State-Owned Psychiatric Hospitals

Section 1 Policy; scope

Sec. 1. (a) This section of the State Plan sets forth procedures for payment for services rendered to Medicaid recipients by duly certified and state-owned psychiatric hospitals. All payments referred to within this section of the State Plan for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this section of the State Plan set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, compensate providers for reasonable, allowable costs incurred by a prudent businessperson, and allow incentives to encourage efficient and economic operations. The system of payment outlined in this section of the State Plan is a retrospective system using interim rates predicated on a reasonable, cost-related basis, in conjunction with a final settlement process. Cost limitations are contained in this section of the State Plan 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 rate higher 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.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3.

Section 2 Definitions

Sec. 2. (a) As used in this section of the State Plan, "all-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing care, room and board, supplies, and ancillary therapy services within a single, comprehensive amount.

(b) As used in this section of the State Plan, "annual, historical, or budget financial report" refers to a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this section of the State Plan which shall constitute a comprehensive basis of accounting.

(c) As used in this section of the State Plan, "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(d) As used in this section of the State Plan, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(e) As used in this section of the State Plan, "office" means the office of Medicaid policy and planning.

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

(g) As used in this section of the State Plan, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) As used in this section of the State Plan, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(i) As used in this section of the State Plan, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) As used in this section of the State Plan, "generally accepted accounting principles" means those accounting principles as established by the American Institute of Certified Public Accountants.

(k) As used in this section of the State Plan, "like levels of care" means psychiatric hospital level of care provided in a state-owned psychiatric hospital.

(l) As used in this section of the State Plan, "ordinary patient related costs" means costs of services and supplies that are necessary in the delivery of patient care by similar providers within the state.

(m) As used in this section of the State Plan, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(n) As used in this section of the State Plan, "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 section of the State Plan.

(o) As used in this section of the State Plan, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

Section 3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

Sec. 3. (a) The basis of accounting used under this section of the State Plan is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board pronouncements shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this section of the State Plan.

(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. State accounting records are maintained on a cash basis, which shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
(2) document such adjustments in a finalized exception report; and
(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this section of the State Plan.

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this section of the State Plan, 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.

Section 4 Financial report to office; annual schedule; prescribed form; extensions

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.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient related interest bearing debt.
(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ordinary charge on the last day of the reporting period.
(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.
(8) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

Section 5 New provider; initial financial report to office; criteria for establishing initial rates; supplemental report

Sec. 5. (a) Rate requests to establish initial rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this section of the State Plan, used to compute rates for active providers shall be followed to compute initial rates for new providers, except that historical data are not available.

Section 6 Active providers; rate review; annual request; additional requests; requests due to change in law

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the interim rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional interim rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional interim rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional interim rate review shall be completed in the same manner as the annual interim rate review, using all other limitations in effect at the time the annual interim review took place.

(c) To request the additional interim review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional interim review shall be effective on the first day of the month following the submission of data to the office.

Section 7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

Sec. 7. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each interim rate review request shall include a budget financial report. If a budget financial report is not submitted, the interim rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.
(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:
(A) Patient census data.
(B) Statistical data.
(C) Ownership and related party information.
(D) Statement of all expenses and all income.
(E) Detail of fixed assets and patient related interest bearing debt.
(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.
(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.
(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.
(3) The provider shall adjust patient census data based on the highest of the following:
(A) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.
(B) Forecasted patient days for the twelve (12) month budget period.

Section 8 Limitations or qualifications to Medicaid reimbursement; advertising

Sec. 8. Advertising is not an allowable cost under this section of the State Plan except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

Section 9 Criteria limiting rate adjustment granted by office

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. Providers reimbursed under this section of the State Plan will be reimbursed with a retrospective payment system. The annual financial reports filed by the providers will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the annual financial report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the interim per diem rates based on the projected budget and paid during the report period will be multiplied by the paid client days to arrive at the annual settlement.

Section 10 Computation of annual and interim rate; allowable costs; review of cost reasonableness

Sec. 10. (a) The annual rate, per Section 6, for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days as determined from the annual financial report, subject to all other limitations described in this section of the State Plan.

(b) Costs and revenues shall be reported as required on the annual financial report form. Patient care costs shall be clearly identified.

(c) 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 the annual financial report that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable.

(e) The interim rate, per Section 6, for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total budgeted costs and budgeted patient days as determined from the budgeted financial report, subject to all other limitations described in this section of the State Plan.

(f) Budgeted Costs and revenues shall be reported as required on the budgeted financial report form. Budgeted patient care costs shall be clearly identified.

(g) The provider shall report as patient care costs only costs that are anticipated to be incurred in the providing of patient care services. The provider shall certify on the budget financial report that costs not related to patient care have been separately identified on the financial report.

(h) In determining reasonableness of budgeted costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose budgeted costs do not appear to be reasonable.

(i) In determining reasonableness of budgeted cost, the office shall compare forecasted data to the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. The office may request satisfactory documentation from providers whose budgeted costs do not appear to be reasonable. Unsupported forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

Section 11 Allowable costs; capital reimbursement; depreciable life

Sec. 11. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

Section 12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

Sec. 12. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property

category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

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

Section 13 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

Sec. 13. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

Section 14 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

Sec. 14. (a) Reasonable compensation of individuals employed or to be employed by a provider is an allowable cost, provided such employees are engaged in, or will be engaged in, patient care-related functions and that forecasted compensation amounts are reasonable in light of historical data under this section and section 15 of this section of the State Plan.

(b) The provider shall report on the financial report form in the manner prescribed, using the forms prescribed by the office, all patient related staff costs and hours incurred, and forecasted to be incurred, to perform the function for which the provider was certified. Both total compensation and total hours worked, and forecasted to be worked, shall be reported. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. Said records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

Section 15 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

Sec. 15. (a) Compensation for management, consultant, or 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, policy making, decision making, and other management and consultant functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractor, and consultant as well as any other individual or entity performing such tasks.

(b) The maximum amount of management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (c), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) The management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 & over	$129,298+ $262/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

Section 16 Allocation of costs

Sec. 16. (a) The detailed basis for allocation of expense between different levels of care in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) Any change in the allocations must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

Section 17 State-owned facilities per diem rate

Sec. 17. The per diem rate for providers reimbursed under this section of the State Plan is an all-inclusive rate. The per diem rate includes all services provided to recipients by the facility.

Section 18 Administrative reconsideration; appeal

Sec. 18. (a) The Medicaid rate setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, 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 request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within 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 evaluate the data. After review, the Medicaid rate setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of 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 a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from 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 request shall be signed by the provider and must be received by the Medicaid audit contractor within 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 audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of 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 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process.