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.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional interim rate review.

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

Sec. 7. (a) 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.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for 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. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

Section 8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

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 rule 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 rate; allowable costs; review of cost reasonableness

Sec. 10. (a) The rate 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, subject to all other limitations described in this section of the State Plan

(b) Costs and revenues shall be reported as required on the financial report forms. 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 all financial reports 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.

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; efunds 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 (d), 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) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the federal Internal Revenue Service as 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.

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

Owner and ManagementCompensation		Owner's Expenses
Beds	Allowance	(12% x bed allowance)
10	$21,542	$2,585
20	$28,741	$3,449
30	$35,915	$4,310
40	$43,081	$5,170
50	$50,281	$6,034
60	$54,590	$6,551
70	$58,904	$7,068
80	$63,211	$7,585
90	$67,507	$8,101
100	$71,818	$8,618
110	$77,594	$9,311
120	$83,330	$10,000

130	$89,103	$10,692
140	$94,822	$11,379
150	$100,578	$12,069
160	$106,311	$12,757
170	$112,068	$13,448
180	$117,807	$14,137
190	$123,562	$14,827
200	$129,298	$15,516
200 & over	$129,298+$262/bed over 200	$15,516+$31/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. (a) The per diem rate for providers reimbursed under this rule is an all-inclusive rate. The per diem rate includes all services provided to recipients by the facility.

(b) Resources from health insurance plans available to the resident shall apply first to defraying the costs of medical services before Medicaid. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services, Veteran’s Administration, and other health insurances. Services reimbursed through other sources shall be segregated and not claimed on the facility’s cost report.

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.

State: Indiana

Adds 405 IAC 1-19 and 405 IAC 1-20 concerning provisions affecting notification requirements and change of ownership for all providers in the Medicaid program, and defines how funds will be allocated (paid and recouped) to long term care providers when a change of ownership occurs.

Rule 19 Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
(A) keep copies of all these requests and the responses to them;
(B) make them available to the office upon request; and
(C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) A long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) The office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

Rule 20. Change of Ownership for a Long Term Care Facility

405 IAC 1-20-1 General

Sec.1. (a) As used in 405 IAC 1-19 and this rule, "long term care facility" means any of the following:

(1) A nursing facility.

(2) A community residential facility for the developmentally disabled.

(3) An intermediate care facility for the mentally retarded.

(b) For Medicaid provider agreement purposes, the provider is the party directly or ultimately responsible for operating the business enterprise. This party is legally responsible for decisions and liabilities in a business management sense. The same party also bears the final responsibility for operational decisions made in the capacity of a governing body and for the consequences of those decisions.

(c) Whether the owner of the provider enterprise (provider) owns the premises or rents or leases the premises from a landlord or lessor is immaterial. However, if the provider enters into an agreement, which allows the landlord to make or participate in decisions about the ongoing operation of the provider enterprise, this indicates that the provider has entered into either a partnership agreement or a management agency agreement instead of a property lease. A new partnership agreement constitutes a change of ownership.

405 IAC 1-20-2 Notification requirements

Sec. 2. (a) When a change of ownership in a long term care facility is contemplated, the transferor provider shall notify the office, or its fiscal agent, no less than forty-five (45) days prior to the effective date of sale or lease agreement that a change of ownership may take place.

(b) Notification shall be in writing and include the following:

(1) A copy of the agreement of sale or transfer.

(2) The expected date of transfer.

(3) If applicable, the name of any individual who has an ownership or control interest, is a managing employee, or an agent of the transferor, who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee.

(c) The transferee shall make application to the office for an amendment to the transferor's provider agreement no less than forty-five (45) days prior to the expected date of transfer in accordance with this rule and 405 IAC 1-14.6-5(c).

(d) If notification requirements from both the transferor and the transferee have not been met on or before the forty-fifth day before the effective date of the change of ownership, all Medicaid payments due to the transferor will be held until such time as the information is received, reviewed, and approved for completeness. Payments will be held until such time as the transferee has fulfilled enrollment requirements in the Medicaid program as set forth in the provider manual and provider enrollment packet.

(e) The effective date of the change of ownership will be determined by the Indiana state department of health's certification and transmittal and amended by the Indiana state department of health, if necessary, to correspond with the transferor/transferee agreement of sale or transfer.

405 IAC 1-20-3 Change of ownership types

Sec. 3. A change of ownership in an existing long-term care facility occurs under, but is not limited to, any of the following circumstances:

(1) For a sole proprietorship, if a provider of services is an entity owned by a single individual, a transfer of title and property to the enterprise to another person or firm, whether or not including a transfer of title to the real estate or if the former sole proprietor becomes one of the members of a business entity succeeding him or her as the new owner.

(2) For a partnership, a new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement, that dissolves the old partnership and creates a new partnership.

(3) For a corporation, a new corporation, the merger of the applicant or provider corporation into another corporation, or the consolidation of two (2) or more corporations, or any other change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation's entity, whether that body is:

(A) a board of trustees;

(B) a board of directors;

(C) the entire membership of the corporation; or

(D) known by some other name.

405 IAC 1-20-4 Change of ownership effect

Sec. 4. When there is a change of ownership of a long term care facility, the office will transfer the provider agreement to the transferee subject to the terms and conditions under which it was originally issued and subject to any existing plan of correction and pending audit findings as follows:

(1) The transferor and transferee shall reach an agreement between themselves concerning Medicaid reimbursements, underpayments, overpayments, and civil monetary penalties.

(2) From the effective date of change of ownership and if all requirements are met, all reimbursements will be made to the transferee, regardless of whether the reimbursement was incurred by a current owner or previous owner.

(3) From the effective date of change of ownership, the transferee shall assume liability for repayment to the office of any amount due the office, regardless of whether liability was incurred by a current owner or operator or by a previous owner or operator.
(4) Liability of current and previous providers to the office shall be joint and several.
(5) A current or previous owner or lessee may request from the office a list of all known outstanding liabilities due the office by the facility and of any known pending office actions against a facility that may result in further liability.
(6) For purposes of this section, examples of reimbursements, overpayments, and penalties shall include, but not be limited to, the following:
(A) Outstanding claims.
(B) Any retro rate adjustment that results in an underpayment or overpayment based upon the transferor's cost report.
(C) Amounts identified during past, present, or future audits that pertain to an audit period prior to a change in ownership.
(D) Pending or completed surveillance utilization review (SUR) audit.
(E) Imposition of penalties due to failure of the provider to be in substantial compliance with applicable federal requirements for nursing facilities participation in the Medicare or Medicaid program.
(F) Civil monetary penalties.
(G) Amounts established by final administrative decisions.

405 IAC 1-20-5 Record retention

Sec. 5. The transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three (3) years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer.

SECTION 3. Upon the effective date of 405 IAC 1-19-2, all disclosing entities have sixty (60) days to comply.