TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #10-183(F)

DIGEST

Amends 405 IAC 1-14.6-2, 405 IAC 1-14.6-4, 405 IAC 1-14.6-7, 405 IAC 1-15-2, 405 IAC 1-15-3, 405 IAC 1-15-5, and 405 IAC 1-15-6 to comport with federal requirements (42 CFR Part 483) implementing version 3.0 of the Minimum Data Set (MDS) effective October 1, 2010; to require resident room numbers be completed and submitted since this information is essential to correctly determine Medicaid case mix reimbursement for special care units; to remove the MDS transmission, therapy and nursing restorative requirements since these requirements are now included in federal regulations; to increase the percentage that the administrative reimbursement component is reduced due to unsupported resident assessment to provide a stronger incentive for facilities to meet minimum MDS requirements; to increase the maximum frequency between MDS audits from no less often than once every 15 months under the current rule to no less often than every 36 months to recognize a reduced overall risk of unsupported assessments; and to modify the frequency and time period that preliminary CMI reports are issued to better correspond with the MDS reporting cycle. Repeals 405 IAC 1-15-7. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 1-14.6-2; 405 IAC 1-14.6-4; 405 IAC 1-14.6-7; 405 IAC 1-15-2; 405 IAC 1-15-3; 405 IAC 1-15-5; 405 IAC 1-15-6; 405 IAC 1-15-7

SECTION 1. 405 IAC 1-14.6-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-2 Definitions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

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. Administrative services and supplies include the following:
(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
(A) allowable and patient-related; and
(B) 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).

(c) "Allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between

allowable fixed costs and patient days using the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(d) "Allowed profit add-on payment" means the portion of a facility's tentative profit add-on payment that, except as may be limited by application of the overall rate ceiling as defined in this rule, shall be included in the facility's Medicaid rate, and is determined based on the facility's nursing home report card score based on the latest published data as of the end of each state fiscal year.

(e) "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 rule.

(f) "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 variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of:

(1) the minimum occupancy requirements as contained in this rule; or

(2) each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(g) "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 section 14(a) of this rule.

(h) "Calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(i) "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.

(j) "Case mix index" or "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.

(k) "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.

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

(m) "Delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the ~~R2b~~ date ~~field on the MDS.~~ **defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the guidelines for use in determining the time-weighted CMI under section 9(e) of this rule.** This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(n) "Desk review" means a review and application of these regulations to a provider submitted annual financial report

including accompanying notes and supplemental information.

(o) "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 of the following:

(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.
(8) Medical records costs.

(p) "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.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(r) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(s) "Forms prescribed by the office" means either of the following:

(1) Cost reporting forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(t) "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.

(u) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(v) "Incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(w) "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) 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.

(x) "Medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients.

(y) "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 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 (9/2000) 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).

(z) "Normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average CMI for all residents.

(aa) "Nursing home report card score" means a numerical score developed and published by the Indiana state department of health (ISDH) that quantifies each facility's key survey results.

(bb) "Office" means the office of Medicaid policy and planning.

(cc) "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.

(dd) "Patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(ee) "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.

(ff) "Related party/organization" means that the provider:
(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;
the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(gg) "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 for all residents and facility-average CMI for Medicaid residents.

(hh) A nursing facility with a "special care unit (SCU) for Alzheimer's disease or dementia" means a 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 April 1, 1997, 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.

~~(hh)~~ **(ii)** "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's nursing home report card score.

~~(ii)~~ **(jj)** "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 rule.

~~(jj)~~ **(kk)** "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).

~~(kk)~~ **(ll)** "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:

(1) are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15; and

(2) result in the assessment being classified into a different RUG-III category.

~~(ll) "Untimely MDS resident assessment" means either of the following:~~

~~(1) A significant change MDS assessment, as defined by CMS' 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.~~

~~(2) A full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6 following the conclusion of all:~~

~~(A) physical therapy;~~

~~(B) speech therapy; and~~

~~(C) occupational therapy.~~

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-2; filed Aug 12, 1998, 2:27 p.m.: 22 IR 69, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2238; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2462; filed Oct 10, 2002, 10:47 a.m.: 26 IR 707; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3869; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2975; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA)

SECTION 2. 405 IAC 1-14.6-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial 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 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:

(1) may be exercised only one (1) time by a provider; and

(2) must coincide with the fiscal year end for Medicare cost reporting purposes.

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. 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.

(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 the last day of the fifth calendar month 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. 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.

(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, and 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.

(10) A copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.

(11) A copy of the crosswalk document used to prepare the Medicaid cost report 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.

(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(13) Schedule for SCU for Alzheimer's disease or dementia.

(d) An extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services 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 reports are received.

(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) 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. If the:

(A) Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary; and

(B) provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary;

then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(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. An 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:

(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.

(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 a transfer to a hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a 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 incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI 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, the assessment or assessments shall be assigned the CMI 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 unsupported MDS resident assessments, then the assessment or assessments shall be counted as an unsupported assessment for purposes of determining whether a corrective remedy shall be applied under subsection (k).~~

~~(k)~~ **(j)** 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:

(A) shall audit a sample of MDS resident assessments; and

(B) ~~will~~ 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 greater than ~~the threshold~~ **twenty** percent ~~as shown in column (B) of the table below,~~ **(20%),** the office or its contractor shall expand ~~the scope of the MDS audit~~ to ~~all~~ **a larger sample of** residents **assessments.** If the percent of assessments in the **initial** sample that are unsupported is equal to or less than ~~the threshold~~ **twenty** percent ~~as shown in column (B) of the table below:~~ **(20%):**

(A) the office or its contractor shall conclude the field portion of the MDS audit; and

(B) no corrective remedy shall be applied.

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

(4) If the percent of assessments **for the initial and expanded sample** of all **assessment audited** residents that are unsupported is greater than ~~the threshold~~ **twenty** percent ~~as shown in column (B) of the table below,~~ **(20%),** a corrective remedy shall apply, which shall be calculated as follows:

(A) 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 **following** table: ~~below:~~

MDS Field Audit for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field audit	**15%**
Second consecutive MDS field audit	**20%**
Third consecutive MDS field audit	**30%**
Fourth or more consecutive MDS field audit or audits	**50%**

(B) 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.

(C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments **for the initial and expanded sample** of all ~~residents~~ **assessments audited** that are unsupported is equal to or less than ~~the threshold~~ **twenty** percent ~~as shown in column (B) of the table below:~~ **(20%):**

(A) the office or its contractor shall conclude the MDS audit; and

(B) 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)~~ **(k)** Based on findings from the MDS audit, beginning on the effective date of this rule, 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 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 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)~~ **(l)** 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:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-4; filed Aug 12, 1998, 2:27 p.m.: 22 IR 72, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2240; errata filed Jun 21, 1999, 12:25 p.m.: 22 IR 3419; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2465; filed Oct 10, 2002, 10:47 a.m.: 26 IR 709; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA)

SECTION 3. 405 IAC 1-14.6-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 7. (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 CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
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 July 1, 2011, 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). 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 used to establish a Medicaid rate for the previous provider 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) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on the following minimum occupancy levels:

(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.

(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%) or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the applicable minimum occupancy requirement described in subsection (d), if both of the following conditions can be established to the satisfaction of the office:

(1) The provider demonstrates that its current resident census has:

(A) increased to the applicable minimum occupancy level described in subsection (d), or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period; and

(B) remained at such level for not fewer than ninety (90) days.

(2) The provider demonstrates that its resident census has:

(A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and

(B) remained at such level for not fewer than ninety (90) days.

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

(g) Except as provided for in subsection (h), the 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
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
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

(h) In place of the CMIs contained in subsection (g), beginning on the effective date of this rule amendment and continuing thereafter, the CMIs contained in this subsection shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one (1) of the following RUG-III groups:

(A) PB2.

(B) PB1.

(C) PA2.

(D) PA1.

(2) The resident has a cognitive **status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, then a cognitive** performance score (CPS) of:

(A) zero (0) – Intact;

(B) one (1) – Borderline Intact; or

(C) two (2) – Mild Impairment.

(3) Based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence control.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before the effective date of this rule amendment.

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned ninety-six percent (96%) of the CMI associated with the RUG-III group determined in this subsection.

		CMIs effective for the period following the effective date of this rule amendment		
RUG-III Group	RUG-III Code	The first calendar quarter through the fourth calendar quarter	The fifth calendar quarter through the eighth calendar quarter	The ninth calendar quarter and thereafter
Reduced Physical Functions	PB2	0.48	0.41	0.30
Reduced Physical Functions	PB1	0.44	0.38	0.28
Reduced Physical Functions	PA2	0.38	0.32	0.24
Reduced Physical Functions	PA1	0.33	0.28	0.21

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

(1) ~~Two (2) preliminary CMI reports. These~~ **A** preliminary CMI ~~reports:~~ **report that will:**

(A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and

(B) 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~~ **twenty-fifth** day of the ~~second~~ **first** 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.

(j) 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 the facilities at a rate of eleven dollars and fifty cents ($11.50) per Medicaid resident day. The additional reimbursement shall:

(1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and

(2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning July 1, 2003, through June 30, 2011, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on effective with this rule amendment and each July 1 thereafter, the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of each state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table:

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-On
0 – 82	$5.75
83 – 265	$5.75 – ((Nursing Home Report Card Score – 82) × $0.03125)
266 and above	$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year may receive a per patient day rate add-on equal to two dollars ($2).

(l) Beginning effective July 1, 2003, through June 30, 2011, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, ~~and operate a special care unit (SCU) for such residents~~ as demonstrated by resident assessment data **as of March 31 of each year.** The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid resident day in their SCU. Only facilities ~~with~~ **that meet the definition for** a SCU for Alzheimer's disease or dementia ~~as demonstrated by resident assessment data as of March 31 of each year~~ shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(m) Nursing facilities that satisfy each of the four (4) conditions listed in this subsection shall qualify for a capital component rate add-on:

(1) Twenty-five percent (25%) or more of its residents as of December 31, 2006, were under the chronological age of twenty-one (21) years of age.

(2) According to the last health facility survey conducted by Indiana state department of health on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i).

(3) The facility bedrooms accommodate no more than four (4) residents.

(4) The facility bedrooms measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.

(n) The capital component rate add-on referenced in subsection (m) shall be calculated by dividing the qualifying facility's debt service associated with financing acquired exclusively to fund any capital costs incurred by the provider to come into compliance with 42 CFR 483.70(d)(1)(i), divided by total patient days from the facility's latest completed annual financial

report. For purposes of this provision, debt service shall mean the total annual interest and principal payments required to be paid on any such financing arrangement or arrangements. The capital component rate add-on shall be determined upon qualification for the add-on shall be determined following the provider's demonstration to the office of qualification for this provision, and shall become effective on the date the provider successfully completes the health facility survey of any new beds as conducted by the state department of health. The capital component rate add-on shall not be updated annually. Refinancing shall be recognized only when the interest rate is less than the original financing. The capital component rate add-on shall continue to apply until the associated financing has been fully paid.

(o) The capital component rate add-on described under subsection (n) shall be exempt from the capital component overall rate ceiling as determined under section 9(c)(4) of this rule.

(p) The capital component rate add-on described under subsection (n) shall be exempt from the maximum allowable increase as determined under section 23 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-7; filed Aug 12, 1998, 2:27 p.m.: 22 IR 74, eff Oct 1, 1998; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2243; readopted filed Jun 27, 2001, 9:40 a.m.:24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2468; filed Oct 10, 2002, 10:47 a.m.: 26 IR 712; errata filed Feb 27, 2003, 11:33 a.m.: 26 IR 2375; filed Jul 29, 2003, 4:00 p.m.: 26 IR 3873; filed Apr 24, 2006, 3:30 p.m.: 29 IR 2978; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 3, 2009, 1:44 p.m.: 20090429-IR-405080602FRA; filed Nov 12, 2009, 4:01 p.m.: 20091209-IR-405090215FRA)*

SECTION 4. 405 IAC 1-15-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-2 Definitions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

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) "Minimum data set" 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 the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. Version 2.0 ~~(1/30/98)~~ **(9/2000)** 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 ~~Health Care Financing Administration (HCFA).~~ **Centers for Medicare and Medicaid Services (CMS).**

(d) "Office" means the office of Medicaid policy and planning. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-2; filed Nov 1, 1995, 8:30 a.m.: 19 IR 350; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

SECTION 5. 405 IAC 1-15-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-3 General requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) The office shall ~~do the following:~~
~~(1) Adopt a schedule for nursing facility MDS data electronic transmission, based on the federal assessment schedule established by HCFA.~~
~~(2) Specify the method by which data shall be transmitted to the office, or its contractor, by nursing facilities.~~
~~(3)~~ provide nursing facilities with technical support in preparing MDS transmission to the office, or its contractor, including, but not limited to, the following:

~~(A)~~ **(1)** Providing training on the transmission of MDS data.
~~(B) Establishing standards for computer software and hardware for use in MDS data transmission.~~
~~(C)~~ **(2)** Any other support that the office deems necessary for successful transmission of MDS data.

(b) Allowable costs incurred by nursing facilities relating to transmission of MDS data to the office shall be reimbursed through the cost reporting mechanism established under 405 IAC 1-14.6. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-3; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2248; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

SECTION 6. 405 IAC 1-15-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-5 MDS audit requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (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~~ **The** 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)~~ **thirty-six (36)** 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~~ **All** MDS assessments, **regardless of payer type, are** subject to **an MDS** audit. ~~will include those assessments most recently transmitted to the office or its contractor in accordance with section 1 of this rule. 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 1 of this rule, 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. *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-5; filed Mar 2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)*

SECTION 7. 405 IAC 1-15-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-15-6 MDS assessment requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Nursing facilities shall complete and transmit ~~to the office or its contractor a new~~ **the resident's room number on all** 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.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 1-15-6; filed Mar*

2, 1999, 4:42 p.m.: 22 IR 2249; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:30 p.m.: 25 IR 2471; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 8. 405 IAC 1-15-7 IS REPEALED.

Notice of Public Hearing