The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Nursing Facility Reimbursement

405 IAC 1-14.7-1 Policy; Scope

Sec. 1. (a) This rule sets forth payment procedures for services rendered to members who are covered by the Indiana Health Coverage Program (IHCP) by nursing facilities. All payments referred to within this rule 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 and in the Indiana Medicaid Provider Reimbursement Manual (IMPRM) that establish parameters regarding the allowability of ordinary patient-related costs and define reasonable nursing facility allowable costs.

(c) Any action that results in recoupment, assessed penalty, or retrospective payment may be addressed through a retroactive reprocessing of claims or settlement process.

405 IAC 1-14.7-2 Definitions

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

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages.

(1) Allowable administrative services and supplies are costs that are patient-related that are necessary for the operation of the nursing facility, but generally cannot be directly tied to a specific member. See the IMPRM for further details and examples of administrative services and supplies.

(2) All nursing facilities shall have their administrative component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(c) "Allowable per patient day cost" means the following:

(1) Legacy System - means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed or field audited cost report, plus a ratio between allowable fixed costs and patient days using the greater of:

(A) the minimum occupancy requirements; or

(B) each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report.

(2) Prospective System - means a ratio between allowable cost and patient days using each provider’s actual occupancy from the most recently completed desk review or field audited cost report using the greater of:

(A) the minimum occupancy requirements; or

(B) each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report.

(d) “Bed days available” means the number of licensed beds reported during the cost reporting period multiplied by the number of calendar days in the cost reporting period. If the number of licensed beds changed during a reporting period,

(1) the number of licensed beds reported on the cost report as of the calendar day immediately following the cost report period end shall be utilized in the calculation of the rate and the related bed days available,

(2) the provider may request in writing with the cost report submission for the weighted average of the number of beds licensed during the cost report period to be utilized in the calculation of the rate and the related bed days available, or

(3) the provider may request the office to calculate bed days available in accordance with Section 6.

(e) "Bi-annual" means a six (6) month period beginning January 1 and July 1.

(f) “Capital component” means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items.

(1) Allowable capital-related items are costs that are patient-related that generally relate to a nursing facility’s physical assets and related ownership costs. See the IMPRM for further details and examples of capital-related items.

(2) All nursing facilities shall have their capital component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(g) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups of the resident classification system prescribed by the office as described in the MDS and Case Mix Index Supportive Documentation Manual based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(h) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and
(2) received written approval from the office to be designated as a children's nursing facility.

(i) "Cost 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.

(j) "Delinquent MDS resident assessment" means an assessment that is inactive or expired due to exceeding maximum thresholds set by the office for filing and inclusion in the time-weighted CMI calculation. This determination is made as described for required filing in the MDS and Case Mix Index Supportive Documentation Manual.

(k) Desk review" means a review and application of these regulations to a provider submitted cost report including accompanying notes and supplemental information within the scope as defined by the office.

(l) “Direct care component” means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages.
(1) Allowable direct patient care services and supplies are costs that are patient-related that generally relate to direct hands-on care or related support of the member. See the IMPRM for further details and examples of direct patient care services and supplies.
(2) All nursing facilities shall have their direct care component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(m) “Employee Benefits” means total allowable employee benefits costs from the most recently desk reviewed or field audited cost report excluding owners’ benefits as described in the IMPRM, unless specified otherwise.

(n) "Field audit" means a review and application of these regulations to a provider submitted cost report including accompanying notes and supplemental information within the scope as defined by the office.

(o) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements.

(p) "Forms prescribed by the office" means either of the following:
(1) Cost Report forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(q) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the Financial Accounting Standards Board.

(r) “IDOH” means the Indiana Department of Health.

(s) “Indiana Medicaid Provider Reimbursement Manual” or “IMPRM” means the policy document supporting the reporting requirements, allowable cost classifications, and calculation of the Medicaid rate.

(t) “Indirect care component” means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages.
(1) Allowable indirect patient care services and supplies are costs that are patient-related that are necessary in the care of the member, but that are not generally directly related to the provision of hands-on care. See the IMPRM for further details and examples of indirect patient care services and supplies.
(2) All nursing facilities shall have their indirect care component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(u) “Inflation factor” means inflating costs using the CMS Nursing Home without Capital Market Basket Index as published by IHS Markit using the time period prescribed by the office.

(v) “Legacy System” means the historic system used to calculate the Medicaid nursing facility per patient day rate at Section 6.

(w) “Medicaid patient days” means total Medicaid days from the most recently desk reviewed or field audited cost report.

(x) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The Indiana system shall employ the MDS 3.0 or subsequent revisions as approved by CMS as detailed in the MDS and Case Mix Index Supportive Documentation Manual.

(y) “MDS and Case Mix Index Supportive Documentation Manual” means the policy document supporting the MDS assessment instrument, MDS assessment processing, MDS supportive documentation requirements, resident classification system, and the CMI calculation.

(z) "MDS review" means a formal official verification and methodical examination and review of resident assessment data and its supporting documentation by the office or its designee.

(aa) “Nonemergency Medical Transportation” or “NEMT” means medical transportation to a covered service when needs are not immediate such as to and from a doctor’s office, the hospital, or other medical office for covered care. NEMT services provided by ambulance providers are not the financial responsibility of nursing facility providers and are not included in the nursing facility Medicaid per diem nor covered under this definition.

(bb) “Nursing Facility Census Data Collection Form” means the form designated by the office for providers to file their monthly census information.

(cc) “Ordinary patient-related costs” means costs of allowable per-diem services and supplies that are necessary in delivery of patient care by similar providers within the state. Services or supplies that Medicaid covers outside of the per-diem rate are not ordinary patient-related costs.

(dd) “Patient/member care” means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

(ee) “Patient days” means total patient days, inclusive of paid leave days, from the most recently desk reviewed or field audited cost report.

(ff) “Prospective system” means the methodology used to calculate the Indiana Medicaid reimbursement per patient day rate in Section 6.

(gg) “Quality Program Manual” means the policy document supporting the calculation of the total quality score.

(hh) “Rate year” means the time period starting July 1 and ending June 30.

(ii) “RSMeans Construction Index” means the simple average of construction costs for Indiana cities listed in the Construction Cost Indexes with RSMeans Data published by Gordian.

(jj) "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 or other policy documents.

(kk) “Rebase” means the process of reestablishing rate component medians, percentiles, prices, and reimbursement rates by incorporating the most recently completed desk or field audited qualifying Medicaid cost reports.

(ll) “Rental rate” means a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in Section 6 of this rule.

(mm) "Resident classification system" means the classification system used to classify residents into groups to determine case mix index values and reimbursement levels as supported by the MDS and Case Mix Index Supportive Documentation Manual.

(nn) "Special Care Unit (SCU) for Alzheimer's disease or dementia" means the nursing facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

(oo) “Therapy component” means the portion of each facility's direct costs for the provision of therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors. All nursing

facilities shall have their therapy component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(pp) "Total quality score" means the sum of the quality points awarded to each nursing facility for all quality measures as described by the Quality Program Manual.

(qq) "Unsupported MDS resident assessment" means an assessment missing one (1) or more data items that are required to classify a resident pursuant to the resident classification system in accordance with the MDS and Case Mix Index Supportive Documentation Manual.

(rr) “Ventilator program” means a nursing facility that meets all of the following:

(1) The nursing facility utilizes an active, ongoing interdisciplinary approach to the resident’s care, including but not limited to participation as needed, by the physician/practitioner, pulmonologist, registered nurse, pharmacist, dietitian, speech therapist, respiratory therapist, physical and/or occupational therapist, and the resident/representative. The interdisciplinary approach shall include a physician that is board certified in pulmonary disease or critical care as recognized by either the American Board of Medical Specialties or American Osteopathic Associations, as applicable.

(2) The nursing facility has a licensed respiratory care practitioner as defined by 844 IAC 11 on-site twenty-four (24) hours per day, seven (7) days per week.

(3) The nursing facility has ventilator back-up provisions including:

(A) Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;

(B) Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery-operated concentrators;

(C) At least one (1) battery operated suction device available per every nine (9) residents on mechanical ventilator or with a tracheostomy;

(D) A minimum of one (1) resident-ready back-up ventilator available in the facility at all times;

(E) An audible, redundant external alarm system connected to emergency power and/or battery back-up and located outside the room of each resident who is ventilator-dependent for the purpose of alerting staff of resident ventilator disconnection or ventilator failure; and

(F) Ventilator equipment (and ideally physiologic monitoring equipment) connected to back-up generator power via clearly marked wall outlets.

(4) The nursing facility has a plan specific for residents who are ventilator dependent which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

(5) The nursing facility has a written training program, including an annual demonstration of competencies, for nursing staff (including nurse aides, registered

nurses, and licensed practical nurses) and respiratory therapy staff providing direct care services for residents who are ventilator dependent.

405 IAC 1-14.7-3 Cost Report Submission and Requirements

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

(1) This rule, the IMPRM, provider bulletins, and any other policy communications.

(2) 42 CFR 413 and the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) GAAP.

The burden of supporting that costs are allowable and patient-related, reasonable, and properly classified lies with the provider.

(b) The provider's cost report shall be completed in accordance with the IMPRM and submitted using cost report forms prescribed by the office. All data elements and attachments identified below shall be completed to provide full financial disclosure. A complete cost report consists of all of the following fully and properly completed items:

(1) The Medicaid cost report and supporting schedules as prescribed by the office.

(2) Medicare cost report for Medicare certified providers as prescribed by the office.

(A) Providers with a Medicare cost report with a fiscal year end other than December 31 shall provide their most recently filed Medicare cost report with the Medicare Administrative Contractor.

(B) Providers may elect to submit a Medicare/Medicaid Reconciliation form approved by the office that provides modifications to the as-filed Medicare cost report due to differences between Medicare and Medicaid allowable cost definitions and classification of costs between cost centers. A revised facility Medicare cost report that incorporates the modifications on the Medicare/Medicaid Reconciliation form shall also be submitted with the Medicare/Medicaid Reconciliation form and the as-submitted Medicare cost report.

(3) Certification by the provider that:

(A) the data are true, accurate, and related to patient care; and

(B) expenses not related to patient care have been clearly identified.

Amendments to the cost report require updated provider certifications.

(4) 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.

(5) A copy of the working trial balance that is a direct product of the accounting system for both the nursing facility and home office (if applicable) that was used in the preparation of their submitted cost report in the format described in the IMPRM. The working trial balance shall include a summation of expense accounts that agree to the total expense amount used to prepare the trial balance crosswalk.
(6) A copy of the trial balance crosswalk document used to prepare the Medicaid cost report (facility and home office, if applicable) that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report. All costs removed from the working trial balance and not reported on the cost report is to be clearly identified in a supporting document. Any costs reported on the cost report and not verifiable on the working trial balance is to be clearly identified and supported with compelling documentation. The crosswalk shall be sorted and subtotaled by Medicaid line number and provided in the manner described in the IMPRM.
(7) A workpaper that provides a detail accounting of the amounts reported in column 24 – Provider Adjustments by line and column number. The workpaper shall distinguish costs by source such as home office, reclassification from another line, etc. The workpaper shall also distinguish whether the cost is personnel or non-personnel cost. Any cost on lines with both columns 2 (personnel) and 3 (other) shall be treated as personnel unless clearly identified.
(8) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(c) For cost reports ending March 31, 2023 or before, each provider shall submit a cost report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The cost report shall coincide with the fiscal year used by the provider to report federal income taxes. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(d) For cost report periods ending April 1, 2023 or after, providers are required to maintain a fiscal year end of December 31. Each provider shall submit a cost report to the office not later than May 31 after the close of the provider's reporting year. Refer to Section 9 for requirements regarding short-period cost reports. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(e) The Nursing Facility Census Data Collection Form is required to be submitted monthly and is due 30 days after the reporting month. The Nursing Facility Census Data Collection Form is required to be filed on the form prescribed by the office and in conformance with the instructions contained within the form.

(f) 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 a cost report coincidental with the time period for any individual facility that receives any central office allocation.

(g) Each provider shall maintain financial records for a minimum period of three (3) years after the date of submission of cost reports to the office. Copies of any financial records or supporting documentation shall 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 different basis. The provider's accounting records shall establish a clear audit trail from their records to the costs reported on their cost reports submitted to the office.

(h) The cost report submission shall contain full disclosure and reporting of revenue, expenses, and property clearly separated between Medicaid, non-Medicaid, patient, and non-patient including, but not limited to the following:

(1) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable and distinguishable from the revenues, expenses, and statistical and financial records of the operations reimbursed by Medicaid;

(2) The detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider as long as the basis is reasonably related to the allocated costs and consistent between accounting periods. The following relationships are required:

(A) Reported expenses and patient census information shall be for the same reporting period.

(B) Nursing salary allocations shall be on the basis of nursing hours worked or patient days and shall be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(C) No allocation of costs between cost report line items shall be permitted.

(D) Allocation methodologies shall have a reasonable relationship to the costs they are allocating.
(E) For allocation of expenses between nursing facilities and other services, accumulated cost and/or patient days are presumed to be a reasonable allocation methodology.
(F) Any changes in the allocation or classification of costs shall be approved by the office prior to the changes being implemented, unless implementing prior period audit adjustments. Proposed changes in allocation or classification methods shall be submitted to the office for approval at least ninety (90) days prior to the provider's cost report due date.

(3) Costs and revenues shall be reported as required on the cost report forms. Allowable patient care costs shall be clearly identified.

(4) The provider shall report as patient care costs only costs that have been incurred in the provision of patient care services. The provider shall certify on all cost reports that costs not related to patient care have been separately identified on the cost report and in accordance with the IMPRM.

(i) The provider shall maintain detailed property documentation including from a related party property company to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such documentation shall be submitted with each cost report, and a complete copy of the documentation shall be submitted to the office upon request.

(j) The provider shall report, all patient-related personnel costs and hours as well as patient related contract costs incurred to perform the function for which the provider was certified. Total personnel cost and total hours shall be reported for all employees. Hours for contracted staff are not required to be reported.

(k) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The 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. These allocations should be supported via time studies or actual time worked.

(l) Allocation of home office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases shall be approved by the office prior to the changes being implemented. Proposed changes in allocation methods shall be

submitted to the office at least ninety (90) days prior to the cost report due date. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care.

(m) Costs from non-bona fide separate related organizations, such as from operating divisions of the provider organization or central office, shall be maintained as a separate set of records with costs separately identified and appropriately allocated to individual facilities. Costs from these related organizations shall be documented and allocated using the Medicaid Home Office Cost Report Form.

405 IAC 1-14.7-4 Scope of Reviews

Sec. 4. (a) The office shall perform a desk review or field audit of the submitted cost report to determine the reasonableness, appropriate classification, and allowability of reporting. The office may request documentation to substantiate the submitted cost report.

(b) The office shall contact providers to notify them that they have been selected for a field audit.

(1) The office shall provide an Audit Notification Letter to the providers identifying all information the provider is required to submit in advance of the field audit date. Failure to submit the required information by the due date in the Audit Notification Letter shall result in the implementation of the prefield information penalty as identified at Section 12.

(2) The office shall schedule the field audit date with the provider. If the office and provider are unable to reach an agreement on a scheduled field audit date, the office shall assign a date for the field audit to begin no earlier than fifteen (15) days after the date that the provider was initially contacted to schedule the field visit. The office shall confirm the field audit date by providing a written notice identifying the date of the scheduled field audit.

(3) 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.

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant

to the office's request, and the office is unable to complete the audit, the following actions shall be taken:

(1) The office shall provide a written notice listing all of the deficiencies in documentation;
(2) The provider shall be allowed fifteen (15) days from the date of the notice to provide the documentation and correct the deficiencies;
(3) Not earlier than fifteen (15) days from the date of the notice, the office shall give a final written notice (Follow-Up Letter) listing all of the outstanding deficiencies in documentation; and
(4) Failure to submit the required information by the due date in the written notice shall result in the implementation of the Field Work – Follow-Up Letter penalty as identified at Section 12.

405 IAC 1-14.7-5 New Provider Reimbursement

Sec. 5. (a) This section describes the treatment of nursing facility providers that have not previously been certified to participate in the Medicaid nursing facility program.

(b) Rate requests to establish an initial rate for a new provider rate shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the enrollment date.

(c) Initial rates shall be effective on the:
(1) enrollment date; or
(2) the date that a service is established; whichever is later.

(d) Initial rates shall be set at the sum of the following:
(1) The statewide average nursing facility quality add-on of the preceding July 1;
(2) Assessment add-on, as determined in subsection (g);
(3) NEMT add-on as determined in Section 7; and
(4) Legacy System medians at the preceding July 1 for each of the following components:
(A) direct care component:
(i) Until the provider has one full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the statewide average Medicaid CMI utilized as determined for the previous July 1 rate effective date.
(ii) Once a provider has one full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the facility's own facility average Medicaid CMI and updated each rate effective date

thereafter.
(B) therapy component,
(C) indirect care component,
(D) administrative component, and
(E) eighty (80) percent of capital component.

(e) A provider shall remain under the initial rate calculation process until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or greater in length available for use in the rebase.

(f) The initial monthly quality assessment value owed to the office shall be determined based on six (6) months of patient days from the required monthly nursing facility census data collection form provider filings. The initial monthly quality assessment value owed to the office shall remain in effect until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or greater in length available for use in the rebase. A retroactive settlement of the initial quality assessment total for all unpaid periods shall occur after the provider's assessment value is determined by the office and the fiscal intermediary has established the monthly assessment receivable.

(g) The assessment add-on is twelve dollars and twenty cents ($12.20) per patient day unless exempt from the assessment add-on as noted in 405 IAC 1-14.7-11. Once the office collects six (6) months of patient days from the required monthly nursing facility census data collection forms, the office shall establish the provider specific assessment add-on and implement on the next rate effective date.

(h) Providers are eligible to participate in the special care unit and ventilator programs and receive additional reimbursement if the qualifications in Section 2 and Section 7 are met.

405 IAC 1-14.7-6 Rate Calculation

Sec. 6. (a) The following section prescribes the detailed rate methodology calculation for each rate component.

(b) Until June 30, 2024, the rate effective date of the annual rebase shall be the first July 1 that falls after the first calendar quarter following the provider's fiscal year end. Beginning July 1, 2024, the annual rebase shall be each July 1 utilizing the most recently desk or field audited cost reports with a fiscal year ending eighteen (18) months or greater prior to the rate effective date.

(c) The annual Medicaid per patient day rate shall be calculated as the sum of the following:

(1) Prospective System rate calculated in accordance with subsection (d) multiplied by the percentage below; and

(2) Legacy System rate calculated in accordance with subsection (e) multiplied by the percentage below.

Rate Effective Date	**Prospective System Rate Percentage**	**Legacy System Rate Percentage**
Before January 1, 2025	0%	100%
January 1, 2025	17%	83%
July 1, 2025	33%	67%
January 1, 2026	50%	50%
July 1, 2026	67%	33%
January 1, 2027	83%	17%
July 1, 2027 and forward	100%	0%

(d) The Prospective System is as follows:

(1) The Prospective System rate is calculated as the sum of the following:

(A) Direct care component. This component is price based with a limit (floor) placed on provider profit and is calculated as follows:

	Table D.1 - Direct Care Component Calculation	
A.	Direct Care Per Patient Day Cost for CMI Adjustment	Value as determined in the Direct Care Per Patient Day Cost for CMI Adjustment table below (Letter F)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B

D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Total CMI Adjusted Direct Care Per Patient Day Costs	C * D
F.	Non-CMI Adjusted Direct Care Per Patient Day Cost	Valued as determined in the Non-CMI Adjusted Direct Care Per Patient Day Cost table below (Letter E)
G.	Total Direct Care Per Patient Day Cost	E + F
H.	Determination of the Statewide Price for the Normalized Direct Care Per Patient Day Cost and Non-CMI Adjusted Direct Care Per Patient Day Cost	The normalized direct care per patient day costs and the non-CMI adjusted direct care per patient day costs (Letter C + Letter F) for each provider are utilized for the percentile array. The allowable cost of the provider identified as the 85th percentile of the Medicaid day-weighted direct care component costs shall be selected as the statewide price for the two components, in accordance with subdivision (4)
I.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
J.	CMI Adjusted Direct Care Per Patient Day Cost Ceiling	Statewide Normalized Direct Care Price determined in H * I
K.	Total Direct Care Per Patient Day Ceiling	J + Statewide Non-CMI Adjusted Direct Care Price determined in H
L.	Allowable Profit	K * 0.05
M.	Direct Care Plus Profit Per Patient Day	G + L
N.	Direct Care Component	Lesser of K or M

Table D.2 - Direct Care Per Patient Day Cost for CMI Adjustment Calculation		
A.	Total Direct Care Costs for CMI Adjustment	Allowable direct care costs for CMI adjustment as described in the IMPRM
B.	Direct Care Costs for CMI Adjustment Pro Rata Employee Benefits	Allowable direct care salaries for CMI adjustment / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Excess Medical Equipment Rental Limitation Calculation table below (Letter G)
D.	Allowable Direct Care Costs for CMI Adjustment	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
F.	Direct Care Per Patient Day Cost for CMI Adjustment	D / E

Table D.3 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0 then D – C. If D – C ≥ 0 then 0.
F.	Patient Days	
G.	Excess Medical Equipment Rental Cost	E * F

Table D.4 - Non-CMI Adjusted Direct Care Per Patient Day Cost Calculation		
A.	Total Non-CMI Adjusted Direct Care Cost	Allowable non-CMI adjusted direct care costs as described in the IMPRM
B.	Non-CMI Adjusted Direct Care Pro Rata Employee Benefits	Allowable non-CMI adjusted direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Allowable Non-CMI Adjusted Direct Care Costs	A + B

D.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
E.	Non-CMI Adjusted Direct Care Per Patient Day Costs	C / D

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost and is calculated as follows:

Table D.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in the Therapy Direct Ancillary Adjustment Calculation table below (Letter L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient days	[redacted]
F.	Therapy Component	D / E

Table D.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in the IMPRM
B.	Total Ancillary Revenue	Total Ancillary Revenue as described in the IMPRM
C.	Medicaid Utilization Ratio	A / B
D.	Direct Ancillary Cost from Medicaid Cost Report	Direct ancillary costs as described in the IMPRM
E.	Direct Ancillary Employee Benefits from Medicaid Cost Report	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
F.	Total Direct Ancillary Costs	D + E
G.	Medicaid Direct Ancillary Costs	C * F
H.	Medicaid Patient Days	[redacted]
I.	Medicaid Direct Ancillary Costs Per Patient Day	G / H
J.	Patient Days	[redacted]
K.	Allowable Direct Ancillary Costs	I * J
L.	Direct Ancillary Cost Adjustment	K – F

The Therapy Direct Ancillary Adjustment Calculation above is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This is a statewide price-based component and is calculated as follows:

Table D.7 - Indirect Care Component Calculation		
A.	Total Indirect Cost	Allowable indirect care cost as described in the IMPRM
B.	Indirect Care Pro Rata Employee Benefits	Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Indirect Ancillary Cost Adjustment (negative value)	Value as described in the Indirect Ancillary Cost Adjustment table below (Letter L)
D.	Allowable Indirect Care Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 85% * bed days available, whichever is greater
F.	Indirect Care Per Patient Day Cost	D / E
G.	Determination of the Statewide Price for the Indirect Care Per Patient Day Cost	Indirect care per patient day costs (Letter F) for each provider is utilized for the percentile array. The allowable cost of the provider identified at the specified percentile shall be selected as the statewide price in accordance with subdivision (4) of this rule subsection. The specified percentile shall be set each July 1 at the percentile of the Medicaid day-weighted indirect care component costs necessary to achieve estimated aggregate Prospective System spending equivalent to the estimated payments calculated in the Legacy System subsection (e) below.
H.	Indirect Care Component	G

Table D.8 - Indirect Ancillary Cost Adjustment Calculation		
A.	Total Ancillary Costs Per Medicare Cost Report	Ancillary costs per the Medicare cost report as described in the IMPRM
B.	Capital Costs Per Medicare Cost Report	Capital costs per the Medicare cost report as described in the IMPRM
C.	Ancillary Costs without Capital	A - B
D.	Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report	Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits) All costs are from the Medicare cost report as described by the IMPRM

E.	Indirect Costs per Medicare Cost Report	C - D
F.	Indirect Costs as a Percentage of Direct Costs	E / D
G.	Indirect Care Component Adjustment	Value determined in Therapy Direct Ancillary Adjustment table above (Letter L) * F
H.	Total Indirect Care Costs Excluding Dietary	Indirect Care Component Calculation table above (Letters A + B) – ((allowable dietary cost) + (allowable dietary salaries / total allowable salaries * allowable employee benefits)) All costs are described by the IMPRM
I.	Total Administrative Costs	Administrative Component Calculation table below (Letters A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))
K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The Indirect Ancillary Cost Adjustment Calculation above is performed by each ancillary cost center as described by the IMPRM.

For providers that are not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), no adjustment resulting from the Indirect Ancillary Cost Adjustment shall be made and they shall be excluded from the administrative and indirect percentile calculation.

(D) Administrative Component. The component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the selected Medicaid day-weighted percentile and is calculated as follows:

Table D.9 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM
C.	Owner, Related Party, Management (ORPM) Compensation Limitation (negative value)	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
D.	Ancillary Adjustment (negative value)	Value as determined in the Indirect Ancillary Cost Adjustment Calculation table above (Letters M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Patient Days or Minimum Occupancy	Patient days or 85% * bed days available, whichever is greater.
G.	Administrative Per Patient Day Cost	E / F
H.	Determination of the Statewide Price for the Administrative Care Per Patient Day Cost	Administrative per patient day costs (Letter G) calculated with uninflated working capital interest for each provider is utilized for the percentile array. The allowable cost of the provider identified as the 50th percentile of the Medicaid day-weighted administrative component costs shall be selected as the statewide price in accordance with subdivision (4) of this rule subsection.
I.	Administrative Component	H

Table D.10 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	

E.	ORPM Per Patient Day Cost	C / D
F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year
G.	Excess ORPM Per Patient Day Cost	If F – E < 0 then F – E. If F – E ≥ 0 then 0.
H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This is calculated utilizing a fair rental value allowance statewide price and provider specific other capital costs subject to an overall cost limitation and is calculated as follows:

	Table D.11 - Capital Component Calculation	
A.	Capital Per Patient Day Cost	Value determined in the Capital Per Patient Day Cost Calculation table below (Letter F)
B.	Median Capital Cost	The capital per patient day cost (Letter A) for each provider are utilized in the median calculation. The capital per patient day cost of the median provider shall be selected in accordance with subdivision (5)
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-on	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0 then 0
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table D.12 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM

C.	Fair Rental Value Allowance	Value as determined in the Fair Rental Value Allowance Calculation table below (Letter E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table D.13 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is utilized in the median calculation. The average historical cost of property per bed of the median provider shall be selected in accordance with subdivision (6)
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in Section 2
E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables above are based on the provider's allowable nursing facility cost which are annualized to a full year cost report period in recognition of the provider's allowable costs as described in the IMPRM.

(3) All allowable rate component costs as identified in the above tables shall be adjusted using the inflation factor. The inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the Medicaid patient day-weighted percentile as identified in the above tables shall be calculated on a statewide basis each July 1 for the direct care, indirect care, and administrative components as follows:

(A) Providers are arrayed in ascending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;

(B) Cumulative Medicaid patient days are calculated for each provider within the array, by adding that provider's Medicaid patient days to all the total of all Medicaid patient days within the array for preceding providers.

(C) The percentage of total cumulative Medicaid patient days for each provider within the array is calculated by dividing their cumulative Medicaid patient days by total Medicaid patient days within the array.
(D) The provider within the array whose percentage of total cumulative Medicaid patient days is equal to or immediately lesser than (if no provider is exactly equal to the Medicaid day-weighed percentile) the rate component Medicaid day-weighted percentile is selected as the allowable cost of the Medicaid patient day-weighted percentile.

(5) The allowable cost of the median patient day as identified in the above tables shall be calculated on a statewide basis each July 1 for the capital component from the most recently desk reviewed or field audited cost report:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;
(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to all the total of all patient days within the array for preceding providers.
(C) The median patient day within the array is calculated by dividing cumulative patient days by two.
(D) The provider within the array whose total cumulative patient days is equal to or immediately greater than the median patient day is selected as the allowable cost of the median patient day.

(6) The average historical cost of property of the median bed in the above table shall be calculated on a statewide basis for facilities that are not acquired through an operating lease arrangement each July 1 as follows:

(A) Land, building, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the RSMeans Construction Index.
(B) Inflated land and building historical costs are added to equipment and other historical property costs which are divided by beds to calculate the average inflated historical costs of property per bed.
(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.
(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of all beds within the array for preceding providers.
(E) The median bed is calculated by dividing total cumulative beds by two.

(F) The provider within the array whose total cumulative beds is equal to or immediately greater than the median bed is selected as the average inflated historical costs of property per bed median.

(7) Beginning July 1, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a 6-month period, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase.
The case mix index for Medicaid residents in each facility shall be:

(A) updated every January 1; and

(B) used to adjust the direct care component that becomes effective on the 6-month period following the updated case mix index for Medicaid residents.

In addition, each facility's total quality score shall be redetermined bi-annually based on the criteria in the Quality Program Manual.

(8) All rate-setting parameters and components used to calculate the annual rebase, except for the case mix index for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in Medicaid rate that is authorized under subdivision (7).

(9) Providers shall pay interest on all 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:

(A) accrue from the date of the overpayment to the provider; and

(B) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(10) When the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes. For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted prior to January 31 preceding the July 1 annual rebase. For the January 1 bi-annual update, the notification of the licensed bed change shall be in writing and submitted prior to July 31 preceding the January 1 bi-annual update. For notifications received by the due date, the annual rebase at July 1 and bi-annual rate at January 1 shall be calculated utilizing the new number of nursing facility licensed beds.

(e) The Legacy System is as follows:

(1) The Legacy System rate is calculated as the sum of the following:

(A) Direct care component. This is calculated utilizing provider specific costs subject to an overall cost limitation and is calculated as follows:

	Table E.1 - Direct Care Component Calculation (Non-children's Nursing Facilities)	
A.	Direct Care Per Patient Day Cost	Value as determined in the Direct Care Per Patient Day Cost table below (Letter K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (Letter A) for each provider are utilized in the median calculation. The direct care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
G.	Profit Ceiling	(F * 110%) * D
H.	Tentative Profit Add-on	If G – E > 0 then 30% * (G – E). If G – E ≤ 0 then 0.
I.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual

J.	Allowed Profit Add-on	H * I
K.	Overall Profit Limit	F * 10%
L.	Medicaid Case Mix Adjusted Costs Plus Profit	E + Lesser of J or K
M.	Overall Rate Component Limit	(F * 120%) * D
N.	Direct Care Component	Lesser of L or M

	Table E.2 - Direct Care Component Calculation (Children's Nursing Facilities only)	
A.	Direct Care Per Patient Day Cost	Value as determined in the Direct Care Per Patient Day Cost table below (Letter K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (Letter A) for each provider are utilized in the median calculation. The direct care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
G.	Profit Ceiling	(F * 110%) * D
H.	Profit Add-on	If G – E > 0 then 30% * (G – E). If G – E ≤ 0 then 0.
I.	Medicaid Case Mix Adjusted Costs Plus Profit	E + H
J.	Overall Rate Component Limit	(F * 120%) * D
K.	Direct Care Component	Lesser of I or J

Table E.3 - Direct Care Per Patient Day Cost Calculation		
A.	Total Direct Care Costs	Allowable direct care costs as described in the IMPRM
B.	Direct Care Pro Rata Employee Benefits	Allowable direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Excess Medical Equipment Rental Limitation Calculation table below (Letter G)
D.	Allowable Direct Care Costs	A + B + C
E.	Variable Direct Care Costs (75% of allowable direct care costs are considered variable)	D * 75%
F.	Patient Days	
G.	Variable Direct Care Costs Per Patient Day	E / F
H.	Fixed Direct Care Costs (25% of allowable direct care costs are considered fixed)	D * 25%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater
J.	Fixed Direct Care Costs Per Patient Day	H / I
K.	Direct Care Per Patient Day Cost	G + J

Table E.4 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0 then D – C. If D – C ≥ 0 then 0.
F.	Patient Days	
G.	Excess Medicaid Equipment Rental Cost	E * F

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost and is calculated as follows:

Table E.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in the Therapy Direct Ancillary Adjustment Calculation table below (Letter L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient days	[redacted]
F.	Therapy Component	D / E

Table E.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in the IMPRM
B.	Total Ancillary Revenue	Total Ancillary Revenue as described in the IMPRM
C.	Medicaid Utilization Ratio	A / B
D.	Direct Ancillary Cost from Medicaid Cost Report	Direct ancillary costs as described in the IMPRM
E.	Direct Ancillary Employee Benefits from Medicaid Cost Report	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
F.	Total Direct Ancillary Costs	D + E
G.	Medicaid Direct Ancillary Costs	C * F
H.	Medicaid Patient Days	[redacted]
I.	Medicaid Direct Ancillary Costs Per Patient Day	G / H
J.	Patient Days	[redacted]
K.	Allowable Direct Ancillary Costs	I * J
L.	Direct Ancillary Cost Adjustment	K – F

The Therapy Direct Ancillary Adjustment Calculation above is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This is calculated utilizing provider specific costs subject to an overall cost limitation and is calculated as follows:

	Table E.7 - Indirect Care Component Calculation	
A.	Indirect Care Per Patient Day Cost	Value as determined in the Indirect Care per Patient Day Cost table below (Letter K)
B.	Median Indirect Care Cost	The indirect care per patient day cost (Letter A) for each provider are utilized in the median calculation. The indirect care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
C.	Profit Ceiling	B * 105%
D.	Tentative Profit Add-on	If (C – A) > 0 then 60% * (C – A). If (C – A) ≤ 0 then 0.
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Indirect Care Cost Plus Profit	A + F
H.	Overall Rate Component Limit	B * 115%
I.	Indirect Care Component	Lesser of G or H

	Table E.8 - Indirect Care Per Patient Day Cost	
A.	Total Indirect Cost	Allowable indirect care cost as described in the IMPRM
B.	Indirect Care Pro Rata Employee Benefits	Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Indirect Ancillary Adjustment (negative value)	Value as described in the Indirect Ancillary Cost Adjustment table below (Letter L)
D.	Allowable Indirect Care Costs	A + B + C
E.	Variable Indirect Care Costs (63% of allowable indirect care costs are considered variable)	D * 63%
F.	Patient Days	
G.	Variable Indirect Care Costs Per Patient Day	E / F

H.	Fixed Indirect Care Costs (37% of allowable indirect care costs are considered fixed)	D * 37%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, actual patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, actual patient days or 85% * bed days available, whichever is greater
J.	Fixed Indirect Care Costs Per Patient Day	H / I
K.	Indirect Care Per Patient Day Cost	G + J

Table E.9 - Indirect Ancillary Cost Adjustment Calculation		
A.	Total Ancillary Costs Per Medicare Cost Report	Ancillary costs per the Medicare cost report as described in the IMPRM
B.	Capital Costs Per Medicare Cost Report	Capital costs per the Medicare cost report as described in the IMPRM
C.	Ancillary Costs without Capital	A - B
D.	Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report	Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits) All costs are from the Medicare cost report as described by the IMPRM
E.	Indirect Costs per Medicare Cost Report	C - D
F.	Indirect Costs as a Percentage of Direct Costs	E / D
G.	Indirect Care Component Adjustment	Value determined in Therapy Direct Ancillary Adjustment table above (Letter L) * F
H.	Total Indirect Care Costs Excluding Dietary	Indirect Care Component Calculation table above (Letters A + B) – ((allowable dietary cost) + (allowable dietary salaries / total allowable salaries * allowable employee benefits)) All costs are described by the IMPRM
I.	Total Administrative Costs	Administrative Component Calculation table below (Letters A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))

K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The Indirect Ancillary Cost Adjustment Calculation above is performed by each ancillary cost center as described by the IMPRM.

For providers that are not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), the following ratios shall be utilized in lieu of the Indirect Costs as a Percentage of Direct Costs (Letter F) above.

Physical Therapy	**Speech Therapy**	**Occupational Therapy**	**Respiratory Therapy**	**X-Ray**	**Laboratory**	**Pharmacy**
23.11%	28.84%	22.15%	5.49%	2.50%	2.75%	1.60%

(D) Administrative Component. The component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the median and is calculated as follows:

Table E.10 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM

C.	Owner, Related Party, Management Compensation Limit (negative value)	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I for applicable rate effective date)
D.	Ancillary Adjustment (negative value)	Value as determined in the Indirect Ancillary Cost Adjustment Calculation table above (Letters M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Variable Administrative Costs (16% of allowable administrative costs are considered variable)	E * 16%
G.	Patient Days	[redacted]
H.	Variable Administrative Costs Per Patient Day	F / G
I.	Fixed Administrative Costs (84% of allowable administrative costs are considered fixed)	E * 84%
J.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater
K.	Fixed Administrative Costs Per Patient Day	I / J
L.	Administrative Per Patient Day Cost	H + K
M.	Determination of the Statewide Price for the Administrative Per Patient Day Cost	The administrative per patient day cost of the median provider calculated with uninflated working capital interest shall be selected in accordance with subdivision (4)
N.	Administrative Component	M

Table E.11 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	[redacted]
E.	ORPM Per Patient Day Cost	C / D

F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year
G.	Excess ORPM Per Patient Day Cost	If F – E < 0 then F – E. If F – E ≥ 0 then 0.
H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This is calculated utilizing a fair rental value allowance statewide price and provider specific other capital costs subject to an overall cost limitation and is calculated as follows:

	Table E.12 - Capital Component Calculation	
A.	Capital Per Patient Day Cost	Value determined in the Capital Per Patient Day Cost Calculation table below (Letter F)
B.	Median Capital Cost	The capital per patient day cost (Letter A) for each provider are utilized in the median calculation. The capital per patient day cost of the median provider shall be selected in accordance with subdivision (4)
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-on	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0 then 0
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table E.13 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM

C.	Fair Rental Value Allowance	Value as determined in the Fair Rental Value Allowance Calculation table below (Letter E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table E.14 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is utilized in the median calculation. The average historical cost of property per bed of the median provider shall be selected in accordance with subdivision (5)
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in Section 2
E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables above are based on the provider's allowable nursing facility cost which are annualized to a full year cost report period in recognition of the provider's allowable costs as described in the IMPRM.

(3) All allowable rate component costs as identified in the above tables shall be adjusted using the inflation factor. The inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the median patient day as identified in the above tables shall be calculated on a statewide basis each July 1 for the direct care, indirect care, administrative, and capital component from the most recently desk reviewed or field audited cost report:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;

(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to all the total of all patient days within the array for preceding providers.
(C) The median patient day within the array is calculated by dividing cumulative patient days by two.
(D) The provider within the array whose total cumulative patient days is equal to or immediately greater than the median patient day is selected as the allowable cost of the median patient day.

(5) The average historical cost of property of the median bed in the above table shall be calculated on a statewide basis for facilities that are not acquired through an operating lease arrangement each July 1 as follows:
(A) Land, building, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the RSMeans Construction Index.
(B) Inflated land and building historical costs are added to equipment and other historical property costs which are divided by beds to calculate the average inflated historical costs of property per bed.
(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.
(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of all beds within the array for preceding providers.
(E) The median bed is calculated by dividing total cumulative beds by two.
(F) The provider within the array whose total cumulative beds is equal to or immediately greater than the median bed is selected as the average inflated historical costs of property per bed median.

(6) Until June 30, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rebase.
(A) The case mix index for Medicaid residents in each facility shall be:
(i) updated each calendar quarter; and

(ii) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

Beginning July 1, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a 6-month period, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase.

(B) The case mix index for Medicaid residents in each facility shall be:

(i) updated every January 1; and

(ii) used to adjust the direct care component that becomes effective on the 6-month period following the updated case mix index for Medicaid residents.

In addition, each facility's total quality score shall be redetermined bi-annually based on the criteria in the Quality Program Manual.

(7) All rate-setting parameters and components used to calculate the annual rebase, except for the case mix index for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in Medicaid rate that is authorized under subdivision (6).

(8) Rates effective until June 30, 2024, retroactive payment or repayment shall be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or 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 shall complete the appropriate Medicaid billing adjustment form 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.

(9) Providers shall pay interest on all 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:

(A) accrue from the date of the overpayment to the provider; and

(B) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(10) Until January 31, 2024, when the number of nursing facility beds licensed by IDOH is changed after the cost reporting period, the provider may request in writing before the effective date of their next annual rebase an additional rebase effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rebase shall be determined using all rate-setting parameters in effect at the provider's latest annual rebase, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

Beginning February 1, 2024, when the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes. For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted prior to January 31 preceding the July 1 rebase. For the January 1 bi-annual update, the notification of the licensed bed change shall be in writing and submitted prior to July 31 preceding the January 1 bi-annual update. For notifications received by the due date, the annual rebase at July 1 and bi-annual rate at January 1 shall be calculated utilizing the new number of nursing facility licensed beds.

405 IAC 1-14.7-7 Additional Reimbursement

Sec. 7. (a)The Special Facility Qualification report (Schedule Z) shall be completed by any provider requesting reimbursement for an SCU and/or Ventilator Program.

(1) Nursing facilities who have previously qualified as an SCU and/or Ventilator facility shall annually recertify that the facility is still in compliance with the requirements to continue to receive reimbursement. For annual recertifications, Schedule Z shall be completed based on the calendar year (January 1 through December 31) reporting period and submitted to the office not later than March 31 following the end of each calendar year.
(2) Nursing facilities who have developed an SCU and/or Ventilator program between October 1 and March 31 shall submit Schedule Z not later than March 31 to determine qualification and eligibility for reimbursement at the following July 1 rate effective date.
(3) Nursing facilities who have developed an SCU and/or Ventilator program between April 1 and September 30 shall submit Schedule Z not later than September 30 to determine qualification and eligibility for reimbursement at the following January 1 rate effective date.
(4) Nursing facilities who have discontinued an SCU and/or Ventilator program shall notify the office and indicate the date in which the program was discontinued.

(5) Nursing facilities who have developed an SCU and/or Ventilator program before December 31, 2023 may submit Schedule Z to determine qualification and eligibility for reimbursement beginning the effective date of the submission assuming that all applicable criteria were met.

(b) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying ventilator program. Additional Medicaid reimbursement shall be made to the facilities at a rate of eighty dollars ($80.00) per eligible Medicaid resident day. The additional reimbursement shall:

(1) begin with the later of the effective date of the program or the first day for residents deemed ventilator dependent in accordance with the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual) or its successor published by CMS; and

(2) remain in effect until the earlier of the first day the resident is no longer deemed ventilator dependent in the RAI Manual or the program terminates.

(c) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying special care unit program. The additional Medicaid reimbursement shall be made to the facilities at a rate of twelve dollars ($12) per eligible Medicaid Alzheimer's and dementia resident day in their SCU. The additional reimbursement shall:

(1) begin with the later of the effective date of the program or the first day for residents diagnosed with Alzheimer's or dementia; and

(2) remain in effect until the earlier of the first day the resident no longer has a diagnosis of Alzheimer's or dementia or the program terminates.

(d) The office shall increase Medicaid reimbursement to all nursing facilities for NEMT through an add-on in the amount of $1.21 per Medicaid resident day.

405 IAC 1-14.7-8 Minimum Data Set

Sec. 8. (a) Nursing facilities are required to electronically transmit MDS resident assessments in a complete, accurate, and timely manner as prescribed in the MDS and Case Mix Index Supportive Documentation Manual. An extension of the electronic MDS assessment due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:

(1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and

(2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(b) If the office determines that a nursing facility has a delinquent MDS resident assessment, the assessment shall be assigned the delinquent classification as prescribed in the MDS and Case Mix Index Supportive Documentation Manual.

(c) The office shall adjust or revise MDS data items that an MDS review determines are unsupported to reflect the resident's highest functioning level that is supported according to the MDS and Case Mix Index Supportive Documentation Manual. Incorporation of any adjustments or revisions may result in a reclassification of the resident pursuant to the resident classification system.

(d) For rates effective prior to June 30, 2024, upon conclusion of an MDS review, the office shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(e) For rates effective beginning July 1, 2024 and after, the result of an MDS review shall be applied in accordance with Section 12. Any CMI change as a result of the MDS review shall not be incorporated into either the Legacy System or Prospective System rate calculations in Section 6.

(f) CMIs are determined as prescribed in the MDS and Case Mix Index Supportive Documentation Manual for each resident to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

(g) The office shall provide each nursing facility with the following:

(1) A preliminary CMI report; and

(2) A final CMI report that shall be utilized to establish the facility-average CMI and the facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(h) In order to determine the normalized allowable direct care costs from each facility's cost report, the office shall determine each facility's CMI for all residents that corresponds to the cost reporting period in accordance with the MDS and Case Mix Index Supportive Documentation Manual.

405 IAC 1-14.7-9 Change of Ownership or Structure

Sec. 9. (a) The office shall be notified within thirty (30) days of any transaction affecting the following:

(1) ownership (operational license),

(2) property ownership,

(3) lessor/lessee,

(4) any management company, or

(5) any change in control or structure (including mergers, exchange of stock, etc.).
The provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership to the office within thirty (30) days following the date requested by the office. The completed checklist shall include all supporting documentation to fully explain the transaction. For providers with an outstanding Checklist of Management Representations Concerning Change in Ownership, a field audit or desk review shall not be performed on any affected cost reports nor shall the affected cost report be used to establish reimbursement rates. Refer to section 12 for imposition of related penalties.

(b) For transactions prior to July 1, 2023, a cost report shall be filed for the first fiscal year end after the transaction date in which the provider has a minimum of six (6) full calendar months of actual historical data. The provider shall submit the cost report by the date identified on the Change of Ownership Letter.

(c) For transactions beginning July 1, 2023, the following shall apply:
(1) The office shall determine the nature of the transaction:
(2) If the nature of the transaction is determined to be one of the following, the fiscal period shall be determined in accordance with subdivision (3).
(A) any change in/to/from related party management company, or
(B) any change in a privately owned or operated nursing facility's ownership (operational license) except for when the seller (or their related entity) becomes the management company.
(3) The fiscal period shall be:
(A) from the start of the provider's required fiscal year through the day immediately preceding the transaction date; or
(B) from the transaction date through December 31.
(4) For any fiscal period identified in subdivision (3), a cost report shall be filed for the fiscal period that has a minimum of six (6) full calendar months of actual historical data. The cost report is due not later than the last day of the fifth calendar month after the fiscal period or thirty (30) days following notification by the office that the cost report shall be filed.

405 IAC 1-14.7-10 Related Parties

Sec. 10. (a) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of

immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Spousal relationship.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

(4) Stepparent, stepchild, stepsister, and stepbrother.

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.

(6) Grandparent and grandchild.

(7) Anyone who has been previously considered immediate family.

(b) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(c) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rebase effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (d) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.

(d) The office may grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management

company or entity in a similar decision making capacity for a NSGO provider shall not be considered an arm's-length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(e) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

(f) If a provider rents, leases, or purchases facilities or equipment from a related party property company, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the average historical cost of property of the median bed except as described in this section for the sale of facilities between family members.

(g) If a sale of facilities between family members meets the following conditions, the cost basis of the facility shall be recognized for the purpose of computing the average historical cost of property of the median bed in accordance with this rule as a bona fide sale arising from an arm's-length transaction, subject to the limitations of subsection (h):
(1) There is no current or previous spousal relationship between parties.
(2) The following persons are considered family members:

(A) Natural parent, child, and sibling.
(B) Adopted child and adoptive parent.
(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(E) Grandparent and grandchild.
(F) Anyone who has been previously considered family members.

(3) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.
(4) The seller is not associated with the facility in any way after the sale other than as a passive creditor.
(5) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.
(6) This family sale exception has not been utilized during the previous eight (8) years on this facility.
(7) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.
(8) If any of the entities involved are corporations, they shall be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(h) In order to establish a historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal. The MAI appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis for purposes of determining the average historical cost of property of the median bed shall be the lower of the historical cost basis of the buyer or the MAI appraisal of facilities and equipment.

(i) If a lease of facilities between family members under subsection (g) qualifies as a capitalized lease under the Statement of Financial Accountant Standards Number 13 as issued by the Financial Accounting Standards Board, the transaction shall be treated as a sale of facilities between family members for purposes of determining the average historical cost of property of the median bed.

405 IAC 1-14.7-11 Quality Assessment Fee

Sec. 11. For nursing facilities certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is

determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed cost report.

405 IAC 1-14.7-12 Penalties and Settlements

Sec. 12. (a) Penalties shall be assessed on a per nursing facility basis.

(b) Reimbursement lost because of any imposed penalty cannot be recovered by the provider.

(c) Penalties may be addressed through a retroactive reprocessing of claims or settlement process.

(d) Beginning April 1, 2024, penalties shall be calculated and assessed in accordance with the following:

	Event	Event Due Date	Penalty Amount	Penalty Assessment Begin Date	Penalty Assessment End Date
(1)	Cost Report Submission for Annual Rebase	End of the fifth month after the fiscal period	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(2)	Cost Report Submission Following a Change in Ownership	Due date identified on the Change of Ownership Letter	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(3)	Change in Ownership Checklist Submission	30 calendar days from checklist request	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(4)	Prefield Information Request	Due date identified on Audit Notification Letter	$15,000	Day 1 after event due date	[redacted]
			$2,000	Each day, days 1 - 30.	Day of complete submission or day 31 whichever is earlier.

(5)	Field Work – Follow-Up Letter (exception noted in subsection (e)	Due date identified on Follow-Up Letter	$15,000	Day 1 after event due date	
			$2,000	Each day, days 1 - 30.	Day of complete submission or day 31 whichever is earlier.

(e) If the nursing facility cannot locate requested information in the Field Work – Follow-up letter as noted in subdivision 4 above, they shall supply a signed declaration, prescribed by the office, that they are unable to produce the requested documentation. This declaration shall be submitted at least one (1) day prior to the due date on the Field Work – Follow-up letter to avoid penalty.

(f) Until March 31, 2024, penalties shall be assessed as follows:
(1) Failure to submit a complete cost report as described in section 3 within the time limit required shall result in the following actions:
(A) When a complete cost report is more than one (1) calendar month past due, the following shall apply:
(i) the rate in effect effective immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end,
(ii) the reduced rate shall remain in effect until the first day of the month after the delinquent complete cost report is received by the office,
(iii) no rate adjustments shall be allowed until the first day of the calendar quarter following receipt of the delinquent complete cost report, and
(iv) no desk review or field audit shall be performed on incomplete submissions.
(B) If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary and the provider fails to submit its Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, the following shall apply;
(i) the rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary,
(ii) the reduced rate shall remain in effect until the first day of the month after the delinquent Medicare cost report is received by the office,
(iii) no rate adjustments shall be allowed until the first day of the calendar quarter following receipt of the delinquent complete cost report, and

(iv) no desk review or field audit shall be performed on incomplete submissions

(2) Failure to submit a completed Checklist of Management Representations Concerning Change in Ownership to the office within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider shall result in the following actions:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period,

(B) The reduced rate shall remain in effect until the first day of the month after the completed Checklist of Management Representations is received by the office, and

(C) No desk review or field audit shall be performed until the completed Checklist of Management Representations is received and reviewed.

(3) In the event the required prefield information has not been submitted by the due date indicated in the audit notification letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day following the date the response was due,

(B) The reduced rate shall remain in effect until:

(i) the first day following the office's receipt of a complete response, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate adjustments shall be allowed until the first day of the calendar quarter following:

(i) the receipt of information requested in the written notice, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(4) In the event the required field work information has not been submitted by the due date indicated in the Field Work – Follow-Up Letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day following the date the response was due.

(B) The reduced rate shall remain in effect until:

(i) the first day following the office's receipt of a complete response, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate adjustments shall be allowed until the first day of the calendar quarter following:

(i) the receipt of information requested in the written notice, or
(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(5) In the event that the documentation submitted for the field audit is inadequate or incomplete or the 10% reduction has expired, the following additional actions shall be taken:

(A) Appropriate adjustments to the applicable cost report shall be made,
(B) The office shall document such adjustments in a finalized exception report, and
(C) The office shall incorporate such adjustments in the prospective rate calculations.

(g) If the office determines due to an MDS review that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any penalty:

(1) The office shall:

(A) review a sample of MDS resident assessments; and
(B) determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the initial sample that are unsupported is:

(A) greater than twenty percent (20%), the office shall expand to a larger sample of residents assessments; or
(B) equal to or less than twenty percent (20%), the office shall conclude the field portion of the MDS review.

(3) For rates effective beginning July 1, 2024 and after, a penalty for unsupported MDS resident assessments shall be calculated as follows:

(A) if the percentage of unsupported assessments for the initial and expanded sample of all assessments reviewed is greater than twenty percent (20%) a penalty shall be applied. The penalty shall be calculated as the administrative component portion of the Legacy System Medicaid rate in effect for the current bi-annual period multiplied by the applicable percentage in the table below multiplied by Medicaid days for the bi-annual rate period.

MDS Field Review for Which Penalty Is Applied	**Penalty Percent**
First MDS Review	7.5%
Second consecutive MDS Review	10%
Third consecutive MDS Review	15%

Fourth or more consecutive MDS Review(s)	25%

(B) Upon conclusion of an MDS review, the office shall calculate and implement a penalty based on changes to the facility's biannual Medicaid CMI. If the recalculated biannual Medicaid CMI is a change from the Medicaid CMI used in the initial Legacy rate calculation before the MDS Review the penalty shall be calculated per the table below:

CMI Penalty Calculation		
A.	Legacy System rate calculated with original biannual Medicaid CMI	The Medicaid rate calculated under Section 6(e) using the CMI prior to the MDS Review.
B.	Legacy System rate calculated with revised biannual Medicaid CMI	The Medicaid rate calculated under Section 6(e) using the CMI after completion of the MDS Review.
C.	Rate Differential	A - B
D.	Medicaid Days	
E.	CMI Penalty	C * D

(4) For rates effective prior to June 30, 2024, if the percentage of unsupported assessments for the initial and expanded sample of all assessments reviewed is greater than twenty percent (20%), a penalty shall apply, which shall be calculated as follows:

MDS Field Review for Which Penalty Is Applied	Administrative Component Penalty Percent
First MDS Review	15%
Second consecutive MDS Review	20%
Third consecutive MDS Review	30%
Fourth or more consecutive MDS Review(s)	50%

(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS review shall be reduced by the percentage as shown in the following table:

(B) In the event a penalty is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office to the provider's allowable administrative costs.

405 IAC 1-14.7-13 Administrative Reconsideration and Appeal Process

Sec. 13. (a) A reconsideration request shall be in writing and contain specific issues to be considered and the rationale for the provider's position. The provider shall timely request administrative reconsideration before filing an appeal. The events detailed below shall be communicated to nursing facilities via a formal letter either through USPS mail or via a secure web portal at which point the period for a timely request begins. The events are:

(1) Schedule of adjustments or a summary of findings resulting from a review performed under section 4;

(2) CMI quarterly or bi-annual updates or recalculation of CMIs due to an MDS review;

(3) All parameters used to calculate an issued rate other than the schedule of adjustments in subdivision 1 and CMIs in subdivision 2 above; and

(4) Penalties or remedies from section 12.

The request shall be signed by the provider or authorized representative of the provider and shall be received by the office not later than fifteen (15) days after the date of issuance. The office shall evaluate the reconsideration request and may affirm or amend 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 under subsection (c).

(b) In accordance with IC 4-21.5-3-2(e) any notification letter served through the United States mail, the fifteen (15) day reconsideration period shall begin three (3) days after the date of the notification letter.

(c) After completion of the reconsideration procedure under subsection (a) the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal shall be signed by the nursing facility provider. Only issues raised by the provider through administrative reconsideration may be subsequently raised in an appeal.

(d) The office may take action to implement changes made in accordance with subsection (a) without awaiting the outcome of an appeal filed in accordance with subsection (c).

(e) 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).

405 IAC 1-14.7-14 Supplemental Payment Calculation

Sec. 14. (a) In addition to the established Medicaid rates for nursing facilities, any non-state government owned or operated nursing facility (NSGO providers) that has entered into an agreement with the office to participate in the nursing facility supplemental payment program shall receive a Medicaid supplemental payment adjustment. Privately owned or operated nursing facilities (Private providers) and non-participating NSGO providers, may only participate in the quality supplemental payment pool as detailed in subsection (c) below. Supplemental payments shall not exceed the upper payment limit for the provider class pursuant to 42 CFR 447.272.

(b) The Medicaid supplemental payment shall be transitioned from the Legacy Supplemental Payment System methodology in subsection (d) to the Pooled Supplemental Payment System methodology in subsection (c). The Medicaid supplemental payment shall be calculated as the sum of the following:
(1) Pooled Supplemental Payment System payment calculated in accordance with subsection (c) multiplied by the percentage below; and
(2) Legacy Supplemental Payment System payment calculated in accordance with subsection (d) multiplied by the percentage below.

Supplemental Payment Periods	**Pooled Supplemental Payment System**	**Legacy Supplemental Payment System**
Prior to July 1, 2024	0%	100%
July 1, 2024 – June 30, 2025	10%	90%
July 1, 2025 – June 30, 2026	40%	60%
July 1, 2026 – June 30, 2027	70%	30%
July 1, 2027 and forward	100%	0%

(c) The Pooled Supplemental Payment System calculates the Medicaid Supplemental Payment on a state fiscal year (SFY) basis utilizing a quarterly (July 1, October 1, January 1, April 1) statewide supplemental payment pool methodology for participating providers. The established supplemental payment pool is distributed to nursing facilities on a quarterly basis utilizing the prescribed methodology detailed below. An interim supplemental payment pool and provider distribution shall be calculated for each quarter of the SFY with a final supplemental payment pool and provider distribution for each quarter occurring after conclusion of the SFY.

(1) The aggregate supplemental payment pool for each quarter of the SFY is established utilizing participating NSGO providers as follows:

(A) Establish the estimated Medicare payments. For each Medicaid resident that is in a nursing facility during an MDS reporting period, the MDS assessments in effect for that period are classified using the Medicare resident classification system. The Medicare rate shall be adjusted by the Medicare geographic wage index and to remove the statewide average impact of covered benefit differences between the Medicare and Medicaid programs. A day-weighted average Medicare rate is determined for each nursing facility by multiplying the estimated Medicare rate for each Medicaid resident assessment by the number of days in the MDS reporting period in which the assessment was active to create that assessment's Medicare rate weight. The sum of each nursing facility's MDS resident assessment Medicare rate weights for the applicable MDS reporting period are divided by the total number of Medicaid resident assessment days detailed on the final MDS resident roster for the applicable reporting period to derive the estimated average Medicare rate. The estimated average Medicare rate for each provider is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to determine the estimated Medicare payments. Provider Medicare payments are summed to establish the total estimated Medicare payments for the supplemental payment period. The MDS reporting periods utilized to determine the interim and final supplemental payment periods are as follows:

Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	March 1 – May 31	June 1 – August 31
October 1 – December 31	June 1 – August 31	September 1 – November 30
January 1 – March 31	September 1 – November 30	December 1 – February 28 (Feb. 29 in leap year)
April 1 – June 30	December 1 – February 28 (Feb. 29 in leap year)	March 1 – May 31

(B) Establish the estimated Medicaid payments for each provider. For each provider, the most recently available Medicaid per diem rate, inclusive of the per diem impact of the Medicaid add-on payments determined in section 7, is

multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to establish Medicaid payments for each provider. Provider Medicaid payments are summed to establish the total estimated Medicaid payments for the supplemental payment period.

(C) Determine the supplemental payment period pool. For each participating provider the estimated Medicaid payment in clause (B) shall be subtracted from their estimated Medicare payments in clause (A) to determine their UPL gap. The sum of each provider's UPL gap shall be the total supplemental payment period pool.

(D) After conclusion of each state fiscal year, the interim payment pool is subject to a final supplemental payment process where the underlying MDS resident assessments, Medicaid days, Medicare rates, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment pool for each quarter of the SFY. The established supplemental payment pools are utilized for calculation of the interim and final payment pool distribution in subdivision 2 below.

(2) The supplemental payment pool distribution is segregated into the Base supplemental payment pool and the Quality supplemental payment pool. Medicaid days and Medicaid rates specified in the tables below are calculated for interim and final supplemental payment periods as described above. Payment to each participating provider for each quarter of the SFY is established as follows:

Uniform Percentage Calculation		
A.	Total Supplemental Payment Pool	Total UPL Gap calculated above
B.	Percentage of Pool Reserved for Quality	See Percentage of Pool Reserved for Quality Table Below
C.	Total Quality Pool	A * B
D.	Total Supplemental Payment Pool Net of Quality	A – C
E.	Total NSGO Provider Medicaid Days	
F.	Average NSGO Supplemental Per Patient Day payment	D / E
G.	Weighted Average NSGO Medicaid Rate	(Sum of the products of each NSGO provider's Medicaid per diem rate * their Medicaid days) / E
H.	NSGO Uniform Percentage	F / G

Percentage of Base Rate Paid Per Quality Point Earned Calculation		
A.	Total Quality Pool	Value as determined in the Uniform Percentage Calculation table above (Letter C)
B.	Facility Total Quality Score Points	Value as determined in accordance with the Quality Program Manual
C.	Medicaid Days	[redacted]
D.	Medicaid Rate	
E.	Total Quality Weight	Sum of the products of B * C * D for each provider
F.	Percentage of Base Rate Paid Per Quality Point Earned	A / E

Quality Percentage Calculation		
A.	Facility Total Quality Score	Value as determined in accordance with the Quality Program Manual
B.	Percentage of Base Rate Paid Per Quality Point Earned	Value as determined in Percentage of Base Rate Paid Per Quality Point Earned Calculation table above (Letter F)
C.	Quality Percentage	A * B

Percentage of Pool Reserved for Quality Table		
A.	January 1, 2025	10%
B.	July 1, 2025	12%
C.	July 1, 2026	14%
D.	July 1, 2027	16%
E.	July 1, 2028	18%
F.	July 1, 2029	20%

Total Provider Medicaid Fee-For-Service (FFS) Supplemental Payment		
A.	NSGO Uniform Percentage	Value as determined in the Uniform Percentage Calculation table above (Letter H). Non-participating NSGO or Non-NSGO provider entity values shall be zero.
B.	Quality Percentage	Value as determined in the Quality Percentage table above (Letter C)
C.	Medicaid Rate	[redacted]
D.	Total Supplemental Payment Rate	(A + B) * C

E.	Total Medicaid FFS Days	Medicaid days for FFS population only. Utilizes the same data source as Total Medicaid days
F.	Total Medicaid Days	[redacted]
G.	Total Medicaid FFS Percentage	E / F
H.	Total Medicaid FFS Supplemental Payment	D * G

(A) After conclusion of each state fiscal year, each provider's interim supplemental payment is subject to a final supplemental payment process where the underlying MDS resident assessment information, Medicaid days, Medicare rate, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment for each quarter using the methodology prescribed in the above table. Any differential between the final and interim supplement payment shall be paid to or recouped from each provider.

(d) The Legacy Supplemental Payment System calculates the Medicaid supplemental payment on a state fiscal year (SFY) basis utilizing a quarterly (July 1, October 1, January 1, April 1) provider specific UPL gap payment methodology for participating NSGO providers. The established supplemental payment pool is distributed to nursing facilities on a quarterly basis utilizing the prescribed methodology detailed below. An interim and final supplemental payment shall be calculated for each quarter:The supplemental payment for each quarter is established as follows:

(A) Establish the estimated Medicare payments. For each Medicaid resident that is in a nursing facility during an MDS reporting period, the MDS assessments in effect for that period are classified using the Medicare resident classification system. The Medicare rate shall be adjusted by the Medicare geographic wage index and to remove the statewide average impact of covered benefit differences between the Medicare and Medicaid programs. A day-weighted average Medicare rate is determined for each nursing facility by multiplying the estimated Medicare rate for each Medicaid resident assessment by the number of days in the MDS reporting period in which the assessment was active to create that assessment's Medicare rate weight. The sum of each nursing facility's MDS resident assessment Medicare rate weights for the applicable MDS reporting period are divided by the total number of Medicaid resident assessment days detailed on the final MDS resident roster for the applicable reporting period to derive the estimated average Medicare rate. The estimated average Medicare rate for each provider is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to determine total

estimated Medicare payments. The MDS reporting periods utilized to determine the interim and final supplemental payment periods are as follows:

For Supplemental Payment Periods Before July 1, 2024		
Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	April 1 – June 30	July 1 – September 30
October 1 – December 31	July 1 – September 30	October 1 – December 31
January 1 – March 31	October 1 – December 31	January 1 – March 31
April 1 – June 30	January 1 – March 31	April 1 – June 30

For Supplemental Payment Periods Beginning July 1, 2024		
Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	March 1 – May 31	June 1 – August 31
October 1 – December 31	June 1 – August 31	September 1 – November 30
January 1 – March 31	September 1 – November 30	December 1 – February 28 (Feb. 29 in leap year)
April 1 – June 30	December 1 – February 28 (Feb. 29 in leap year)	March 1 – May 31

(B) Establish the estimated Medicaid payments for each provider. For each provider, the most recently available Medicaid per diem rate, inclusive of the per diem impact of the Medicaid add-on payments determined in section 7, is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to establish total Medicaid payments for each provider.

(C) Determine the total UPL gap for each provider. For each provider the estimated total Medicaid payment in clause (B) shall be subtracted from their estimated total Medicare payments in clause (A) to determine their UPL gap. For interim payment periods, any provider with a negative UPL gap (Medicaid payments exceed their specific Medicare UPL limit) shall not receive a payment under the legacy method, nor be required refund the Medicaid program at that

time. Any required refund to the Medicaid program shall occur only during the final supplemental payment process as described in clause (F).

(D) Determine the Medicaid FFS percentage for each provider. Divide each provider's Medicaid FFS days by total Medicaid Days for the supplemental payment period to establish the Medicaid FFS percentage.

(E) Determine the total supplemental payment for each provider. For each provider multiply their UPL gap calculated in clause (C) by the Medicaid FFS percentage calculated in clause (D) to determine the total supplemental payment for the supplemental payment period.

(F) After conclusion of each state fiscal year, the interim SFY quarterly supplemental payments are subject to a final supplemental payment process where the underlying MDS resident assessments, Medicaid days, Medicare rates, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment. Any differential between the final and interim supplement payment shall be paid to or recouped from each provider. Any provider with a negative UPL gap (Medicaid payments exceed their specific Medicare UPL limit), shall be required to refund the Medicaid program for the differential.

Reimbursement for Religious Non-Medical Health Care Institutions

(a) Care for residents in a Religious Non-Medical Health Care Institution approved by the office may be reimbursed pursuant to the case mix reimbursement methodology found at 405 IAC 1-14.6.23

(b) Religious Non-Medical Health Care Institutions are not required to electronically transmit MDS resident assessment information.

(c) Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Prior to the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted to reflect a case mix level of Reduced Physical Function PD 1. Initial interim rates shall be effective on the certification date or the date that a service is established, whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(d) Normalized allowable cost shall be the facility's total allowable direct patient care costs divided by a case mix level of Reduced Physical Function PD 1.

(e) The case mix index for Medicaid residents used to adjust the direct care component that becomes effective on the second calendar quarter following the facility's fiscal year end shall be a case mix level of Reduced Physical Function PD 1. No adjustment to the direct care component to reflect changes in the facility's Medicaid casemix for the three calendar quarters following the effective date of the annual rate review shall be performed.

(f) Except as noted in this section all other sections of 405 IAC 1-14.6 shall apply.

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Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set
405 IAC 1-15-1 Scope

Sec. 1. (a) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit minimum data set (MDS) information for all nursing facility residents to the office. The MDS data is used to establish and maintain a case mix system for Medicaid reimbursement to nursing facilities and other Medicaid program management purposes.

(b) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit the end of therapy date for physical, occupational and speech therapy services provided to a resident in a format specified by the Office.

405 IAC 1-15-2 Definitions

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

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) “End of therapy date” means the date each therapy regimen ended for physical therapy, occupational therapy, or speech therapy, which is the last date the resident received therapy treatment.

(d) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. The Indiana system shall employ the MDS 3.0 or subsequent revisions as approved by CMS.

(e) "Resident classification system" means the classification system used to classify residents into groups to determine reimbursement levels as supported by the MDS and Case Mix Index Supportive Documentation Manual.

405 IAC 1-15-4 MDS Supporting Documentation Requirements

Sec. 4. (a) Supporting documentation requirements for all MDS data elements that are utilized to classify nursing facility residents in accordance with the resident classification system are contained in the MDS and Case Mix Supportive Documentation Manual. Additional guidance may be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(b) Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are utilized to classify nursing facility residents in accordance with the resident classification system. Such supporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to review.

405 IAC 1-15-5 MDS Review Requirements

Sec. 5. (a) The office shall periodically review the MDS assessments and supporting documentation data maintained by nursing facilities for all residents, regardless of payer type. The reviews shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be reviewed no less frequently than every thirty-six (36) months. Advance notification shall be provided by the office for all MDS reviews, except for follow-up reviews that are intended to ensure compliance with validation improvement plans.

(b) All MDS assessments data, regardless of payer type, are subject to an MDS review.

(c) When conducting the MDS reviews, the office shall consider all MDS supporting documentation data that is provided by the nursing facility and is available to the reviewers prior to the exit conference. MDS supporting documentation data that is provided by the nursing facility after the exit conference begins shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office, a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 that shall be the basis for the MDS review.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments data have been transmitted, shall be referred to the Indiana Medicaid Fraud Control Unit for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

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