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State/Territory Name: Indiana

State Plan Amendment (SPA) #: 20-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

November 9, 2020

Allison Taylor, Medicaid Director
Family Social Services Administration
402 West Washington, Room W461
Indianapolis, IN 46204

RE: State Plan Amendment (SPA) 20-0013

Dear Ms. Taylor:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0013. This State Plan Amendment makes changes to implement an end of therapy reclassification methodology in the RUG IV, 48-Group model for payment of nursing facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2020. We are enclosing the CMS-179 (HCFA-179) and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

For

Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 20-013

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 413.337

7. FEDERAL BUDGET IMPACT (*thousands*):
a. FFY 2020 $ (600)
b. FFY 2021 $ (2,200)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D 4-9; 13-15; 21-23; 45, 47,

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D 4-9; 13-15; 21-23; 45, 47

10. SUBJECT OF AMENDMENT:
This State Plan amendment makes changes to the State Plan per Indiana Code 12-15-14-8(b) which directs the Office of Medicaid Policy and Planning to implement an end of therapy reclassification methodology in the RUG IV, 48-Group model for payment of nursing facilities.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Allison Taylor

14. TITLE: Medicaid Director

15. DATE SUBMITTED: September 1, 2020

16. RETURN TO:
Allison Taylor
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Sara Albertson, Federal Relations Lead

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/1/2020

18. DATE APPROVED: 11/9/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For

21. TYPED NAME: Rory Howe

2 Acting Director

23. REMARKS:

(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 date defined by CMS for determining delinquency or an assessment that is not completed within the time prescribed in the requirement 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) "Department head" means an individual(s) responsible for the supervision and management of a nursing facility department. Home Office personnel responsible for the supervision and oversight of facility department heads qualify as general line personnel.

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

(p) "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 performed by licensed or certified nursing staff.
(2) Nurse consulting services directly related to the provision of hands-on resident care.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records personnel and software costs.
(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental costs for these items are limited to one dollar and fifty cents ($1.50) per resident day.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and nonlegend sterile water products used for irrigation or humidification.
(13) Educational seminars for direct care staff.
(14) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis by the member, nursing facility care staff, or by prescriber's order as a part of routine care as defined in subsection (mm).
(15) Parenteral and Enteral Nutrition costs other than meals, nutritional supplements, sterile water, and legend and non-legend drugs.
(16) Costs for the coding and input of MDS data.

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

(r) "Episode" means a continuous time period of physical therapy, occupational therapy, or speech therapy that may include one or more therapy regimen(s) during a stay.

(s) "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.

(t) "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.

(u) "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%

(v) "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.

(w) "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.

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

(y) "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.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) Non-Ambulance transportation costs related to activities and other non-covered services.
(15) Admissions.
(16) Behavioral and Psychological consulting services.
(17) Nursing consulting services, whether provided by internal facility personnel, central office personnel, or contracted, that are not directly related to the provision of hands-on resident care. Such nursing consulting services include, but are not limited to:
(A) health survey;
(B) quality assurance processes; and
(C) MDS consultation (excluding data input and coding).
(18) Non-nursing patient care services performed by either certified or non-certified personnel that perform attendant, sitter, minder or other indirect care functions.

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

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

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

(cc) "Nursing home health survey score" means the total weighted health survey score developed and published by CMS that quantifies each facility's key survey results.

(dd) "Occupational Therapy" means services provided by a licensed occupational therapist or licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

(ee) "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.

(ff) "Pastoral Care" means care performed by a member of any religious order that is spiritual in nature or provides spiritual value, which means to counsel others.

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

(hh) "Physical Therapy" means services provided by a licensed physical therapist or certified physical therapist's assistant under the direct supervision of a licensed physical therapist or physician.

(ii) "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.

(jj) "Regimen" means a systematic plan for physical, occupational, and/or speech therapy designed to improve and maintain the health of a resident.

(kk)"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.

(ll) "Respiratory Therapy" mean services provided by a licensed respiratory therapists or certified respiratory therapy technician.

(mm) "Routine care" means care that does not treat or ameliorate a specific defect or specific physical or mental illness or condition.

(nn) "RUG-IV resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG-IV group, the RUG-IV group with the greatest CMI will be utilized to calculate the facility-average CMI for all residents and facility-average CMI for Medicaid residents.

(oo) "Speech Therapy" means speech pathology services rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist or a registered speech-language pathology aide. Speech Therapy services also include audiology services rendered by a licensed audiologist or a person registered for his or her clinical fellowship year who is supervised by a licensed audiologist or a registered audiology aide under the direct on-site supervision of a licensed audiologist.

(pp) 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 August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

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

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

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

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

(D) Performs the following duties:

(i) Oversees the operations of the unit.

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

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

(qq) "Tentative profit add-on payment" means the profit add-on payment calculated under this rule before considering a facility's total quality score.

(rr) "Therapy component" means the portion of each facility's 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. Therapy services shall be limited to the following:

(1) Physical Therapy
(2) Occupational Therapy
(3) Speech Therapy
(4) Respiratory Therapy.

(ss) "Total quality score" means the sum of the quality points awarded to each nursing facility for all four (4) quality measures as determined in section 7(m)(1) through 7(m)(4) of this rule.

(tt) "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).

(uu) "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-IV resident classification system:

(1) are not supported according to the MDS supporting documentation requirements as set forth in 405 IAC 1-15; and
(2) result in the assessment being classified into a different RUG-IV category.

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

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

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.
(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.
(3) Costs must be reported in conformance with GAAP.

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

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

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

(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 is a direct product of the accounting system for both the facility and home office (if applicable) that was used in the preparation of their submitted annual financial report.
(11) A copy of the trial balance crosswalk document used to prepare the Medicaid cost report (facility and home office, if applicable) that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report. The crosswalk must be sorted and subtotaled by Medicaid line number.
(12) Detailed schedule of provider adjustments reported on Schedule E, column 24.
(13) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.
(14) Medicare cost report for Medicare certified providers.
(15) A copy of the working trial balance that is a direct product of the accounting system for related entities whose costs or assets are reported on the annual financial report.
(16) Workpapers supporting all related entities removal of profit and nonallowable costs.

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

(e) Failure to submit a complete annual financial report as defined in subsection (c) above 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 a complete annual financial report is more than one (1) calendar month past due, the rate effective immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent complete 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 complete 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 its 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 and end of therapy date information in a complete, accurate, and timely manner. MDS resident assessment and end of therapy date 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 and end of therapy date 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-IV classifications:
(1) LC2 classification for residents discharged before completing an initial assessment where the reason for discharge was death or a transfer to a hospital.
(2) RAB classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a hospital.

(h) If the office 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-IV group "BC1 - Delinquent".

(i) If the office determines due to an MDS review that a nursing facility has unsupported MDS resident assessments or end of therapy dates, then the following procedures shall be followed in applying any corrective remedy:
(1) The office shall:
(A) review a sample of MDS resident assessments;
(B) determine the percent of assessments in the sample that are unsupported; and
(C) review a sample of end of therapy dates.
(2) If the percent of assessments in the initial sample that are unsupported is greater than twenty percent (20%), the office shall expand to a larger sample of residents assessments. If the percent of assessments in the initial sample that are unsupported is equal to or less than twenty percent (20%):
(A) the office shall conclude the field portion of the MDS review; and
(B) no corrective remedy shall be applied.
(3) For nursing facilities with MDS reviews performed on the initial and expanded sample of residents assessments, the office will determine the percent of all assessments reviewed that are unsupported.
(4) If the percentage of unsupported assessments for the initial and expanded sample of all assessments reviewed is greater than twenty percent (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 review shall be reduced by the percentage as shown in the following table:

MDS Field Review for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field review	15%
Second consecutive MDS field review	20%
Third consecutive MDS field review	30%
Fourth or more consecutive MDS field review or reviews	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 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 assessments reviewed that are unsupported is equal to or less than twenty percent (20%):

(A) the office shall conclude the MDS review; and

(B) no corrective remedy shall apply.

(j) Based on findings from the MDS review the office shall make adjustments or revisions to all MDS data items and end of therapy dates that are required to classify a resident pursuant to the RUG-IV resident classification system that are not supported according to the MDS supporting documentation requirements as set forth in 405 IAC 1-15. Such adjustments or revisions to the MDS and end of therapy date 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 requirements as set forth in 405 IAC 1-15. The resident assessment and end of therapy date data will then be used to reclassify the resident pursuant to the RUG-IV resident classification system by incorporating any adjustments or revisions made by the office.

(k) Upon conclusion of an MDS review, the office shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(l) The Employee Turnover report (Schedule X) and the Special Care Unit report (Schedule Z) shall be completed by all providers based on the calendar year (January 1 through December 31) reporting period. Schedules X and Z must be submitted to the office not later than March 31 following the end of each calendar year. Reports submitted after March 31 will not be considered in the determination of the subsequent annual rate review.

(g) In place of the CMIs contained in subsection (f), 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-IV groups:

(A) PB2.

(B) PB1.

(C) PA2.

(D) PA1.

(2) The resident has a cognitive status indicated by a brief interview of mental status (BIMS) score 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 bowel continence control as reported on the MDS, the resident is not experiencing occasional, frequent, or complete incontinence.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.

(5) If the office 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-IV group determined in this subsection.

RUG-IV Group	RUG-IV Code	CMI Table
Reduced Physical Functions	PB2	0.29
Reduced Physical Functions	PB1	0.28
Reduced Physical Functions	PA2	0.21
Reduced Physical Functions	PA1	0.19

(h) For purposes of determining the CMI:

(1) When a therapy end date is reported, assessments classified in a rehabilitation RUG-IV category shall be re-classified without therapy minutes and therapy days beginning the calendar day following the reported end of the therapy episode.

(2)When an end of therapy date is not reported for:

(A) non-Medicaid assessments, the rehabilitation RUG-IV category shall continue until the next assessment.

(B) Medicaid assessments, the rehabilitation RUG-IV category shall be re-classified without therapy minutes and therapy days beginning the calendar day following the reported start of the therapy episode.

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

(1) A preliminary CMI 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 but completed or any corrected MDS assessments and end of therapy dates.

The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments and end of therapy dates received by the fifteenth day of the second month following the end of a calendar quarter. These assessments and end of therapy dates 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 will 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) The office will increase Medicaid reimbursement to nursing facilities that provide specialized care to Medicaid residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of December 31 of each year. Medicaid Alzheimer's and dementia residents shall be determined to be in the SCU based on an exact match of room numbers reported on Schedule Z with the room numbers reported on resident assessments and tracking forms. Resident assessments and tracking forms with room numbers that are not an exact match to the room numbers reported on Schedule Z will be excluded in calculating the number of Medicaid Alzheimer's and dementia resident days in their SCU. Resident days used in this calculation shall be based on the time-weighted days from the final CMI reports utilizing MDS assessments. The additional Medicaid reimbursement shall equal twelve dollars ($12) per Medicaid Alzheimer's and dementia resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. The additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(l) The office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on each facility's total quality score. For purposes of determining the nursing facility quality rate add-on, each nursing facility shall be awarded a total quality score no greater than one hundred (100). Each nursing facility's quality rate add-on shall be determined as follows:

Nursing Facility Total Quality Score	Nursing Facility Quality Rate Add-On
0 – 23	$0
24 – 79	$18.45 – ((80 - Nursing Facility Total Quality Score) × 0.323684)
80 – 100	$18.45

(m) Each facility's total quality score will be determined annually based on the points from the criteria below:

(1) Nursing home health survey score. The office shall determine each nursing facility's quality points using the nursing home health survey score.

(A) Effective July 1, 2019, each nursing facility shall be awarded not more than fifty-five (55) quality points based on its nursing home health survey score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published nursing home health survey score as of June 30, 2019. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Health Survey Scores	Quality Points Awarded
0 – 21	55
22 – 77	Proportional quality points awarded as follows: 55 – [(nursing home health survey score – 21) × 0.96491228]]
78 and above	0

(B) Effective July 1, 2020 and thereafter, each nursing facility shall be awarded not more than twenty-five (25) quality points based on its nursing home health survey score. Each nursing facility's quality points shall be determined using each nursing facility's most recently published nursing home health survey score as of June 30, 2020, and each June 30 thereafter. Each nursing facility's quality points under this subdivision shall be determined as follows:

Nursing Home Health Survey Scores	Quality Points Awarded
0 – 21	25
22 – 77	Proportional quality points awarded as follows: 25 – [(nursing home health survey score – 21) × 0.4385965]]
78 and above	0

(C) Facilities that did not have a nursing home health survey score published as of June 30, shall be awarded the statewide average quality score for this measure.

(2) Long-stay quality measures.

(A) The office shall determine each nursing facility's long-stay quality points using the following nursing home compare long-stay quality measures published by CMS.

(i) Percentage of long-stay residents whose need for help with daily activities has increased

Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set

405 IAC 1-15-1 Scope

Sec. 1. (a) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit minimum data set (MDS) information for all nursing facility residents to the office. Such MDS information shall include the resident's room number on all comprehensive or quarterly MDS assessments and tracking forms. The MDS data is used to establish and maintain a case mix system for Medicaid reimbursement to nursing facilities and other Medicaid program management purposes.

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

405 IAC 1-15-2 Definitions

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

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

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

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

405 IAC 1-15-5 MDS review requirements

Sec. 5. (a) The office shall periodically review the MDS supporting documentation and end of therapy date data maintained by nursing facilities for all residents, regardless of payer type. The reviews shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be reviewed no less frequently than every thirty-six (36) months. Advance notification of up to seventy-two (72) hours shall be provided by the office for all MDS reviews, except for follow-up reviews that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up reviews shall not be required.

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

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

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

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