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State/Territory Name: IN

State Plan Amendment (SPA) #: 14-0004

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

JAN 30 2015

Mr. Joseph Moser, Director of Medicaid
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street, Room W461
Indianapolis, IN 46204-2739

ATTN: Amber Swartzell, State Plan Coordinator

RE: Indiana State Plan Amendment (SPA) 14-0004

Dear Mr. Moser:

The Centers for Medicare and Medicaid Services (CMS) has reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-0004. Effective for services on or after July 1, 2014, this amendment extends the nursing facility quality assessment fee enhanced reimbursement provisions through June 30, 2017, makes changes to direct care services and supplies, and makes changes to requirements for reporting when there is a nursing facility change in ownership. This State plan amendment (SPA) also includes sunset dates for the rate reductions approved in Indiana SPA 13-005, which were inadvertently omitted. Specifically, the state is including the sunset date of June 30, 2015 for the rate reductions for nursing facilities, non-state owned Intermediate Care Facilities for Individuals with Intellectual Disabilities, and Community Residential Facilities for the Developmentally Disabled.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

If you have any questions, please contact Fredrick Sebree at (217) 492-4122 or via email at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-004

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(13) of the Social Security Act (42 USC 1396a(a)(13)); 42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $0
b. FFY 2015 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 D, pages 3, 4, 4a, 15, 16, 18, 22, 22 continued, 22 A, 23, 23 A, 23 B, 23 C, 37, 44 continued, and 119.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 D, pages 3, 4, 15, 16, 18, 22, 22 continued, 22 A, 23, 23 A, 23 B, 23 C, 37, 44 continued, and 119.

10. SUBJECT OF AMENDMENT:
Extends the nursing facility quality assessment fee (QAF) enhanced reimbursement provisions through June 30, 2017, makes changes to direct care services and supplies, and makes changes to requirements for reporting when there is a nursing facility change in ownership.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph Moser

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 8/20/2014

16. RETURN TO:
Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Amber Swartzell, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 30 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is based on the facility's total quality score.

(e) "Annual financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(f) "Average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) "Average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

(h) "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(i) "Capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(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 cost for these items are limited to one dollar and fifty cents ($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 nonlegend sterile water products used for irrigation or humidification.

(13) Educational seminars for direct care staff.

(14) Skin protectants, sealants, moisturizers, and ointments that are applied on an "as needed basis" by the member, care staff, or by prescribers order as a part of "routine" care.

(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 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates; penalty for untimely filing of Checklist of Management Representations

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 initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In conjunction with establishing an initial interim rate, a new operation shall submit a Nursing Facility Quality Assessment Form that contains projected patient census data from the first day of operation through the provider's first fiscal year end with a minimum of six (6) months of actual historical data. Following completion of the provider's first fiscal year end with a minimum of six (6) months of actual historical data, the provider shall submit a Nursing Facility Quality Assessment Form reporting actual patient census data covering the period from the first day of operation until the provider's first fiscal year end with a minimum of six (6) months of actual historical data. This form shall be submitted to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. Failure to submit a Nursing Facility Quality Assessment Form shall result in the actions specified at section 4(e) of this rule. This form will not be required after the quality assessment expires.

(d) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, the new provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership to the office or its contractor within thirty (30) days following the date the Checklist of Management Representations request is sent to the provider. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor. If the completed Checklist of Management Representations has not been submitted within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider, the Medicaid rate currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period. The penalty shall remain until the first day of the month after the completed Checklist of Management Representations is received by the office or its contractor. Reimbursement lost because of the penalty cannot be recovered by the provider.

(e) For a new operation, the interim quality assessment and Medicaid rate add-on shall be based on projected patient days. A retroactive settlement of the quality assessment and Medicaid rate add-on will be determined, based on actual patient days, for the time period from the first day of operation until the first annual rate effective date associated with the provider's first fiscal year end with a minimum of six (6) months of actual historical data.

405 IAC 1-14.6-6 Active providers; rate review

Sec. 6. (a) The:

(1) normalized average allowable cost of the median patient day for the direct care component; and

(2) average allowable cost of the median patient day for the indirect, administrative, and capital components;

shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The:

(1) normalized allowable per patient day cost for the direct care component; and

(2) allowable per patient day costs for the therapy, indirect care, administrative, and capital components;

shall be established once per year for each provider based on the annual financial report.

CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, 2017 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:

RUG-III Group	RUG-III Code	CMI Table
Reduced Physical Functions	PB2	0.30
Reduced Physical Functions	PB1	0.28
Reduced Physical Functions	PA2	0.24
Reduced Physical Functions	PA1	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) Reserved

(l) Beginning effective July 1, 2013 through June 30, 2017, 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. Medicaid Alzheimer and dementia residents shall be determined to be in the SCU based on an exact match of room numbers reported on Schedule Z with the room numbers reported on resident assessments and tracking forms. Resident assessments and tracking forms with room numbers that are not an exact match to the room numbers reported on Schedule Z will be excluded in calculating the number of Medicaid Alzheimer and dementia resident days in their SCU. The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid Alzheimer and dementia 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) Beginning July 1, 2013 through June 30, 2017, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on each facility's total quality score. For purposes of determining the nursing facility quality rate add-on, each facility's total quality score will be determined annually. Each nursing facility's quality rate add-on shall be determined as follows:

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 – 18	$0
19 – 83	$14.30 – ((84 - Nursing Facility Total Quality Score) x 0.216667)
84 – 100	$14.30

(n) Each nursing facility shall be awarded no more than one hundred (100) quality points as determined by the following eight (8) quality measures:

(1) Nursing Home Report Card Score. The office or its contractor shall determine each nursing facility's quality points using the report card score published by the Indiana state department of health. Each nursing facility shall be awarded not more than seventy-five (75) quality points based on its nursing home report card score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published report card score as of June 30, 2013, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Report Card Scores	Quality Points Awarded
0 – 82	75
83 – 265	Proportional quality points awarded as follows: 75 – [(facility report card score – 82) x 0.407609]
266 and above	0

Facilities that did not have a nursing home report card score published as of June 30, 2013, or each June 30 thereafter, shall be awarded the statewide average quality points for this measure.

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 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).

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

(3) 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).

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

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

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

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

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

Table 1				
Children's Nursing Facilities				
	Direct Care Profit Add-on Percentage		Direct Care Profit Ceiling Percentage	
Effective Date	October 1, 2011 through June 30, 2017	July 1, 2017 and after	October 1, 2011 through June 30, 2017	July 1, 2017 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, 2017	July 1, 2017 and after	October 1, 2011 through June 30, 2017	July 1, 2017 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 total quality score.

Table 3	
Total Quality Score	Percentage
84 - 100	100%
19 - 83	100% + ((Total Quality Score - 84) / 66)
18 and below	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, 2017	July 1, 2017 and after	October 1, 2011 through June 30, 2017	July 1, 2017 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 3, based on the facility's total quality score.

(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 5; minus

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

Table 5		
Capital Component Profit Ceiling Percentage		
Effective Date	October 1, 2011 through June 30, 2017	July 1, 2017 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 3, based on the facility's total quality score.

(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 6.

Table 6		
Direct Care Component Overall Rate Ceiling Percentage		
Effective Date	October 1, 2011 through June 30, 2017	July 1, 2017 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 7.

Table 7		
Indirect Care Component Overall Rate Ceiling Percentage		
Effective Date	October 1, 2011 through June 30, 2017	July 1, 2017 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 8.

Table 8		
Capital Component Overall Rate Ceiling Percentage		
Effective Date	October 1, 2011 through June 30, 2017	July 1, 2017 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).

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, 2017, 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, 2017, 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, 2017, 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, 2017, 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 1-14.6-26 Reduction to Medicaid rate for nursing facilities

Notwithstanding all other provisions of this rule,

(a) For the period beginning October 1, 2011 and continuing through December 31, 2013, all rates established under this rule shall be reduced by five percent (5%) per Medicaid resident per day; and

(b) For the period beginning January 1, 2014 and continuing through June 30, 2015, all rates established under this rule shall be reduced by three percent (3%) per Medicaid resident per day,

except for the following:

(1) The difference between:

(i) the quality rate add-on as described in subsection 7(m) of Legislative Services Agency (LSA) Document #12-279, posted as a final rule in the Indiana Register at:
http://10.2.1.232/Laws_Regs/Documents/LSA%2012-279(F)%20-%20GH%20Audit%20&%20NF%20Audit%20-%20VBP.pdf
effective July 1, 2013, 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 section 7(k) of LSA Document #10-183, posted as a final rule in the Indiana Register at:
http://www.in.gov/legislative/iac/20101201-IR-405100183FRA.xml.pdf
effective December 1, 2010; and

(2) The difference between:

(i) the quality assessment rate add-on calculated using the assessment rates in section 57 of LSA Document #12-396(E), posted as an emergency rule in the Indiana Register at:
http://10.2.1.232/Laws_Regs/Documents/LSA%2012-396(E)%20-%20NF%20QAF%20&%20Audit%20Changes%20Emergency%20Rule.pdf
effective July 1, 2012; and

(ii) the quality assessment rate add-on calculated using the assessment rates in section 24(a) of LSA Document #10-65, posted as a final rule in the Indiana Register at:
http://www.in.gov/legislative/iac/20101201-IR-405100065FRA.xml.pdf
effective December 1, 2010.

405 IAC 1-12-27 Rate Reduction

Sec. 27. Per diem Medicaid rates paid to nonstate owned intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD) are subject to the following rate reductions:

(a) For the period beginning July 1,2011 and continuing through December 31, 2013, reimbursement rates established under this rule shall be reduced by three percent (3%) per Medicaid resident per day, and

(b) For the period beginning January 1, 2014 and continuing through June 30, 2015, reimbursement rates established under this rule shall be reduced by one percent (1%) per Medicaid resident per day.