(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

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

(1) Medicaid residents.

(2) All residents.

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

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and

(2) received written approval from the office to be designated as a children's nursing facility.

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

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

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

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

(1) Nursing and nursing aide services.

(2) Nurse consulting services.

(3) Pharmacy consultants.

(4) Medical director services.

(5) Nurse aide training.

(6) Medical supplies.

(7) Oxygen.

(8) Medical records costs.

(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental costs for these items are limited to $1.50 per resident day.

(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.

(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.

(12) Legend and 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.

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) 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, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15.

(3) Costs must be reported in conformance with generally accepted accounting principles.

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

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.

(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.

(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice, and shall describe the reasons the extension is necessary.

(d) In the event the deficiencies in documentation are not corrected within the time limit specified in section (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the office's receipt of a complete response.

(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).

(4) No rate increases will be allowed until the first day of the calendar quarter following the office's receipt of the response and requested documentation, or the expiration of the reduction..

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The 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 document and 405 IAC 1-14.6, 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 or desk review establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

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

(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, 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 July 1, 2003, 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) Rental cost for low air loss mattresses, pressure support surfaces, and oxygen concentrators;
(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, exceed five hundred dollars ($500), but 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 except as follows:

(A) For the period from 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.

(B) For the period from 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	July 1, 2003, through June 30, 2014	July 1, 2014, and after	July 1, 2003, through June 30, 2014	July 1, 2014 , and after
Percentage	30%	52%	110%	105%

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 aids and eyeglasses;
(3) All costs associated with pastoral care;
(4) All costs associated with resident and family gifts such as 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; and
(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) For facilities other than nonstate government owned nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction, in an open competitive market.

(b) For nonstate government owned (NSGO) nursing facilities, costs applicable to services, facilities, and supplies furnished to the provider by organizations related by common ownership or control to either the current NSGO provider, or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider, must be included in the allowable cost of the NSGO provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction in an open competitive market.

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

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law, stepson-in-law, stepdaughter-in-law.
(6) Grandparent and grandchild.

(d) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

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

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

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for a nonstate government owned (NSGO) provider shall not be considered an arm's length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to other 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.
(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

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

(b) The fair rental value allowance is calculated as follows:

(1) Determine, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including:

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

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

the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility that are used to provide nursing facility services to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

405 IAC 1-14.6-13 Reporting of financing arrangements; working capital; interest; allocation of loans

Sec. 13. (a) All patient-related property financing arrangements shall be fully and completely disclosed on the forms prescribed by the office.

Sec. 18. (a) Compensation for:

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

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

shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. Beginning effective July 1, 2003, through June 30, 2014, compensation subject to this limitation includes wages, salaries, and fees for the owner, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks. Beginning effective July 1, 2014, and thereafter, wages, salaries, and fees paid for the owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks are subject to this limitation.

(b) 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. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after they have been computed. If the provider disagrees with the rate the provider may request an administrative reconsideration from the Medicaid rate-setting contractor. Such reconsideration requests 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, the provider may request administrative reconsideration from the Medicaid audit contractor. Such reconsideration requests 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 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 may request an administrative reconsideration from the Medicaid rate-setting contractor. Such reconsideration requests 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 MDS audit 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 an appeal must be signed by the nursing facility provider.

(e) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

405 IAC 1-12-2 Definitions
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. 2. (a) The definitions in this section apply throughout this rule.

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

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

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

(2) Costs must be reported in conformance with cost finding principles published 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 and shall describe 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) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1)

(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.

(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(e) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The 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

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 must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased **as** an arm's-length transaction, in an open competitive market.

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

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

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

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

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

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

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

(4) The organization actually furnishes such services, facilities, or supplies to other 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 granted for any period of time, up to the maximum period 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 may request an administrative reconsideration from the Medicaid rate-setting contractor. Such reconsideration requests 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 the provider disagrees with the preliminary recalculated Medicaid rate or allowable cost redetermination resulting from a financial audit adjustment or reportable condition, the provider may request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration requests 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 an appeal must be signed by the provider.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

OS Notification

State/Title/Plan Number: Indiana 12-011

Type of Action: SPA Approval

Required Date for State Notification: April 14, 2013

Fiscal Impact:

FY 2012	$0
FY 2013	$0

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

Eligibility Simplification: No **Number of Potential Newly Eligible People: 0**

Provider Payment Increase: No **Delivery System Innovation: No**

# of People Losing Medicaid Eligibility: 0 **Reduces Benefits: No**

Detail:
Effective for services on or after July 1, 2012, this amendment proposes to revise reimbursement methodologies for nursing facility (NF) and intermediate care facilities for the mentally retarded (ICF/MR) services. Specifically, this amendment clarifies methodology regarding overpayments; limits reimbursement for the rental costs for low air mattresses, pressure support surfaces, and oxygen concentrators; identifies actions to be taken in the event of cost report deficiencies; clarifies allowable costs for non-state government-owned (NSGO) NFs in a related party transaction; and implements other administrative changes to nursing facility and ICF/MR reimbursement. The State estimates this amendment will have no impact on the Federal budget. There are no issues with the UPL. Funding the non-federal share of payments for NF and ICF/MR services comes from a combination of state appropriations, provider taxes, and IGTs. The state met public process requirements. Indiana has no I/T/Us so tribal consultation was not necessary.

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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National Institutional Reimbursement Team