

FREE STANDING CLINIC SERVICES

The Office of Medicaid Policy and Planning (OMPP), in accordance with 42 CFR 447.325, will not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

OUTPATIENT HOSPITAL SERVICES

The reimbursement methodology for all covered outpatient hospital and freestanding and provider-based ambulatory surgical care center services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

- (a) Reimbursement for outpatient surgical procedures will be based on the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003. Surgical procedures shall be classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology and shall be paid a rate established for each ASC payment group. The Office of Medicaid Policy and Planning will classify outpatient surgical procedures not classified into an ASC group by Medicare into one of the nine ASC groups designated by Medicare, or additional payment groups.
- (b) Payments for emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the statewide fee schedule amount in effect during state fiscal year 2003.
- (c) Payments for nonemergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the statewide fee schedule amount in effect during state fiscal year 2003.
- (d) The fixed fee for laboratory procedures is based on the Medicare fee schedule amounts. Reimbursement for the technical component of radiology procedures is based on the statewide fee schedule amount in effect during state fiscal year 2003.
- (e) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., will be based on the Indiana Medicaid statewide fee schedule amounts in effect during state fiscal year 2003.
- (f) Payments will not be made for outpatient hospital and freestanding and provider-based ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

The established rates for hospital outpatient and freestanding and provider-based ambulatory surgical center reimbursement shall be reviewed annually by the Office of Medicaid Policy and Planning and adjusted no more frequently than every second year and in accordance with this section to ensure that revisions contain appropriate incentives for provision of primary and preventive care.

TN No. 03-020
Supersedes
TN No. 94-009

Approval Date _____

Effective Date 4/01/2004

MEDICAID OUTPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

“Safety-net hospital”, for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

A. For the state fiscal years ending on or after June 30, 2000, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital’s cost report filed with the office for the hospital’s fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid outpatient services provided by the hospital during the hospital’s fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital’s customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection A. of this section, subject to the provisions of subsection B. of this section.

B. If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

C. (1) For the Eligibility Period** beginning July 1, 2001, outpatient safety-net hospitals, meeting the office’s Medicaid safety-net criteria as described in A. above (the “office’s Medicaid outpatient safety-net criteria”), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office’s Medicaid outpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive outpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the “outpatient safety-net amount”). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable .

(2) For the Eligibility Periods beginning after June 30, 2001, an outpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid outpatient safety-net payment adjustment in the amount of 100% of the outpatient safety-net amount, will continue to receive Medicaid outpatient safety-net payment adjustments in the amount of 100% of the outpatient safety-net amount for subsequent Eligibility Periods in which it meets the office’s Medicaid outpatient safety-net criteria, unless the hospital has a lapse in meeting the office’s Medicaid outpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office’s Medicaid outpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid outpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid outpatient safety-net payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination† by the office, if the hospital is able to meet the office's Medicaid outpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid outpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, outpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

- (a) licensed under IC 16-21,
- (b) meeting the office's Medicaid outpatient safety-net criteria for the current Eligibility Period, and
- (c) which did not meet the office's Medicaid outpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid outpatient safety-net payment adjustments equal to 33 1/3% of their outpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

- (a) meeting the office's Medicaid outpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or
- (b) meeting the office's Medicaid outpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6) If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

This new payment methodology will only apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.

† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.

TN No. 03-015
Supercedes
TN No. NEW

Approval Date _____

Effective Date September 2, 2003

MUNICIPAL HOSPITAL PAYMENT ADJUSTMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A), Section 1903 (w)(3), and Section 1903 (w)(6) of the Act, the Indiana Medicaid program (the "Office") adopts the following definitions and methodologies to identify and make payment adjustments to Municipal Hospitals.

II. DEFINITIONS

"Non-State Government-Owned Or Operated Hospital" has the following meaning: a health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

"Municipal Hospital" has the following meaning: a non-state government-owned or operated health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, or Indiana Code 16-23.

"Medicaid Payments" are all payments made to Municipal Hospitals by on or behalf of the Office pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code. This includes, but is not limited to, claim specific payments for outpatient Medicaid services, non-claim specific additional Medicaid payments such as the Medicaid Hospital Care for the Indigent (HCI) add-on payments, and the payment adjustments provided for in this state plan amendment. This does not include the Disproportionate Share Hospital (DSH) payments made pursuant to Indiana Code 12-15-16 and 12-15-19, which contain the methodologies used to determine and distribute DSH payments.

"Medicaid Services" are those outpatient services provided by a Municipal Hospital that are reimbursable under the Medicaid program.

III. PAYMENT ADJUSTMENTS

A Municipal Hospital ("hospital") shall receive, in addition to its allowable regular Medicaid claims payments to which it is entitled, a payment adjustment calculated in the following manner:

- (1) For each state fiscal year ending after June 30, 2000, reimbursement in the form of a single payment, equal to the difference between:
 - (a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year; and

- (b) an amount equal to 100 percent of a reasonable estimate by the Office of the amount that would have been paid for those service under Medicare payment principles.
- (2) The payment adjustment identified above shall be made after the close of the applicable state fiscal year.
- (3) Notwithstanding the foregoing, subject to the applicable payment limits under 42 CFR 447.321, the office may enter into agreements with hospitals, individually or in combination, to permit hospitals to receive lesser or greater payment adjustments, made after the close of the applicable state fiscal year, up to, but not to exceed the difference between:
 - (a) The aggregate amount of Medicaid payments to all hospitals made pursuant to the Medicaid reimbursement provisions under Indiana Code 12-15, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by all hospitals during the state fiscal year; and
 - (b) The aggregate amount, as reasonably estimated by the office, that all hospitals would have been paid for those services under Medicare payment principles.

However, the office may not enter into an agreement with a hospital if, in doing so, another hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement, will receive under (1) above an amount less than what the hospital would have otherwise received under the formula set forth in (1).

Outpatient Hospital Medicaid Upper Payment Limit Test

As required by 42 CFR 447.321, the office will compute an upper payment limit test on an annual basis. Aggregate payments to categories of facilities may not exceed 100 percent of a reasonable estimate of what would have been paid using Medicare payment principles.

The office will estimate Medicare payments using the Medicare Ambulatory Payment Classification (APC) for hospitals under 42 CFR 419. The upper payment limit test will use Medicare payment rates and policies in effect for the period of the upper payment limit test. Hospitals will be categorized by their organizational type under 42 CFR 447.321, including privately owned and operated, non-state government owned or operated, and state owned or operated facilities. In computing estimated Medicare payments, the office will include estimated Medicare payments for allowable bad debt under 42 CFR 413.80. Estimated Medicare payments for outpatient graduate medical education will not be considered under the outpatient upper payment limit test.

TN No. 03-010

Supercedes

TN No. 01-008

Approval Date: _____

Effective Date: July 1, 2003

Psychiatric Residential Treatment Facility Services

For purposes of this section, "Psychiatric residential treatment facility" (PRTF) means a PRTF licensed under *470 IAC 3-13* and meeting the requirements set forth in *405 IAC 5-20-3.1*.

Reimbursement for Medicaid-covered psychiatric residential treatment facility services is made in accordance with the following prospective reimbursement methodology. The statewide prospective per diem shall constitute full reimbursement. There shall be no year-end cost settlement payments.

Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:

- (1) PRTFs shall be reimbursed for services provided to Medicaid recipients based upon the lower of:
 - (A) the state-wide PRTF prospective per diem rate calculated by the Office or
 - (B) the usual and customary daily charges billed for the psychiatric treatment of eligible recipients
- (2) The applicable PRTF payment per diem rate determined in section (1) shall provide reimbursement for all Medicaid-covered services provided in the psychiatric residential treatment facility except for those costs described in section (3). Providers will include, and rates will be determined using, only those allowable costs set out in Medicaid PRTF provider cost reporting instructions and update bulletins.
- (3) The per diem rate determined in section (1) shall exclude costs incurred for pharmaceutical services and physician services provided to eligible recipients. Medicaid reimbursement for costs incurred for pharmaceutical services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in *405 IAC 5-24*. Medicaid reimbursement for costs incurred for physician services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in *405 IAC 5-25*.
- (4) All costs utilized to determine the statewide prospective per diem rate in section (1)(A) shall be subject to reasonability standards as set forth in the *Medicare Provider Reimbursement Manual*, CMS-Pub. 15-1, Chapter 25.

- (5) The per diem rate determined in section (1) shall exclude such costs unrelated to providing psychiatric residential services including, but not limited to the following:
- (A) group education including elementary and secondary education
 - (B) advertising or marketing
 - (C) non-psychiatric specialty programs
- (6) Medicaid reimbursement for Medicaid-covered psychiatric services provided to recipients residing in a psychiatric residential treatment facility shall be limited to the payments described in *405 IAC 1-21*. Medicaid reimbursement for Medicaid-covered services not related to the recipient's psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are performed at a location other than the PRTF.
- (7) The established per diem rate for psychiatric residential treatment facilities shall be reviewed annually by the OMPP or its contractor by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.

PRTFs shall file a cost report annually using a uniform cost report form prescribed by the Office of Medicaid Planning and Policy (OMPP). The OMPP or its contractor may audit or review the cost reports as it deems necessary.

Supplemental Payments to Privately-owned Hospitals

I. General

A Privately-owned Hospital means an acute care hospital that is (i) licensed under IC 16-21, and (ii) Privately-owned and operated in accordance with 42 CFR 447.272(a)(3) and 42 CFR 447.321(a)(3). In addition to regular claims payments and any other payment adjustments to which they are entitled, each hospital that is a Privately-owned Hospital may receive an additional outpatient Medicaid supplemental amount for each state fiscal year ending after June 30, 2003, which shall not exceed the outpatient upper payment limit in accordance 42 CFR 447.321.

II. Outpatient Supplemental Payment Pool

The office will calculate an Outpatient Supplemental Payment Pool for each state fiscal year ending after June 30, 2003. This Outpatient Supplemental Payment Pool will include the outpatient Medicaid supplemental amount, which is an amount equal to the difference between the aggregate of actual Medicaid payments made to all Privately-owned Hospitals for Medicaid outpatient hospital services (excluding Medicaid disproportionate share payments made pursuant to IC 12-15-16, 12-15-17, and 12-15-19), and the office's reasonable estimate of the amount that would have been paid for those services using Medicare payment principles, subject to limits imposed by 42 CFR 447.321. The Outpatient Supplemental Payment Pool will be equal to the amount of the outpatient Medicaid supplemental amount.

III. Payment Methodology

For each state fiscal year ending after June 30, 2003, the Outpatient Supplemental Payment Pool will be established and distributed to Privately-owned Hospitals in the following manner:

(1) An amount equal to the lesser of (i) the amount of the Supplemental Payment Pool; or (ii) five million dollars (\$5,000, 000), will be paid to a Privately-owned Hospital that has in excess of seventy thousand (70,000) Medicaid inpatient days.

(2) Following the payment under (1) above, if there is an amount remaining in the Outpatient Supplemental Payment Pool after the payment under (1) above has been made, that remaining amount will be paid to all Privately-owned Hospitals on a pro rata basis based upon the number of each Privately-owned Hospital's Medicaid inpatient days. For purposes of this Section III (2) the non-federal share of such payments will not exceed the amount transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Privately-owned Hospitals with larger numbers of Medicaid inpatient days will receive a higher amount of the amount remaining in the Outpatient Supplemental Payment Pool than Privately-Owned Hospitals having smaller numbers of Medicaid inpatient days. The amount of a payment shall be determined and distributed after the end of each state fiscal year.

(3) In the event the entirety of the aggregate Outpatient Supplemental Payment Pool is not distributed after the payments indicated in (1) and (2) above have been made, the remaining amount will be paid on a pro rata basis to any Privately-owned Hospital that enters into an agreement with the office for such payment, based on each Privately-owned Hospital's Medicaid weighted inpatient days. For Children's hospitals (as identified by the office), weighted Medicaid inpatient days will be calculated by taking Medicaid days and multiplying them by 120%, consistent with the Medicaid DRG add-on. In addition, all hospitals' Medicaid days (including Children's hospitals) will be weighted further by their Medicaid Case Mix. The amount(s) of a Privately-owned Hospital's payment(s) under this clause (3) will not exceed the amount of the remaining Outpatient Supplemental Payment Pool..

Adjustments

Notwithstanding III (2) above, the office may enter into an agreement with any Privately-owned Hospital whereby the Privately-owned Hospital waives payments described in III (2) above or accepts a lesser or greater amount than provided in III (2) above, subject to the hospital's payment limitations as described in 42 CFR 447.321. However, the office may not enter into an agreement with a Privately-owned Hospital if, in doing so, another Privately-owned Hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement will receive an amount less than what the hospital would have otherwise received under the formula set forth in III (2).

TN No. 03-008

Supersedes

TN No. none

Approval Date _____

Effective Date July 1, 2003

MEDICAID HOSPITAL REIMBURSEMENT ADD-ON PAYMENT METHODOLOGY TO COMPENSATE HOSPITALS THAT DELIVER HOSPITAL CARE FOR THE INDIGENT PROGRAM SERVICE

In order to be eligible for and to receive a payment under the Indiana Hospital Care for the Indigent Care (HCI) program, a hospital must (1) be enrolled in and be providing services to patients enrolled in the Indiana Medicaid program during the state fiscal year for which payment is being made; and (2) have an audited cost report from the most recent common state fiscal year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year, unless extenuating circumstances exist. Hospitals that are no longer accepting Medicaid and HCI patients shall not receive payment under this section. Reimbursement under this program will be in the form of Medicaid add-on payments. The Medicaid add-on payments will provide additional reimbursement to eligible hospitals for the Medicaid-covered hospital services the hospitals provide to Medicaid enrollees. The amount and availability of the add-on payments will be limited by the upper payment limit imposed under 42 C.F.R. §§ 447.321, the amount of services rendered to Medicaid and HCI patients, and the rates for outpatient hospital services as stated in Attachment 4.19-B, Page 2 of this state plan. The add-on payments will be calculated and paid using the formula set forth below.

An eligible hospital for HCI purposes is defined as an acute care hospital licensed under Indiana Code 16-21, as defined and interpreted in the disproportionate share payment section of the Indiana Medicaid state plan amendment, and as defined and interpreted under the prior Medicaid HCI add-on payment methodology.

PAYMENT FORMULA

In accordance with I.C. 12-15-15-9.6, for each state fiscal year beginning July 1, 2003 and thereafter, the total Medicaid HCI add-on payments to hospitals for a state fiscal year shall not exceed an amount equal to all amounts transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund, including amounts attributable to each county's *ad valorem* HCI property tax levy, for a state fiscal year. A Medicaid add-on payment due to an eligible hospital must be based on a formula that provides additional Medicaid reimbursement for outpatient hospital services the hospital provides to Medicaid enrollees. The amount and availability of a Medicaid add-on payment for a hospital will be limited by the upper payment limits imposed under 42 CFR § 447.321. Variations in the amount of Medicaid add-on payments paid to eligible hospitals will be based upon the amount of outpatient hospital services an eligible hospital provides to Medicaid enrollees, the hospital's HCI patient case-load, and the amount of funds, including a county's *ad valorem* HCI property tax levy, transferred to the state hospital care for the indigent fund by each county to which one or more of the eligible hospital's HCI claims are attributed.

TN No. 03-007

Supersedes

TN No. new

Approval Date _____

Effective Date July 1, 2003

STEP 1: For each eligible hospital, the Office of Medicaid Policy and Planning (“office”) shall identify the outpatient hospital services the hospital provided to Medicaid enrollees during the state fiscal year.

STEP 2: For each eligible hospital, the office shall calculate the amount of Medicaid reimbursement paid to the hospital for covered outpatient hospital services the hospital provided to Medicaid enrollees identified in STEP 1.

STEP 3: For each eligible hospital, the office shall calculate an amount equal to the amount calculated under STEP 3F of the following formula:

STEP 3A: Identify:

(1) Each eligible hospital that provided necessary emergency medical care during the state fiscal year to an individual who qualifies under IC 12-16-3.5 et seq. and the rules promulgated thereunder, and;

(2) the county of residence of the individual or, if the individual was not a resident of Indiana or the individual’s Indiana county of residence cannot be ascertained, the county where the onset of the medical condition that necessitated the individual’s emergency medical care occurred.

STEP 3B: For each county identified in (2) of STEP 3A, identify:

(1) each eligible hospital that provided care described in (1) of STEP 3A attributed to the county during the state fiscal year; and

(2) the total amount (using the office's fee for service reimbursement rates) of all eligible hospital episodes of care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3C: For each county identified in (2) of STEP 3A, identify the amount of the county’s HCI funds, including its HCI *ad valorem* property taxes, transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3D: For each eligible hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, calculate the hospital's percentage share of the county's HCI funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount (using the office’s fee for service reimbursement rates) of the hospital's care described in (1) of STEP 3A attributed to the county during the state fiscal year, calculated as a percentage of the total amount (using the office’s fee for service reimbursement rates) of all hospital care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3E: For each hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, multiply the hospital's percentage share calculated under STEP 3D by the amount of the county's HCI funds transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3F: Determine the sum of all amounts calculated under STEP 3E for each eligible hospital identified in (1) of STEP 3A with respect to each county identified in (2) of STEP 3A.

STEP 4: Subject to STEP 5 and STEP 6, the office shall pay to each eligible hospital a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 3F and, in doing so, shall allocate the amount of the payment to each of the Medicaid covered hospital services identified for the hospital under STEP 1.

STEP 5: The office's allocation of a payment described in STEP 4 for a hospital's Medicaid-covered outpatient service shall be limited to an amount not to exceed either (1) the amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2, does not exceed the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

STEP 6: For any eligible hospital: (1) which receives a payment under STEP 4 that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limits under 42 CFR § 447.321, the office shall calculate an amount equal to the amount calculated for the hospital under STEP 6H below:

STEP 6A: Identify each county whose transfer of HCI funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) in STEP 3A above attributed to the county during the state fiscal year.

STEP 6B: For each county identified in STEP 6A, calculate the difference between the amount of HCI funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) of STEP 3A above attributed to the county during the state fiscal year.

STEP 6C: Calculate the sum of the amounts calculated for the counties under STEP 6(B).

STEP 6D: Identify each hospital: (1) which receives a payment under STEP 4 above that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limit under 42 CFR § 447.321.

STEP 6E: Calculate for each hospital identified in STEP 6D the difference between the hospital's payment under STEP 4 above and the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year.

STEP 6F: Calculate the sum of the amounts calculated for each of the hospitals under STEP 6E.

STEP 6G: For each hospital identified in STEP 6D, calculate the hospital's percentage share of the amount calculated under STEP 6F. Each hospital's percentage share is based on the amount calculated for the hospital under STEP 6E calculated as a percentage of the sum calculated under STEP 6F.

STEP 6H: For each hospital identified in STEP 6D, multiply the hospital's percentage share calculated under STEP 6G by the sum calculated under STEP 6C.

STEP 7: Subject to STEP 8, the office shall pay to each eligible hospital identified in STEP 6 a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 6H and, in doing so, shall allocate the amount of the payment to each of the hospital services identified for the hospital under STEP 1.

STEP 8: The office's allocation of a payment described in STEP 7 for a hospital's Medicaid-covered outpatient service shall be limited to an amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2 and STEP 4, does not exceed either (1) the amount of the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

Total non-federal share of payments to hospitals under this program for each state fiscal year may not exceed the amount equal to the product calculated when the amount transferred to the Medicaid indigent care trust fund by counties is multiplied by the state Medicaid medical assistance percentage for the state fiscal year for which the payments are made.

TN No. 03-007

Supersedes

TN No. new

Approval Date _____

Effective Date July 1, 2003

In the event there are insufficient state matching funds to pay each hospital the amounts calculated, the amount paid to each hospital will be reduced proportionate to the amount of the deficiency of funds. Payments shall be made prior to December 15 that next succeeds the end of the state fiscal year.

EFFECTIVE DATE Subject to approval by CMS, these payments are to be effective on July 1, 2003.

TN No. 03-007

Supersedes
TN No. new

Approval Date _____

Effective Date July 1, 2003

State of Indiana

Attachment 4.19-B

Page 2a

RURAL HEALTH CLINIC SERVICES

Effective for services provided prior to January 1, 2001, and pursuant to 42 CFR 447.371, Indiana Medicaid will reimburse rural health clinic services in the following manner:

- a. The rural health clinic services including independent health clinics as defined in Section 440.20 (b), will be reimbursed at the reasonable cost rate per visit determined by the designated regional Medicare contractor. Each certified clinic will directly provide the contractor with the required cost data as needed to determine the all-inclusive rate for the particular clinic at the beginning of the report period.
- b. Rural health clinics referred to as provider clinics, which are an integral and subordinate part of a hospital, skilled nursing facility, or home health agency will be reimbursed by the same rate setting method used for the parent facility.

Payments made according to a cost reimbursement rate per visit will be subject to reconciliation after the close of the reporting period, in accordance with 42 CFR 405.2427. Indiana will use the final rate determined by the intermediary based on actual cost and visits for the reporting period.

- c. The "other ambulatory services," as described by 42 CFR 440.20 (c), are those services Indiana will reimburse in addition to "rural health clinic services." Examples are: transportation, durable medical equipment, prosthetic devices, eye glasses, prescribed drugs, physical therapy and related services, optometric services, chiropractic services, podiatry services, dental services (including those services rendered in conjunction with the EPSDT Program), and others listed in the State Plan and covered by the Indiana Medicaid Program in other settings.

Indiana Medicaid will reimburse for such services according to its customary method of payment. The rate for these services will be determined on a fee for service basis as in other settings under the State Plan, but will not exceed the upper limits as required by 42 CFR 447. If other reimbursement options become available at a later date, Indiana Medicaid reserves the right to re-evaluate and change its present method.

Effective January 1, 2001, in accordance with Section 702(b)(aa)(3) of BIPA of 2000, Indiana Medicaid will provide for payment for services provided by Rural Health Clinics in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing all covered RHC services and those ambulatory services previously paid on a fee-for-service basis during the provider's fiscal years 1999 and 2000. The rate per visit from each applicable cost report year will be inflated and averaged using the MEI. The per visit rate will take into account applicable limits that are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take

TN # 01-004
Supersedes
TN # 94-009

Approval Date 11/16/01

Effective Date 1/1/01

State of Indiana

Attachment 4.19-B

Page 2a.1

into account any increase or decrease in the scope of such services furnished by the center or clinic during the provider's fiscal year 2000, and increased by the percentage increase in the most current quarterly historical MEI (as defined in section 1842(I)(3)) applicable to primary care services (as defined in section 1842(I)(4)) for that fiscal year. This Prospective Payment System rate will be increased annually beginning January 1, 2002 by the percentage increase in the MEI and adjusted to take into account any increase or decrease in the scope of such services furnished by the RHC.

Until 1999 and 2000 cost reports are finalized and received by the office, Indiana Medicaid will provide for payment using an interim prospective payment rate to Rural Health Clinics in the following manner:

The interim PPS rate will be established from rates paid during years 1999 and 2000. These amounts will be indexed (inflated) for MEI for each year and then a simple average of these two inflated amounts will be the rate paid.

In compliance with Section 702(b)(aa)(6)(B), a reconciliation back to January 1, 2001 will be performed to reconcile the interim PPS rate to the final PPS rate.

The establishment of an initial year rate for new providers certified after January 1, 2001, shall be determined in accordance with Section 702(b)(aa)(4) of BIPA 2000, taking into consideration geographic location, Medicaid utilization and similarity of services. In the absence of comparable data, the new clinic may be required to submit historical data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described in the paragraph above.

The office will provide for a supplemental payment for Rural Health Clinics furnishing services pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), in accordance with Section 702(b)(aa)(5), effective for services provided on or after January 1, 2001. The supplemental payments will be calculated based on the provider's base rate, as adjusted for MEI and any change in the scope of service, multiplied by the number of valid RHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four months. The provider is responsible for submitting the managed care claims to the office or its contractor for calculation of the supplemental payment.

Field audits may be conducted annually on a selected number of Rural Health Clinics.

TN # 01-004
Supersedes
TN # 94-009

Approval Date 11/16/01

Effective Date 1/1/01

HOSPICE SERVICES

Reimbursement for hospice care shall be made according to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the hospice wage index published by CMS.

Medicaid reimbursement for hospice services will be made at one of four all-inclusive per diem rates for each day in which a Medicaid recipient is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine Home Care. The hospice will be paid at the routine home care rate for each day the recipient is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(2) Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty four (24) hours a day.

(3) Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. For the day of discharge, the appropriate home care rate, routine or continuous, is paid unless the patient dies as an inpatient.

(4) General Inpatient Care. Subject to the limitations below, the hospice provider will be paid at the general inpatient rate for each day the recipient is in an approved inpatient hospice facility and is receiving general inpatient care for pain control or acute or chronic symptom management which cannot be managed in other settings. For the day of discharge, the appropriate home care rate, routine or continuous, is paid unless the patient dies as an inpatient.

TN # 03-006

Supersedes

TN # 97-009

Approval Date _____

Effective Date 8/1/03

HOSPICE SERVICES, continued

When routine home care or continuous home care is furnished to a recipient who resides in a nursing facility, the nursing facility is considered the recipient's home. (See Attachment 4.19-D, page 65 for the description of an additional per diem amount to be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services.)

Reimbursement for inpatient respite care or general inpatient care is available only for a recipient who resides in a private home. Reimbursement for inpatient respite care or general inpatient care is not available for a recipient who resides in a nursing facility.

Limitations on payments for inpatient care:

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid recipients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice provider or its contracted agent(s). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows:

- (1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).
- (2) If the total number of days of inpatient care to Medicaid hospice recipients is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.
- (3) If the total number of days of inpatient care to Medicaid hospice recipients is greater than the maximum number of inpatient days computed in subdivision (1) above, then the payment limitation will be determined by the following method:
 - (A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.
 - (B) Multiplying excess inpatient care days by the routine home care rate.
 - (C) Adding together the amounts calculated in subdivisions (3)(A) and (3)(B) above.
 - (D) Comparing the amount in subdivision (3)(C) above with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid recipients exceeds the amount calculated in subdivision (3)(C) above is due from the hospice provider.

TN # 97-009

Supersedes

TN # -Approval Date 11/25/97Effective Date 7/1/97

HOSPICE SERVICES, continued

Reimbursement for physician services:

The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Indiana Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for non-volunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients.

TN # 97-009

Supersedes

TN # _____

Approval Date 11/25/97Effective Date 7/1/97