Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for Individuals with Developmental Disabilities and Community Residential Facilities for the Developmental Disabled

405 IAC 1-12-1 Policy; scope

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid **members** by duly certified nonstate-operated **ICFs/IID**, nonstate-operated CRMNFs, and nonstate-operated CRFs/DD. All payments referred to within this rule 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 system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of **ordinary patient or member related** costs and define reasonable allowable costs.

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

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

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

405 IAC 1-12-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate that, at a minimum, reimburses for all nursing or resident:
(1) care;
(2) room and board;
(3) supplies; and
(4) ancillary services;
within a single, comprehensive amount.

(c) "Allowable cost" means a computation performed by the **office** to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.

(f) "Annual or historical 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, which shall constitute a comprehensive basis of accounting.

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable resident-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 16(a) of this rule.

(h) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1 and shall be computed on a statewide basis for like levels of care, with the exceptions noted in this subsection, as follows:

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental homes multiplied by one hundred fifty-nine percent (159%).
(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(i) "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

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

(k) "DDRS" means the Indiana division of disability and rehabilitative services.

(l) "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(m) "Department head" means an individual(s) responsible for the supervision and management of an ICF/IID or CRF/DD department. Home Office personnel responsible for the supervision and oversight of facility department heads qualify as general line personnel.

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

(o) "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year-end.

(p) "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

(q) "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.

(r) "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

(s) "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(t) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the designated authority that governs the preparation of financial statements based on whether an entity is government or nongovernment owned, or whether it is governed by the requirements of the state board of accounts.

(u) "Like levels of care" means care:
(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ICF/IID; or
(3) provided in a nonstate-operated ICF/IID licensed as a CRMNF.

(v) "Non-rebasing year" means the year during which nonstate operated ICFs/IID and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:
October 1, 2019, through September 30, 2020
October 1, 2020, through September 30, 2021
October 1, 2021, through September 30, 2022
October 1, 2023, through September 30, 2024
October 1, 2025, through September 30, 2026
And every second year thereafter.

(w) "Ordinary patient or member-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

(x) "Patient or resident/member care" means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

(y) "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(z) "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 rule.

(aa) "Rebasing year" means the year during which nonstate operated ICFs/IID and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

October 1, 2018, through September 30, 2019
October 1, 2022, through September 30, 2023
October 1, 2024, through September 30, 2025

And every second year thereafter.

(bb) "Related party/organization" means that the provider:

(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;

the organization furnishing the service, facilities, or supplies.

(cc) "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

(dd) "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

(ee) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults.

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

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than **GAAP. All cost and charges reported on the provider's cost report must also be recorded on the provider's financial statements.** Costs **and charges** must be reported **on** the cost report in accordance with the following authorities, in the hierarchical order listed:

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

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with **GAAP.**

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

(c) **The auditor shall schedule the field audit visit with the provider. If the auditor and provider are unable to reach an agreement on a scheduled field audit date, the auditor will assign a date for the field audit to begin no earlier than sixty (60) days after the date that the provider was initially contacted to schedule the field visit.**

(1) The auditor will confirm the field audit date by providing a written notice identifying the date of the scheduled field audit and all information the provider is required to submit in advance of the field audit date. The notice will be provided at least sixty (60) days prior to the commencement of field work, and will allow the provider a minimum of thirty (30) days to submit the required information, which shall be due to the auditor no less than thirty (30) days prior to the date of the scheduled field audit.

2) After assignment of a field audit date, a provider may submit a one-time request that the scheduled field audit be postponed to a later date.

(A) The office shall approve or deny the request in writing within fifteen (15) days of receiving the request.

(B) Any delay of the scheduled field audit date does not extend the due date of the required information.

(3) Failure to submit the required information by the due date in the written notice shall result in the following actions being taken:

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

(B) The ten percent (10%) rate reduction shall remain in place until the first day of the month following the earlier of the receipt of information requested in the written notice or one (1) year after the effective date of the ten percent (10%) rate reduction.
(C) No rate increases will be allowed until the first day of the month following the earlier of the receipt of information requested in the written notice, or one (1) year after the effective date of the ten percent (10%) rate reduction.
(D) No reimbursement for the difference between the rate that would have otherwise been in effect and the reduced rate is recoverable by the provider.

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

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.
(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.
(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason(s) the extension is necessary.

(**e**) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.
(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.
(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).
(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.
(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

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

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

(2) The **office** shall document such adjustments in a finalized exception report.

(3) The **office** shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

(g) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized 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.

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

(i) The burden of substantiating that costs are patient or resident related lies with the provider.

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

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 **enrollment** 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 or resident 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 or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and **customary** charge.
(8) Certification statement signed by the provider that:
    (A) the data are true, accurate, related to patient or resident care; and
    (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed 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 **timely** requests 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. Untimely requests for an extension will not result in a change to the original due date, nor will it alleviate the provider from the penalty provision in subsection (d).**

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions: