405 IAC 1-14.6-2 Definitions

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

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
(A) allowable and patient-related; and
(B) appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) All staff travel and mileage.
(7) Telephone.
(8) License dues and subscriptions.
(9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.
(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified mental retardation professional (QMRP).
(16) Educational seminars for administrative staff.
(17) Support and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.

(c) "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or
(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(j) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups under the resource utilization group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.
(2) All residents.

(k) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and
(2) received written approval from the office to be designated as a children's nursing facility.

(l) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(m) "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the date defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the guidelines for use in determining the time-weighted CMI under section 9(e) of this rule. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(n) "Desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(o) "Direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all of the following:

(1) Nursing and nursing aide services.
(2) Nurse consulting services.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.
(9) Rental costs for short-term (thirty (30) days or less), nonrecurring and intermittently used low air loss mattresses, pressure support surfaces, oxygen concentrators, and therapy equipment. Providers must maintain and make available for inspection adequate documentation to support the short-term and nonrecurring nature of the rental expense.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents incurred by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and Non-Legend Sterile Water used for any purpose.
(13) Educational seminars for direct care staff.

(p) "Fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(s) "Forms prescribed by the office" means either of the following:

(1) Cost reporting forms provided by the office.

(2) Substitute forms that have received prior written approval by the office.

(t) "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(u) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(v) "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(w) "Indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.
(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) All costs related to non-ambulance travel and transportation of residents.

(hh) A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a nursing facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

(ii) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's nursing home report card score.

(jj) "Therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this rule.

(kk) "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).

(ll) "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.

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) Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule.
(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15.
(3) Costs must be reported in conformance with Generally Accepted Accounting Principles.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:
(1) The auditor shall give a written notice listing all of the deficiencies in documentation.
(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.
(3) Not later than thirty (30) days of the date of the notice described in subsection (1), the provider may seek one (1) thirty (30) day extension to respond to the notice, describing the reason(s) the extension is necessary.
(d) In the event the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:
(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.
(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.
(3) No rate increases will be allowed until the first day of the calendar quarter following the receipt of the response and requested documentation.
(4) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.
(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:
(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.
(2) The audit contractor shall document such adjustments in a finalized exception report.(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.
(3) The rate setting contractor shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

(f) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this document and 405 IAC 1-14.6, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field or desk audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

(g) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improve efficiency, economy, and quality of resident care. The burden of demonstrating that costs are patient-related lies with the provider.

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option:

(1) may be exercised only one (1) time by a provider; and

(2) must coincide with the fiscal year end for Medicare cost reporting purposes.

If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office 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 completed in accordance with applicable instructions and submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, and related to patient care; and

(B) expenses not related to patient care have been clearly identified.

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

(10) A copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.
(11) A copy of the crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report.
(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(d) An extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:
(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.
(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the:
(A) Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary; and
(B) provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary;
then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. An extension of the electronic

(k) Based on findings from the MDS audit 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.

(l) Upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and
(2) any payment adjustment shall be made.

(m) The Employee Turnover report, Schedule X, and the Special Care Unit report, Schedule Z, shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates

Sec. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Before the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's CMI for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's CMI for Medicaid residents. Initial interim rates shall be effective on the:

(1) certification date; or

(2) date that a service is established;

whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(b) Before the first annual rate review, the rate will be adjusted effective on each calendar quarter under section 6(d) of this rule to account for changes in the provider's CMI for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the

CMS Nursing Home without Capital Market Basket index as published by DRI/WEF A. 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 I, Year 1
April 1, Year 1	October 1, Year 1
July I, Year 1	January I, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, 2014, 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:

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, 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:

(A) PB2
(B) PB1
(C) PA2
(D) PA1

(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to 10 or if there is not a BIMS score then 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.

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned 96% of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	CMI Table	CMI Table
		Effective 10/1/2011 through 12/31/2011	Effective 1/1/2012 and thereafter
Reduced Physical Functions	PB2	0.41	0.30
Reduced Physical Functions	PB1	0.38	0.28
Reduced Physical Functions	PA2	0.32	0.24
Reduced Physical Functions	PA1	0.28	0.21

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

(1) A preliminary CMI report that will:

(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and

(B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(j) The office will increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents ($11.50) per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning October 1, 2011 through June 30, 2014, 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, 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 the state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	$14.30
83 – 265	$14.30 – ((Nursing Home Report Card Score – 82) × $0.0777)
266 and above	$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year may receive a per patient day rate add-on equal to two dollars ($2).

(l) Beginning effective October 1, 2011, through June 30, 2014, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(m) 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 (m) 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 upon qualification for the 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) For the period October 1, 2011, through June 30, 2012, the office shall increase Medicaid reimbursement to nursing facilities by seventy-five cents ($0.75) per Medicaid resident day to reimburse costs associated with the following selected facility expenditures:

(1) Short-term, (thirty (30) days or less) nonrecurring rental expenses for low air loss mattresses and pressure support surfaces, oxygen concentrators, and therapy equipment that are only used intermittently and not routinely;
(2) Cable or satellite television provided in resident rooms;
(3) Pets, pet supplies and maintenance, and veterinary expenses;
(4) Direct resident care support and license fees for software to support hands-on resident care;
(5) Replacement dentures for Medicaid residents incurred by the facility that exceed state Medicaid plan limitations for dentures; and
(6) Assets identifiable to patient care that conform to the capitalization requirements at Section 14(e) of this rule, that exceed five hundred dollars ($500), and are less than one thousand dollars ($1,000).

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 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 one hundred percent (100%) of the average allowable cost of the median patient day. However, for the period October 1, 2011, through June 30, 2012, the administrative component shall be equal to one hundred ten percent (110%) of the average allowable cost of the median patient day, and for the period July 1, 2012, through June 30, 2013, the administrative component shall be equal to one hundred eight percent (108%) 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	October 1, 2011, through June 30, 2014	July 1, 2014, and after	October 1, 2011, through June 30, 2014	July 1, 2014, 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	October 1, 2011, through June 30, 2014	July 1, 2014, and after	October 1, 2011, through June 30, 2014	July 1, 2014, 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	
0 – 82	100%
83 – 279	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	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	October 1, 2011, through June 30, 2014	July 1, 2014, and after	October 1, 2011, through June 30, 2014	July 1, 2014, 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	
0 – 82	100%
83 – 279	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	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	October 1, 2011, through June 30, 2014	July 1, 2014, 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	
0 – 82	100%
83 – 279	100% - ((Nursing Home Report Card Score - 82) × 0.50505%)
280 and greater	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	October 1, 2011, through June 30, 2014	July 1, 2014, 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	October 1, 2011, through June 30, 2014	July 1, 2014, 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	October 1, 2011, through June 30, 2014	July 1, 2014, and after
Percentage	100%	80%

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

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines:

(1) shall be published as a provider bulletin; and

(2) may be updated by the office as needed.

Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

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405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

(e) The following costs are not considered allowable costs and shall not be included in the established rate:

(1) All over the counter, legend and non-legend drugs.
(2) Cost of replacement hearing aides and eyeglasses.
(3) All costs associated with pastoral care.
(4) All costs associated with resident and family gifts, including, but not limited to, flowers, bibles and memory books.
(5) All costs associated with collection fees
(6) All costs, fees and dues associated with lobbying activities
(7) All costs of acquisitions, such as the purchase of corporate stock as an investment or purchases of new facilities
(8) All costs associated with barber and beauty shop activities
(9) All costs associated with marketing

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law, stepson-in-law, stepdaughter-in-law.
(6) Grandparent and grandchild.
(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rate review effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (e) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, documentation to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties, such as invoices, standard charge master listings, and remittances, must be submitted.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public on an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.

(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.

(4) The organization actually furnishes such services, facilities, or supplies to other non-related party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(f) The related party exception shall be for any period of time, up to the maximum term of two (2) years.

405 IAC 1-14.6-12 Allowable costs; fair rental value allowance

Sec. 12. Providers shall be reimbursed for the use of allowable patient-related facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property, except that rental costs for short-term (thirty (30) days or less), nonrecurring and intermittently used low air loss mattresses, pressure support surfaces, oxygen concentrators, and therapy equipment shall be reimbursed in the direct care component. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is appropriately allocated to the facility.

(1) The fair rental value allowance is calculated by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

(A) land, building, improvements, vehicles, and equipment; and

(B) costs;

required to be capitalized in accordance with generally accepted accounting principles. Land, buildings, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the

a historical cost of at least one thousand dollars ($1,000), the cost shall be capitalized and included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

405 IAC 1-14.6-15 Valuation; sale or lease among family members

Sec. 15. (a) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the average historical cost of property of the median bed except as described in this section for the sale of facilities between family members.

(b) If a sale of facilities between family members meets the following conditions, the cost basis of

Sec. 18. (a) Compensation for:

(1) owner, related party, management, general line personnel, and consultants who perform management functions; or

(2) any individual or entity rendering services above the department head level;

shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. Beginning effective October 1, 2011, through June 30, 2014, compensation subject to this limitation includes wages, salaries, and fees for owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning effective July 1, 2014, and thereafter, wages, salaries, and fees paid for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.

(b) Beginning effective October 1, 2011, through June 30, 2014, the maximum allowable amount for owner, related party, and management compensation shall be the average allowable cost of the median patient day for owner, related party, and management compensation subject to this limitation as defined in subjection (a). The average allowable cost of the median patient day shall be updated four (4) times per year effective January 1, April 1, July 1, and October 1.

(c) Beginning effective July 1, 2014, the maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount:

(1) under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator; or

(2) of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees.

If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or the costs shall be disallowed.

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor not later than forty-five (45) days after release of the rate as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If a provider disagrees with the preliminary recalculated Medicaid rate resulting from a financial audit adjustment or reportable condition under subsection 1(e)(4) of this rule, the provider may request administrative reconsideration by the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid rate-setting contractor not later than forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall forward the administrative reconsideration to the MDS audit contractor who shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the Medicaid rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3. The request for appeal shall be signed by the nursing facility provider.

405 IAC 1-14.6-23.1 Reduction to Medicaid rate for nursing facilities

Notwithstanding all other provisions of this rule, for the period beginning October 1, 2011, and continuing through June 30, 2013, all rates established under this rule, except for the following, shall be reduced by five percent (5%) per Medicaid resident per day:

(1) For the period October 1, 2011, through June 30, 2012, seventy-five cents ($0.75) per Medicaid resident day to reimburse costs associated with selected facility expenditures as described in subsection 7(p) of this rule;

(2) The difference between:

(i) the nursing home report card score rate add-on as described in subsection 7(k) of this rule, and

(ii) the nursing home report card score rate add-on calculated using each facility's current nursing home report card score, and the nursing home report card score rate add-on parameters contained in subsection 7(k) of LSA Document #10-183, posted at 20101201-IR-405100183FRA.

(3) The difference between:

(i) the administrative rate component, as described in subsection 9(a)(4) of this rule, and

(ii) one hundred percent (100%) of the average allowable administrative cost of the median patient day.

(4) The difference between:

(i) the quality assessment rate add-on as, described in section 24(c) of this rule, and

(ii) the quality assessment rate add-on calculated using the assessment rates in subsection 24(a) of LSA Document #10-65, posted at 20101201-IR-405100065FRA.

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Nursing facilities that were paid a Medicaid per diem rate between July 1, 2011, and September 30, 2011 will be eligible for a supplemental add-on amount to be applied to their per diem rate effective for the period of October 1, 2011 through December 31, 2011. This supplemental add-on amount is calculated as the difference between a. and b. described below:

a. A July 1, 2011, Medicaid rate calculated in accordance with methods and parameters of the State Plan in effect on June 30, 2011, with the exception that the five percent (5%) per resident day rate reduction under the approved State Plan Amendment TN# 11-001 shall not be applied.

b. A July 1, 2011, Medicaid rate calculated in accordance with methods and parameters of the State Plan in effect on July 1, 2011, with the exception that the five percent (5%) per resident day rate reduction under the approved State Plan Amendment TN# 11-001 shall not be applied.

The supplemental add-on amount calculated above and added to the Medicaid per diem rate shall be subject to the five percent (5%) per resident day rate reduction.

OS Notification

State/Title/Plan Number:	**Indiana 11-020**	
Type of Action:	**SPA Approval**	
Required Date for State Notification:	**May 24, 2012**	
Fiscal Impact:	**FY 2012**	**$83,200,000**
	FY 2013	**$57,590,000**

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 October 1, 2011, this amendment makes changes to increase Medicaid reimbursement to nursing facilities to promote improvements in quality of care as well as extend the effective dates of rate parameters and limitations, increase administrative reimbursement, and clarify provider cost classification and reporting issues. The non-Federal share of these payments is funded by a combination of State appropriations, provider taxes, and IGTs. The State met public process requirements. There are no issues with the UPL**

Until June 30, 2011, the Indiana State plan provided for multiple add-ons to the Medicaid rate for NFs. The State submitted TN 11-020 which would continue the add-ons through June 30, 2014. However, the SPA was submitted October 4, 2011 with an effective date of October 1, 2011. So, for the period of July 1, 2011 through September 30, 2011, the state plan no longer provided for these add-ons. The State has been continuing to pay the add-ons even through the period that the state plan no longer provides for this payment methodology. In order to address this issue, TN 11-020 also proposes for a supplemental payment, effective for the time period of October 1, 2011 through December 31, 2011, that would pay NFs the amount that the State plan would have provided for the period of July 1, 2011 through September 30, 2011, had the add-ons still been provided for under the State plan. The supplemental payment is only intended to account (in the state plan) for the payments that were made, during the gap period of July 1 through September 30 of 2011, without State plan authority.

The State has demonstrated they have enough UPL room for these supplemental payments for the time period of October 1, 2011 through December 31, 2011. The state has been provided guidance on how to properly claim these payments on the quarterly CMS-64 report. The State was instructed to make a decreasing adjustment for the amount of the payments made during the period of 7/1 thru 9/30/11, and then an increasing adjustment for the amount of those same payments for the period of 10/1 thru 12/31/11.

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.

CMS Contact:

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