October 1, 2005, through September 30, 2006
October 1, 2007, through September 30, 2008
October 1, 2009, through September 30, 2010
And every second year thereafter.

(x) "Office" means the Indiana office of Medicaid policy and planning.

(y) "Ordinary patient or resident-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

(z) "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(aa) "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(bb) "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.

(cc) "Rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

October 1, 2002, through September 30, 2003
October 1, 2004, through September 30, 2005
October 1, 2006, through September 30, 2007
October 1, 2008, through September 30, 2009

And every second year thereafter.

(dd) "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.

(ee) "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

(ff) "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

(gg) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults.

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. Costs must be reported in the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule and any financial report instructions.

(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.

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

as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

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

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

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

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

405 IAC 1-12-11 Allowable costs; services provided by parties related to 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.

(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 facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.

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

(4) The organization actually furnishes such services, facilities, or supplies to other 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 1-12-26 Administrative reconsideration; appeal

Sec. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider 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 or allowable cost determinations 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 allowable cost determination, 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 (c).

(b) If a provider disagrees with the preliminary recalculated Medicaid rate resulting from a financial audit adjustment or reportable condition, 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 the 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 or allowable cost determinations as 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 (c).

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

405 IAC 1-12-27 Rate Reduction

Sec. 27. Per diem Medicaid rates paid to nonstate owned intermediate care facilities for the mentally retarded (ICFsIMR) and community residential facilities for the developmentally disabled (CRFsIDD) are subject to a 3% rate reduction effective July 1, 2011. The 3% rate reduction will remain in effect through June 30, 2013.

OS Notification

State/Title/Plan Number: Indiana 11-021

Type of Action: SPA Approval

Required Date for State Notification: March 28, 2012

Fiscal Impact:

FY 2011	$0
FY 2012	$0

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: No

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 proposes technical changes to the reimbursement methodology for private intermediate care facilities for the mentally retarded (ICF/MR) and community residential facilities for the developmentally disabled (CFR/DD). Specifically, this amendment clarifies cost reporting policy, revises the actions taken by the State in response to field audits finding inadequate or lack of supporting cost data, enhances the list of those considered to be immediate family for purposes of determining services provided by related parties, modify the requirements to receive a related party exception, and clarifies the administrative reconsideration and appeals process. The State estimates the this amendment will have no impact on the Federal budget. The State met public process requirements. Funding the non-Federal share of Medicaid payments for ICF/MR and CFR/DD services comes from a combination of State appropriations and provider tax.

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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