

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 11/25/97

Effective 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