(2) If a provider of services holds a current license that would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDRS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each **CRF/DD** provider.

405 IAC 1-12-23 Medical or nonmedical supplies and equipment; personal care items

Sec. 23. (a) Routine and nonroutine medical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill **Medicaid** for such items in addition to the established rate. Under no circumstances shall the routine and nonroutine medical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:

(1) Hairbrushes and combs.
(2) Dental adhesives and caps.
(3) Toothpaste.
(4) Shower caps.
(5) Nail files.
(6) Lemon glycerine swabs.
(7) Mouthwashes.
(8) Toothbrushes.
(9) Deodorants.
(10) Shampoos.
(11) Disposable tissues.
(12) Razor.
(13) Any other items or equipment covered by Medicaid and specifically requested by a resident and not routinely provided by the provider.

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to **Medicaid.**

405 IAC 1-12-24 Assessment methodology

Sec. 24. (a) This subsection is intentionally left blank.

(b) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:

(1) For an annual rate review, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

(2) For a base rate review, from the provider's previous base financial reporting period as set out in section 5(c) of this rule.

(3) For an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in section 5(a) of this rule. The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the annualized bed days available to determine the new provider's annualized assessment.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) This subsection is intentionally left blank.

(d) For an **ICF/IID** that is licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

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405 IAC 1-12-25 Reimbursement for day services

Sec. 25. For **ICF/IID** and CRF/DD facilities, the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.

405 IAC 1-12-26 Administrative reconsideration; appeal

Sec. 26. (a) The **office** 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 by the **office**. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the **office** not later than forty-five (45) days after release of the rate or allowable cost determinations as computed by the **office**. Upon receipt of the request for reconsideration, the **office** shall evaluate the data. After review, the **office** may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The **office** shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the **office** 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 **office**. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the **office** not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate or allowable cost determinations as computed by the **office**. Upon receipt of the request for reconsideration, the **office** shall evaluate the data. After review, the **office** may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The **office** shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the **office** 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.

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Rate-Setting Criteria for State-Owned Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

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, state-owned intermediate care facilities for the mentally retarded (ICF/MR) and state-owned nursing facilities. 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 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 Governmental Accounting Standards Board (GASB).

(k) As used in this section of the State Plan , "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) As used in this section of the State Plan , "like levels of care" means ICF/MR level of care provided in a state-owned ICF/MR, and nursing facility level of care provided in a state-owned nursing facility.

(m) 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.

(n) 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.

(o) 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 .

(p) 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 pronouncement 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.