(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.

405 IAC 1-14.6-2 Definitions

Sec. 2. **(a) As used in this rule, "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 determined based on the facility's nursing home report card score based on the latest published data as of the end of each state fiscal year.**

(b) As used in this rule, "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) Travel.
(7) Telephone.
(8) License dues and subscriptions.
(9) Office supplies.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified mental retardation professional (QMRP).

(c) As used in this rule, "allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed 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) As used in this rule, "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.

(e) As used in this rule, "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.

(f) As used in this rule, "average historical cost of property of the median bed" means the allowable patient-related property 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.

(g) As used in this rule, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(h) As used in this rule, "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.

(i) As used in this rule, "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.

(j) As used in this rule, "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.

(k) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(l) As used in this rule, "delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(m) As used in this rule, "desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(n) As used in this rule, "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.

(o) As used in this rule, "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.

(p) 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 and resident assessment data and its supporting documentation by auditors.

(q) As used in this rule, "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%

(r) As used in this rule, "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.

(s) As used in this rule, "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.

(t) 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.

(u) As used in this rule, "incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(v) As used in this rule, "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.

(w) As used in this rule, "medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

(x) As used in this rule, "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 the Medicaid program. 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 the Centers for Medicare and Medicaid Services (CMS).

(y) As used in this rule, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

(z) As used in this rule, "nursing home report card score" means a numerical score developed and published by the Indiana state department of health (ISDH) that quantifies each facility's key survey results.

(aa) As used in this rule, "office" means the office of Medicaid policy and planning.

(bb) As used in this rule, "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) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(dd) 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.

(ee) As used in this rule, "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) As used in this rule, "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.

(gg) As used in this rule, "tentative profit add-on payment" means the profit add-on payment calculated pursuant to this rule before considering a facility's nursing home report card score.

(hh) As used in this rule, "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.

(ii) As used in this rule, "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).

(jj) As used in this rule, "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.

(kk) As used in this rule, "untimely MDS resident assessment" means either of the following:

(1) A significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly.

(2) A full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6 following the conclusion of all:

(A) physical therapy;

(B) speech therapy; and

(C) occupational therapy.

~~(hh) As used in this rule, "untimely MDS resident assessment" means either of the following:~~
~~(1) A significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly.~~
~~(2) A full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6 following the conclusion of all:~~
~~(A) physical therapy;~~
~~(B) speech therapy; and~~
~~(C) occupational therapy.~~

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

Sec. 3.(a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing 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. 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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth (5th) 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 certification of a provider. This option may be exercised only one (1) time by a provider and 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 ~~**and electronic cost report (ECR) file**~~ copy of their Medicare cost report that covers their most recently completed historical reporting period. ~~**Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.**~~

(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 (5th) 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 or its contractor. 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 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 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.

(10) Copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.

(11) Copy of 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) 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 (7^{th}) 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 Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the 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. Extension of the electronic

applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

Effective Date	Threshold Percent	Administrative Component Corrective Remedy Percent
(A)	(B)	(C)
October 1, 2002	40%	5%
January 1, 2004	30%	10%
April 1, 2005	20%	15%

(l) Based on findings from the MDS audit, beginning on the effective date of this rule, the office or its contractor 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 or its contractor.

(m) ~~**Beginning on the effective date of this rule,**~~ Upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated

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, **2011**, 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 or its contractor 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 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) below,** 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

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) above, beginning on January 1, 2010 and continuing thereafter, 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 of the following RUG-III groups: PB2, PB1, PA2, or PA1,

(2) the resident has a Cognitive Performance Score (CPS) of:

zero (0) – Intact;

one (1) – Borderline Intact; or

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 control, and

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

		CMIs effective for the period following the effective date of this rule amendment		
RUG-III Group	**RUG-III Code**	**The first (1st) calendar quarter through the fourth (4th) calendar quarter**	**The fifth (5th) calendar quarter through the eighth (8th) calendar quarter**	**The ninth (9th) calendar quarter and thereafter**
Reduced Physical Functions	**PB2**	**0.48**	**0.41**	**0.30**
Reduced Physical Functions	**PB1**	**0.44**	**0.38**	**0.28**
Reduced Physical Functions	**PA2**	**0.38**	**0.32**	**0.24**
Reduced Physical Functions	**PA1**	**0.33**	**0.28**	**0.21**

(i) The office or its contractor shall provide each nursing facility with the following:

(1) Two (2) preliminary CMI reports. These preliminary CMI reports:

(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 first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second 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 ~~may~~ 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 July 1, 2003, through June 30, **2011**, 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 effective with this rule amendment, and each July 1 thereafter, the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of each 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	$5.75
83 – 265	$5.75 – [(Nursing Home Report Card Score – 82) x $0.03125]
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~~ will receive a per patient day rate add-on equal to two dollars ($2).

(l) Beginning effective July 1, 2003, through June 30, **2011**, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, and operate a special care unit (SCU) for such residents as demonstrated by resident assessment data. The additional Medicaid reimbursement shall equal **twelve dollars ($12.00)** per Medicaid resident day in their SCU. Only facilities with a SCU for Alzheimer's disease or dementia as demonstrated by resident assessment data as of **March 31 of each year** shall be eligible to receive the additional reimbursement. **Such additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.**

(m) Nursing facilities that satisfy each of the four (4) conditions listed in this subsection shall qualify for a capital component rate add-on:

(1) Twenty-five percent (25%) or more of its residents as of December 31, 2006, were under the chronological age of twenty-one (21) years of age.

(2) According to the last health facility survey conducted by Indiana state department of health on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i).

(3) The facility bedrooms accommodate no more than four (4) residents.

(4) The facility bedrooms measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.

(n) The capital component rate add-on referenced in subsection (l) shall be calculated by dividing the qualifying facility's debt service associated with financing acquired exclusively to fund any capital costs incurred by the provider to come into compliance with 42 CFR 483.70(d)(1)(i), divided by total patient days from the facility's latest completed annual financial report. For purposes of this provision, debt service shall mean the total annual interest and principal payments required to be paid on any such financing arrangement or arrangements. The capital component rate add-on shall be determined following the provider's demonstration to the office of qualification for this provision, and shall become effective on the date the provider successfully completes the health facility survey of any new beds as conducted by the state department of health. The capital component rate add-on shall not be updated annually. Refinancing shall be recognized only when the interest rate is less than the original financing. The capital component rate add-on shall continue to apply until the associated financing has been fully paid.

(o) The capital component rate add-on described under subsection **(n)** shall be exempt from the capital component overall rate ceiling as determined under section 9(c)(4) of this rule.

(p) The capital component rate add-on described under subsection **(n)** shall be exempt from the maximum allowable increase as determined under section 23 of this rule.

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

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~~ calculated below**. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) 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).

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

(3) 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).

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

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

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

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

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

Table 1
Children's Nursing Facilities

	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, and after	July 1, 2003, through June 30, **2011**	July 1, **2011**, and after
Percentage	30%	52%	110%	105%

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

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

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

Table 2
Non-Children's Nursing Facilities

	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, and after	July 1, 2003, through June 30, **2011**	July 1, **2011**, 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 nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 3. – Allowed Direct Care Profit Add-On Percentage		
Nursing Home Report Card Score	**Effective Dates**	
	First (1st) Full Calendar Quarter through Fourth (4th) Full Calendar Quarter Following Rule Effective Date	**Fifth (5th) Full Calendar Quarter Following Rule Effective Date, and Thereafter**
0 – 82	**100%**	**100%**
83 – 357	**100% - [(Nursing Home Report Card Score – 82) x 0.36232%]**	**N/A**
358 and greater	**0%**	**N/A**
83 – 279	**N/A**	**100% - [(Nursing Home Report Card Score - 82) x 0.50505%]**
280 and greater	**N/A**	**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**

	Indirect Care Profit Add-on Percentage		Indirect Care Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, and after	July 1, 2003, through June 30, **2011**	July 1, **2011**, 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 5, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 5. – Allowed Indirect Care Profit Add-On Percentage		
Nursing Home Report Card Score	**Effective Dates**	
	First (1st) Full Calendar Quarter through Fourth (4th) Full Calendar Quarter Following Rule Effective Date	**Fifth (5th) Full Calendar Quarter Following Rule Effective Date, and Thereafter**
0 – 82	**100%**	**100%**
83 – 357	**100% - [(Nursing Home Report Card Score – 82) x 0.36232%]**	**N/A**
358 and greater	**0%**	**N/A**
83 – 279	**N/A**	**100% - [(Nursing Home Report Card Score - 82) x 0.50505%]**
280 and greater	**N/A**	**0%**

(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 6; minus

(B) a provider's allowable per patient day cost.

Table 6

	Capital Component Profit Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, 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 7, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 7. – Allowed Capital Profit Add-On Percentage		
Nursing Home Report Card Score	**Effective Dates**	
	First (1st) Full Calendar Quarter through Fourth (4th) Full Calendar Quarter Following Rule Effective Date	**Fifth (5th) Full Calendar Quarter Following Rule Effective Date, and Thereafter**
0 – 82	**100%**	**100%**
83 – 357	**100% - [(Nursing Home Report Card Score – 82) x 0.36232%]**	**N/A**
358 and greater	**0%**	**N/A**
83 – 279	**N/A**	**100% - [(Nursing Home Report Card Score - 82) x 0.50505%]**
280 and greater	**N/A**	**0%**

(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 **8**.

Table **8**

	Direct Care Component Overall Rate Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, 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 **9**.

Table **9**

	Indirect Care Component Overall Rate Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, 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 **10**.

Table **10**

	Capital Component Overall Rate Ceiling Percentage	
Effective Date	July 1, 2003, through June 30, **2011**	July 1, **2011**, and after
Percentage	100%	80%

(4) For the therapy component, no overall rate component limit shall apply.

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405 IAC 1-14.6-21 Allocation of expenses

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) ~~**Nothing in this rule is intended to alter the appropriate classification of costs on the annual financial report from the appropriate classification of costs under 405 IAC 1-14.1** ***[405 IAC 1-14.1 was repealed filed May 30, 1997, 4:25 p.m.: 20 IR 2774.]***~~. 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.

405 IAC 1-14.6-23 Limitation to Medicaid rate increases for nursing facilities

Sec. 23. Notwithstanding all other provisions of this rule, for the period October 1, 2007, through June 30, 2011, nursing facility rates that have been calculated under this rule shall be limited to a maximum allowable increase as follows:

(1) For annual rate reviews effective October 1, 2007, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's latest annual Medicaid rate with an effective date prior to March 31, 2007.

(2) For annual rate reviews effective July 1, 2008, the maximum allowable increase of seven percent (7%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of October 1, 2007.

(3) For annual rate reviews effective July 1, 2009, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2008.

(4) For annual rate reviews effective July 1, 2010, the maximum allowable increase of three percent (3%) per annum shall be applied to a provider's annual Medicaid rate with an effective date of July 1, 2009.

(5) The therapy rate component shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this section.

(6) Beginning on the first (1st) full calendar quarter following the effective date of this rule amendment, the direct care component shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this section.

(7) Beginning on the first full calendar quarter following the effective date of this rule amendment, the nursing home report card score rate add-on shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this section.

(8) A provider's annual Medicaid rate may be in effect for longer or shorter than twelve (12) months. In such cases, the maximum allowable increase percent shall be proportionately increased or decreased to cover the actual time frame their previous annual rate was in effect, using a twelve (12) month period as the basis.

(9) Should a provider's quality assessment rate change subsequent to the effective date of their annual Medicaid rate, the office shall restate the provider's Medicaid quality assessment rate add-on and the maximum allowable increase using the new quality assessment rate, applying all provisions of this rule. A provider's Medicaid rate restated under this provision shall be used to calculate their subsequent maximum allowable increase as determined in subdivisions (1) through (4) of this section.

(10) The additional reimbursement authorized by section 7**(j)** of this rule shall be excluded for purposes of calculating the maximum allowable increase pursuant to subdivisions (1) through (4) of this section when the nursing facility's prior annual Medicaid rate does not include this additional reimbursement.

OS Notification

State/Title/Plan Number: Indiana 09-006

Type of Action: SPA Approval

Required Date for State Notification: May 27, 2010

Fiscal Impact:

FY 2010	$(4,700,000)
FY 2010	$(6,300,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after January 1, 2010, this amendment proposes to revise the reimbursement methodology for nursing facilities (NF). Specifically, this amendment increases the add-on for NFs that provide inpatient services to more than 8 ventilator-dependent residents and increases the add-on for NFs that provide specialized care to residents with Alzheimer's Disease or dementia, and operate a special care unit (SCU). Also, this amendment increases the add-on to NFs to encourage improved quality of care to residents based on a nursing home report card score. Additionally this amendment proposes decreases due to increasing the minimum occupancy standards for the direct, indirect, and administrative components for providers with more than 50 beds and also proposes a decrease to the profit add-on component of the NF reimbursement rate. Finally, with this amendment the direct care component of the reimbursement rate and the report card score add-on are no longer subject to a maximum allowable increase.

The Federal budget impact as a result of this amendment is a decrease of $4.7 million in FFY10 and a decrease of $6.3 million in FFY 2011. Although there were increases in some areas such an the Ventilator Add-on, Special Care Unit Add-on, the Report Card Score Add-on, and the changes to the Maximum Allowable Increase, there were also fiscal decreases due to the Minimum Occupancy Standard & Administrative Component as well as the Profit Add-on. The fiscal decreases exceed the fiscal increases resulting in an overall decrease in the federal budget impact. Funding the non-Federal share of these payments comes from State appropriations, permissible provider taxes, and IGTs. The State has provided a UPL demonstration that looks

acceptable.

The State was asked the access questions due to the rate decreases and the responses were acceptable. The State does not feel that the reduction in rates is large enough to affect access to care and services as required under 1902(a)(30). Over the last several years, the State performed extensive modeling of the impact that the proposed reimbursement changes would have on Medicaid rates, met regularly with providers and their representatives, advocates and members of the Legislature, and obtained substantial input from all stakeholders.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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