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

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. Rural Health Clinics will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to Rural Health Clinics for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. Rural Health Clinics will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit. Effective November 1, 2022, long-acting reversible contraception (LARC) will be reimbursed according to the Medicaid professional fee schedule. All rates are published on the agency's website at www.in.gov/medicaid/.

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.

HOSPICE SERVICES

I. Levels of Care

a. Reimbursement for Medicaid hospice care services are made in accordance with the rates published by CMS annually. 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.

b. With the exception of payment for physician services Medicaid reimbursement for hospice services will be made at one of six (6) predetermined rates for each day in which a Medicaid **member** is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine home care- Days 1-60.
(2) Routine home care- Days over 60.
(3) Continuous home care.
(4) Inpatient respite care.
(5) General inpatient hospice care.
(6) Service Intensity Add-On

c. **Service Intensity Add-On (SIA):**
Effective for hospice services with dates of service on or after January 1, 2016, a service intensity add-on payment will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS. The following conditions must be met to qualify for the SIA payment:
(1) The day is a routine home care level of care day,
(2) The day occurs during the last 7 days of life and the Medicaid member is discharged deceased, and
(3) Direct patient care is provided by a Registered Nurse or a Social Worker that day.

d. Routine Home Care. The hospice will be paid at **one of** the routine home care rate for each day the **member** is at home, under the care of the hospice provider, and not receiving continuous home care. **Medicaid reimbursement for routine home care will be made at one (1) of two (2) all-inclusive per diem rates:**

(1) Higher base payment for the first 60 days of hospice care.
(2) Reduced base payment for days 61 and over of hospice care.
(3) A minimum of sixty (60) days gap in hospice services is required to reset the counter which determines which payment category a participant is qualified for.

e. 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.

f. Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the **member** is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the **member** when necessary to relieve the family **members** or other persons caring for the **member**. 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.

g. General Inpatient Care. Subject to the limitations below, the hospice provider will be paid at the general inpatient hospice rate for each day the **member** in an approved inpatient hospice facility and is receiving **services related to the terminal illness. The member must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the member's record must clearly explain the reason for admission and the member's condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.**

h. Additional amount for Nursing Facility Residents. When hospice care is furnished to an individual residing in a nursing facility, pay the hospice an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This amount is determined in accordance with the rates established under Section 1902(a)(13) of the Act . The additional amount paid to the hospice on behalf of an individual residing in a nursing facility must equal 95 percent of the per diem rate that you would have paid to the nursing facility for that individual in that facility under your State plan.

i. When routine home care or continuous home care is furnished to a **member** who resides in a nursing facility, the nursing facility is considered the **member's** home.

j. Reimbursement for inpatient respite care is available only for a **member** resides in a private home. Reimbursement for inpatient respite care is not available for a **member** who resides in a nursing facility.

k. Reimbursement for the service intensity add-on (SIA) is available only for routine home care provided in a member's home or in a nursing facility, when a Medicaid member is residing in the nursing facility.

l. When a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.

II. Limitations on Payments for Inpatient Care

a. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid **members**. 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 **members** during the same period by the designated hospice provider or its contracted agent or agents. 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.

b. 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 **members** 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 **members** is greater than the maximum number of inpatient days computed in subdivision (1), 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 clauses (A) and (B).
(D) Comparing the amount in clause (C) 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 **members** exceeds the amount calculated in clause (C) is due from the hospice provider.

III. Reimbursement for Physician Services

a. 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 **member'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 hospice care.

b. Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual 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.

c. Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual 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 Medicaid 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.

d. 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.