residential provider will be available and prepared to go forward with the hearing.
2. The department files a written motion for continuance for good cause<sup>13</sup>.
3. The administrative law judge orders a continuance for good cause<sup>14</sup>.

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<sup>13</sup> The following shall constitute good cause requested by the department: (1) A necessary witness, or the counsel or other necessary representative of the department, is or will be unavailable on the scheduled hearing date, for a reason or reasons that could not have been anticipated at the time the hearing was scheduled; (2) A motion or other proceeding relating to the appeal is pending that could be dispositive of the appeal, or otherwise materially affect the course or conduct of the hearing; (3) Any other good cause, as determined by the ALJ at a prehearing conference.

<sup>14</sup> The following shall constitute good cause on motion of the ALJ: (1) Unanticipated congestion of the hearing calendar; (2) Unavailability of the assigned ALJ due to unforeseen circumstances, or a change in the judge assigned to the appeal; (3) Any other good cause, as determined by the general counsel of the department or the general counsel's designee.

If a hearing continuance is granted, the ALJ shall promptly schedule and conduct a prehearing conference under IC 4-21.5-3-18 to address the rescheduling of the hearing and any other matters relating to expediting decision of the appeal or otherwise resolving the issues presented.

Unless an extension of time is granted by the general counsel of the department for good cause stated on the record, an ALJ will issue a decision within ninety (90) days after completion of the hearing.

If the ALJ decision is favorable to the residential provider, the department can request a final agency action. If the ALJ decision is favorable to the department, the residential provider can request a final agency action. Instructions and time frames for this request will be included in the ALJ decision.

***Rate in Effect during Pendency of Review and Appeal of the Base Rate and Other Cost Based Rates***

The department will pay, during the time the review and/or appeal is being conducted, the amount stated in the most recent rate letter that was mailed to the residential provider in accordance with 465 IAC 2-16-20(e) or (g).

If a new rate is calculated based on the administrative review or appeal, such rate will be retroactive to the effective date stated in the rate letter that was mailed to the residential provider. Any payments made by the department to your agency after the effective date in the rate letter that was mailed to the residential provider will be adjusted up or down in accordance with the new rate, if applicable, following completion of the administrative review or appeal.