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**TITLE 405 OFFICE OF THE SECRETARY OF
FAMILY AND SOCIAL SERVICES**

LSA Document #01-442(E)

DIGEST

Temporarily amends 405 IAC 1-14.6-2, 405 IAC 1-14.6-3, 405 IAC 1-14.6-4, 405 IAC 1-14.6-5, 405 IAC 1-14.6-6, 405 IAC 1-14.6-7, 405 IAC 1-14.6-9, and 405 IAC 1-14.6-20 to revise case mix reimbursement methodology by modifying the payment methodology for therapy, for repairs and maintenance costs, reduce the profit-add-on percentage, and update case mix indices. Temporarily amends 405 IAC 1-15-1, 405 IAC 1-15-5, and 405 IAC 1-15-6 to clarify when MDS assessments are due at the conclusion of therapies and to make technical changes. Authority: IC 4-22-2-37.1; IC 12-8-1-12. Effective December 27, 2001.

SECTION 1. (a) As used in this document and 405 IAC 1-14.6, “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. Administrative services and supplies include the following:

- (1) Administrator and co-administrators, owners’ compensation (including directors’ fees) for patient-related services.**
- (2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.**
- (3) Office and clerical staff.**
- (4) Legal and accounting fees.**
- (5) Advertising.**
- (6) Travel.**
- (7) Telephone.**
- (8) License dues and subscriptions.**
- (9) Office supplies.**
- (10) Working capital interest.**
- (11) State gross receipts taxes.**
- (12) Utilization review costs.**
- (13) Liability insurance.**
- (14) Management and other consultant fees.**
- (15) Qualified mental retardation professional (QMRP).**

(b) As used in this document and 405 IAC 1-14.6, “allowable per patient day cost” means a ratio between allowable cost and patient days.

(c) As used in this document and 405 IAC 1-14.6, “annual financial report” refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider’s economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this document and 405 IAC 1-14.6.

(d) As used in this document and 405 IAC 1-14.6, “average allowable cost of the median patient day” means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(e) As used in this document and 405 IAC 1-14.6, “average historical cost of property of the median bed” means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of 405 IAC 1-14.6-14(a) of this rule.

(f) As used in this document and 405 IAC 1-14.6, “calendar quarter” means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(g) As used in this document, “capital component” means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

- (1) The fair rental value allowance.
- (2) Property taxes.
- (3) Property insurance.

(h) As used in this document and 405 IAC 1-14.6, “case mix index” (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office 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.

(i) As used in this document and 405 IAC 1-14.6, “cost center” means a cost category delineated by cost reporting forms prescribed by the office.

(j) As used in this document and 405 IAC 1-14.6, “delinquent MDS resident assessment” means an assessment that is not electronically transmitted by the fifteenth day of the second month following the end of a calendar quarter, or an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS.

(k) As used in this document and 405 IAC 1-14.6, “desk audit” means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor’s written findings and recommendations.

(l) As used in this document and 405 IAC 1-14.6, “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. Direct care services and supplies include all:

- (1) nursing and nursing aide services;
- (2) nurse consulting services;
- (3) pharmacy consultants;
- (4) medical director services;
- (5) nurse aide training;
- (6) medical supplies;
- (7) oxygen; and
- (8) medical records costs.

(m) As used in this document and 405 IAC 1-14.6, “fair rental value allowance” means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(n) As used in this document and 405 IAC 1-14.6, “field audit” means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(o) As used in this document and 405 IAC 1-14.6, “forms prescribed by the office” means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(p) As used in this document and 405 IAC 1-14.6, “general line personnel” means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(q) As used in this document and 405 IAC 1-14.6, “generally accepted accounting principles” or “GAAP” means those accounting principles as established by the American Institute of Certified Public Accountants.

(r) As used in this document and 405 IAC 1-14.6, “incomplete MDS resident assessment” means an assessment that does not contain all data items that are required to classify a resident pursuant to the RUG-III resident classification system, for example, MDS RUG fields that include blanks, out-of-range, or inconsistent responses, or an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(s) As used in this document and 405 IAC 1-14.6, “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. Indirect care services and supplies include the following:

- (1) Allowable dietary services and supplies.
- (2) Raw food.
- (3) Patient laundry services and supplies.
- (4) Patient housekeeping services and supplies.
- (5) Plant operations services and supplies.
- (6) Utilities.
- (7) Social services.
- (8) Activities supplies and services.
- (9) Recreational supplies and services.
- (10) Repairs and maintenance.

(t) As used in this document and 405 IAC 1-14.6, “minimum data set (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 the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration.

(u) As used in this document and 405 IAC 1-14.6, “medical and nonmedical supplies and equipment” include those items generally required to assure adequate medical care and personal hygiene of patients.

(v) As used in this document and 405 IAC 1-14.6, “normalized allowable cost” means total allowable direct patient care costs for each facility divided by that facility’s average case mix index (CMI) for all residents.

(w) As used in this document and 405 IAC 1-14.6, “office” means the office of Medicaid policy and planning.

(x) As used in this document and 405 IAC 1-14.6, “ordinary patient-related costs” means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(y) As used in this document and 405 IAC 1-14.6, “patient/recipient care” means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(z) As used in this document and 405 IAC 1-14.6, “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 document and 405 IAC 1-14.6.

(aa) As used in this document and 405 IAC 1-14.6, “related party/organization” means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(bb) As used in this document and 405 IAC 1-14.6, “RUG-III resident classification system” means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI and facility-average CMI for Medicaid residents.

(cc) As used in this document and 405 IAC 1-14.6, “therapy component” means the portion of each facility’s direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors, as determined by this document and 405 IAC 1-14.6.

(dd) As used in this document and 405 IAC 1-14.6, “unit of service” means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(ee) As used in this document and 405 IAC 1-14.6, “unsupported MDS resident assessment” means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system is not supported according to the MDS supporting documentation guidelines as set forth in this document and in 405 IAC 1-15.

(ff) As used in this document and 405 IAC 1-14.6, “untimely MDS resident assessment” means a significant change MDS assessment, as defined by CMS’s Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident’s condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by this document and 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy.

SECTION 2. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing change of provider transactions unless otherwise prescribed by this document or 405 IAC 1-14.6.

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

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

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

(d) Each provider shall submit confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

(e) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this document and 405 IAC 1-14.6, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field or desk audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

(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 an annual financial report coincidental with the time period for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improve efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient-related lies with the provider.

SECTION 3. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.

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

- (1) Patient census data.
- (2) Statistical data.
- (3) Ownership and related party information.
- (4) Statement of all expenses and all income, excluding non-Medicaid routine income.
- (5) Detail of fixed assets and patient-related interest bearing debt.
- (6) Complete balance sheet data.
- (7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.
- (8) Certification by the provider that:
 - (A) the data are true, accurate, related to patient care; and
 - (B) expenses not related to patient care have been clearly identified.
- (9) 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.

(d) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the

office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.

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

(1) No rate review shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the new operation is not currently enrolled or submitting MDS assessments under the Medicare program and the provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment, or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or transfer to hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or transfer to hospital.

(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has transmitted incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has untimely MDS resident assessments, then such assessment(s) shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).

(k) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office or its contractor shall audit a sample of MDS resident assessments and will determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the sample that are unsupported is greater than the threshold percent as shown in column (B) of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are unsupported is equal to or less than the

threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the MDS audit and no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on all residents, the office or its contractor will determine the percent of assessments audited that are unsupported.

(4) If the percent of assessments of all residents that are unsupported is greater than the threshold percent as shown in column (B) of the table below, a corrective remedy shall apply, which shall be calculated as follows. The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below. In the event a corrective remedy 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 or its contractor to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments of all residents that are unsupported is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the audit and no corrective remedy shall apply.

(6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table in this subdivision, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) as follows:

| Effective Date | Threshold Percent | Administrative Component Corrective Remedy Percent |
|-----------------|-------------------|--|
| (A) | (B) | (C) |
| October 1, 2002 | 40% | 5% |
| January 1, 2004 | 30% | 10% |
| April 1, 2005 | 20% | 15% |

(l) Based on findings from the MDS audit, beginning on the effective date of this document, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in this document and 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in this document and 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(m) Beginning on the effective date of this document, upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made.

SECTION 4. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. 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 retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's case mix index for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's case mix index for Medicaid residents. 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 document and 405 IAC 1-14.6 shall apply.

(b) Prior to the first annual rate review, the rate will be adjusted effective on each calendar quarter pursuant to SECTION 5(d) of this document to account for changes in the provider's case mix index for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the initial

interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor.

SECTION 5. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative and capital components shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The normalized allowable per patient day cost for direct care, and the allowable per patient day costs for the therapy, indirect care, administrative, and capital components shall be established once per year for each provider based on the annual financial report.

(c) The rate effective date of the annual rate review shall be the first day of the second calendar quarter following the provider's reporting year end.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will 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 will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be updated each calendar quarter and shall be used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office.

SECTION 6. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

| <u>Effective Date</u> | <u>Midpoint Quarter</u> |
|-----------------------|-------------------------|
| January 1, Year 1 | July 1, Year 1 |
| April 1, Year 1 | October 1, Year 1 |
| July 1, Year 1 | January 1, Year 2 |
| October 1, Year 1 | April 1, Year 2 |

(b) Notwithstanding subsection (a), beginning on the effective date of this document through September 30,

2003, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, 2003, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report for which a rate has been established shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) The normalized average allowable cost of the median patient day for direct care costs and the average allowable cost of the median patient day for indirect care, administrative and capital-related costs shall not be less than the average allowable cost of the median patient day effective October 1, 1998.

(e) Allowable costs per patient day for capital-related costs shall be computed based on an occupancy level equal to the greater of ninety-five percent (95%), or the provider's actual occupancy from the most recently completed historical period.

(f) The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents, and the facility-average CMI for Medicaid residents.

| RUG-III Group | RUG-III Code | CMI Table |
|------------------------|--------------|-----------|
| Special Rehabilitation | RAD | 2.02 |
| Special Rehabilitation | RAC | 1.69 |
| Special Rehabilitation | RAB | 1.50 |
| Special Rehabilitation | RAA | 1.24 |
| Extensive Services | SE3 | 2.69 |
| Extensive Services | SE2 | 2.23 |
| Extensive Services | SE1 | 1.85 |
| Special Care | SSC | 1.75 |
| Special Care | SSB | 1.60 |
| Special Care | SSA | 1.51 |
| Clinically Complex | CC2 | 1.33 |
| Clinically Complex | CC1 | 1.27 |
| Clinically Complex | CB2 | 1.14 |
| Clinically Complex | CB1 | 1.07 |
| Clinically Complex | CA2 | 0.95 |
| Clinically Complex | CA1 | 0.87 |
| Impaired Cognition | IB2 | 0.93 |
| Impaired Cognition | IB1 | 0.82 |
| Impaired Cognition | IA2 | 0.68 |
| Impaired Cognition | IA1 | 0.62 |
| Behavior Problems | BB2 | 0.89 |
| Behavior Problems | BB1 | 0.77 |
| Behavior Problems | BA2 | 0.67 |
| Behavior Problems | BA1 | 0.54 |

| | | |
|----------------------------|-----|------|
| Reduced Physical Functions | PE2 | 1.06 |
| Reduced Physical Functions | PE1 | 0.96 |
| Reduced Physical Functions | PD2 | 0.97 |
| Reduced Physical Functions | PD1 | 0.87 |
| Reduced Physical Functions | PC2 | 0.83 |
| Reduced Physical Functions | PC1 | 0.76 |
| Reduced Physical Functions | PB2 | 0.73 |
| Reduced Physical Functions | PB1 | 0.66 |
| Reduced Physical Functions | PA2 | 0.56 |
| Reduced Physical Functions | PA1 | 0.50 |
| Unclassifiable | BC1 | 0.48 |
| Delinquent | BC2 | 0.48 |

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

- (1) Two (2) preliminary CMI reports. These preliminary CMI reports serve as confirmation of the MDS assessments transmitted by the nursing facility, and provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments. The first preliminary report will be provided by the seventh day of the first month following the end of a calendar quarter. The second preliminary report will be provided by the seventh day of the second month following the end of a calendar quarter.
- (2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(h) The office may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to such facilities at a rate of eight dollars and seventy-nine cents (\$8.79) per Medicaid resident day.

SECTION 7. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative and capital components, plus a potential profit add-on payment. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

- (1) The indirect care, administrative, and capital components, are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).
- (2) The therapy component is equal to the provider's allowable per patient day costs.
- (3) The direct care component is equal to the provider's normalized allowable per patient day costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(b) The profit add-on payment will be calculated as follows:

- (1) For the direct care component, the profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:
 - (A) the normalized average allowable cost of the median patient day for direct care costs times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus
 - (B) a provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.
- (2) For the indirect care component, the profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:
 - (A) the average allowable cost of the median patient day times one hundred percent (100%); minus
 - (B) a provider's allowable per patient day cost.
- (3) For the administrative component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%); minus
(B) a provider's allowable per patient day cost.

(4) For the capital component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus
(B) a provider's allowable per patient day cost.

(5) For the therapy component, the profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs, times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).

(2) The average allowable cost of the median patient day for indirect care costs times one hundred percent (100%).

(3) The average allowable cost of the median patient day for administrative costs times one hundred percent (100%).

(4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).

(5) For the therapy component, no overall rate component limit shall apply.

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall 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).

SECTION 8. (a) Therapy services provided to Medicaid recipients by nursing facilities are included in the established rate. Under no circumstances shall therapies for nursing facility residents be billed to Medicaid through any provider. Therapy services for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed by Medicaid.

(b) For purposes of determining allowable therapy costs, the office or its contractor shall adjust each provider's cost of therapy services reported on the Nursing Facility Financial Report, including any employee benefits prorated based on total salaries and wages, to account for non-Medicaid payers, including Medicare, of therapy services provided to nursing facility residents. Such adjustment shall be applied to each cost report in order to remove reported costs attributable to therapy services reimbursed by other payers. The adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

SECTION 9. This section requires nursing facilities certified to provide nursing facility care to Medicaid recipients to electronically transmit minimum data set (MDS) information for all residents, including residents in a noncertified bed, to the office of Medicaid policy and planning for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes.

SECTION 10. (a) The office or its contractor shall periodically audit the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such audits shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be audited no less frequently than every fifteen (15) months. Advance notification of up to seventy-two (72) hours shall be provided by the office or its contractor for all MDS audits, except for follow-up audits that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up audits shall not be required.

(b) The MDS assessments subject to audit will include those assessments most recently transmitted to the office or its contractor in accordance with SECTION 9 of this document. The office may audit additional MDS

assessments if it is deemed necessary. All supportive documentation to be considered for MDS audit must meet the criteria as specified in Section AA9 on the MDS Version 2.0 Basic Assessment Tracking Form.

(c) When conducting the MDS audits, the office or its contractor shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the auditors prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office or its contractor, a computer generated copy of the MDS assessment that is transmitted in accordance with SECTION 9 of this document, which shall be the basis for the MDS audit.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments have been transmitted, shall be referred to the Medicaid fraud control unit (MFCU) of the Indiana attorney general's office for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

SECTION 11. Nursing facilities shall complete and transmit to the office or its contractor a new full or quarterly MDS assessment for all residents not in a continuing Medicare Part A stay after the conclusion of all physical, speech, and occupational therapies. This requirement only applies when the immediately preceding assessment for a resident classified him/her in the Rehabilitation category. Such new full or quarterly assessments shall be completed in order that the MDS assessment reference date (A3a) shall be no earlier than eight (8) days and no later than ten (10) days after the conclusion of all physical, speech, and occupational therapies. If the resident expires or is discharged from the facility, no such new full or quarterly assessment is required.

SECTION 12. This document expires March 26, 2002.

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