

## HOME HEALTH CARE SERVICES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of home health services, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in provider bulletins issued periodically by the office

Home health care agencies will be reimbursed for covered services provided to Medicaid recipients through standard, statewide rates, computed as:

- (1) one overhead cost rate per provider, per recipient, per day; plus
- (2) the staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

The **overhead cost rate** is a flat, statewide rate, based on ninety-five percent (95%) of the statewide median overhead cost per visit. The statewide median overhead cost per visit is derived in the following manner:

- (1) Determine for each home health agency the total patient-related costs submitted by home health agency providers on forms prescribed by the Office, less direct staffing and benefit costs, divided by the total number of home health agency visits during the Medicaid reporting period for that provider. The result of this calculation is an overhead cost per visit for each home health agency.
- (2) Array all home health agency providers in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.
- (3) The statewide median overhead cost per visit is the cost of the agency at the point in the overhead cost array at which one-half (1/2) of the overhead cost observations are from higher-cost agencies and one-half (1/2) are from lower-cost agencies.

The **staffing cost rate** is a flat, statewide rate based on ninety-five percent (95%) of the statewide median direct staffing and benefit costs per hour for each of the following disciplines:

- (1) Registered nurse
- (2) Licensed practical nurse
- (3) Home health aide
- (4) Physical therapist
- (5) Occupational therapist
- (6) Speech pathologist

The statewide median direct staffing and benefit costs per hour is derived in the following manner:

- (1) Determine for each home health agency total patient-related direct staffing and benefit costs submitted by home health agency providers on forms prescribed by the Office, divided by the total number of home health agency hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each home health agency and discipline.
- (2) Array all home health agency providers in the state in accordance with their staffing cost rate per hour for each discipline, from the highest to the lowest.
- (3) The statewide median staffing cost rate per hour for each discipline is the cost of the agency at the point in the staffing cost array in which one-half (1/2) of the cost observations are from agencies with higher staffing rates per hour, and one-half (1/2) are from agencies with lower staffing rates per hour.

All home health agencies must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all home health agency personnel.

Medicare-certified home health agency providers are required to submit a Medicaid cost report on forms prescribed by the Office and the most recently filed Medicare cost report. Non-Medicare-certified home health agency providers are required to submit a Medicaid cost report on forms prescribed by the Office and the latest fiscal year-end financial statements.

Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Centers for Medicare & Medicaid Services Home Health Agency Market Basket index. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the next expected rate period.

The semi-variable cost will be removed from the overhead cost calculated in accordance with 405 IAC 1-4.2-4(b), and added to the staffing cost calculated in accordance with 405 IAC 1-4.2-4(c), based on hours worked.

Field audits will be conducted yearly on a selected number of home health agencies. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.

Financial and statistical documentation may be requested by the Office or its contractor. This documentation may include, but is not limited to, the following:

- (1) Medicaid cost reports
- (2) Medicare cost reports
- (3) Statistical data
- (4) Financial statements
- (5) Other supporting documents deemed necessary by the Office or the rate setting contractor.

Each provider shall submit an annual financial report to the Office not later than one hundred fifty (150) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of the provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

Extension of the one hundred fifty (150) day filing period shall not be granted unless the provider substantiates to the Office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the Office, prior to the date due, with a full and complete explanation of the reasons an extension is necessary. The office shall review the request for an extension and notify the provider of approval or disapproval within ten (10) days of receipt of the request. If the request for extension is disapproved, the report shall be due twenty (20) days from receipt of the disapproval from the Office.

When an annual financial report is thirty (30) days past due and an extension has not been granted, payment for all Indiana Medicaid claims filing by the provider shall be withheld effective on the first day of the month following the thirtieth (30<sup>th</sup>) day the annual financial report is past due. Payment shall continue to be withheld until the first day of the month after the delinquent annual financial report is received by the Office. After receipt of the delinquent annual financial report, the dollar amount paid to the provider for the claims that were withheld shall be reduced by ten percent (10%). Reimbursement lost because of the ten percent (10%) penalty cannot be recovered by the provider.

When an annual financial report is sixty (60) days past due and an extension has not been granted, the office shall notify the provider that the provider's participation in the Indiana Medicaid program shall be terminated. The termination shall be effective on the first day of the month following the ninetieth (90<sup>th</sup>) day the annual financial report is past due, unless the provider submits the delinquent annual financial report before that date.

Failure to submit requested documentation may result in the imposition of the ten percent (10%) and termination penalties described above and sanctions set forth in IC 12-15-22-1.

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Retroactive payment will be required when any of the following occur:

- (1) A field audit identifies overpayment by Medicaid.
- (2) The provider knowingly receives overpayment of a Medicaid claim from the Office.  
In this event, the provider must:
  - (A) complete appropriate Medicaid billing adjustment forms; and
  - (B) reimburse the Office for the amount of the overpayment.

New rates set on July 1, 2008, shall be:

- (1) effective on July 1; and
- (2) annually adjusted thereafter based upon the most recently submitted financial and statistical documentation as filed by all providers of services who billed Medicaid for services provided during the cost report period.

The rates paid to providers in accordance with methods described in Attachment 4.19-B for home health services are subject to a 5% reduction for services on or after April 1, 2010. The 5% rate reduction will remain in effect through June 30, 2013. These rates are published in provider bulletins, which are accessible through the agency's website. The State's website, [www.indianamedicaid.com](http://www.indianamedicaid.com) allows providers access to all provider bulletins.

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TN# 10-002

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**Medical Supplies, Equipment, and Appliances Suitable for Use in the Home****Medical Supplies**

Reimbursement for medical supplies is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:

- (1) The Indiana Medicare fee schedule amount adjusted by a multiplier of eight-tenths (0.8), if available. If this amount is not available, then
- (2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
- (3) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (.75).

All reimbursement for medical supplies provided on or after July 1, 2011, that has been calculated under methods described above shall be reduced by five percent (5%), except for blood glucose monitors, diabetic test strips, items with rates based on acquisition cost, and items with payment based on the manufacturer's suggested retail price. The 5% reduction will remain in effect through June 30, 2013.

Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. The agency's fee schedule rates are published on the agency's website at [www.indianamedicaid.com](http://www.indianamedicaid.com).

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**Medical Supplies, Equipment, and Appliances Suitable for Use in the Home****Medical Equipment**

Medical equipment (ME) means equipment that can withstand repeated use and includes, but is not limited to, the following items: prosthetics, orthotics, beds, canes, walkers, crutches, wheelchairs, traction equipment, and oxygen and oxygen equipment.

Reimbursement for ME is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:

- (1) The Indiana Medicare fee schedule amount, if available. If this amount is not available, then
- (2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
- (3) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (.75).

Reimbursement for hearing aids is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:

- (1) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
- (2) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (.75).

Reimbursement rates for binaural hearing aids will be twice the monaural rate.

Reimbursement of a hearing aid dispensing fee is available. The dispensing fee is a one-time dispensing fee. The dispensing fee may be billed only in conjunction with a hearing aid procedure code that has an established fee schedule amount. The dispensing fee includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on hearing aid use. The dispensing fee reimbursement rate is effective for hearing aids dispensed on or after July 1, 2011.

All reimbursement for ME and hearing aids provided on or after July 1, 2011, that has been calculated under methods described above shall be reduced by five percent (5%), except for blood glucose monitors, ME and hearing aids with rates based on acquisition cost, items with payment based on the manufacturer's suggested retail price, and the hearing aid dispensing fee. The 5% reduction will remain in effect through June 30, 2013.

Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. The agency's fee schedule rates are published on the agency's website at [www.indianamedicaid.com](http://www.indianamedicaid.com).

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## FEDERALLY QUALIFIED HEALTH CENTERS

Effective for services provided prior to January 1, 2001, and in accordance with Section 6404 of the Omnibus Budget Reconciliation Act of 1989, Indiana Medicaid will pay 100 percent of the costs that are reasonable and related to the cost of furnishing Federally Qualified Health Center (FQHC) services and will meet the requirements of Section 6303 of the *State Medicaid Manual* regarding payment for FQHC services.

Indiana reimburses FQHC services at interim reimbursement rates established by the agency, subject to a retrospective cost settlement process. Interim payment will be based upon and cover the reasonable costs of providing services to Medicaid beneficiaries. Such costs are not to exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Effective January 1, 2001, in accordance with Section 702(b)(aa)(6) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Indiana Medicaid will provide for payment under an alternative payment methodology to FQHCs for services described in section 1905(a)(2)(C). The alternative payment methodology is 100 percent of the costs that are reasonable and related to the cost of furnishing FQHC services, meeting the requirements of Section 6303 of the *State Medicaid Manual*, the *FQHC Cost Reporting Guidelines for Indiana Medicaid* manual (February 7, 2000) regarding payment for FQHC services, and all applicable reimbursement policies in effect on December 31, 2000.

Effective January 1, 2002, in accordance with Section 702(b)(aa)(3) of BIPA, Indiana Medicaid will provide for payment for services provided by FQHCs in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs to the center or clinic for furnishing all Medicaid covered services during fiscal years 1999 and 2000. The rate per visit from each

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rate will take into account productions screens and applicable limits, (based on the provider's fiscal years ending in 1999 and 2000) which 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 2001, 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 FQHC.

In the event a final settlement has not been reached on the provider's 1999 and 2000 FQHC cost reports by December 31, 2001, the alternative methodology may be extended for a period of not more than 180 days. If cost reports have not been finalized after a period of not more than 180 days, an interim prospective payment system rate equal to the most recent rate on file will be used to reimburse FQHC services until such time that the cost reports are final. This interim PPS rate will be adjusted annually beginning January 1, 2003 by the MEI.

In conformance with Section 702(b)(aa)(6)(B) of BIPA, a reconciliation will be performed to ensure that each center or clinic received reimbursement for such services in an amount that is at least equal to the amount that would have been paid under the Prospective Payment System described in Section 702(b)(aa) of BIPA.

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 cost data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described above.

The office will provide for a supplemental payment for FQHCs 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, 2002. 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 FQHC 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 Federally Qualified Health Centers.

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In accordance with Section 1902(bb)(6) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Indiana Medicaid will provide for payment under an alternative payment methodology to Federally Qualified Health Centers (FQHCs) for the integration of primary and behavioral health care services, and for the achievement of performance measures, effective for FQHC fiscal years which include dates of service occurring July 1, 2009 and after. To qualify for the alternative payment methodology, the FQHC must implement a care plan that fully integrates primary and behavioral health care services at the FQHC. The FQHCs primary and behavioral health integration plan must be approved by the Office of Medicaid Policy and Planning (the Office) and the Department of Mental Health and Addiction (DMHA). The integration plan must incorporate the following characteristics:

- Incorporation of screening and evaluation processes to identify targeted patient population
- Establishment of appropriate levels of behavioral health staffing
- Physical integration of the provision of primary and behavioral health care together at the same FQHC location
- Performance of medical and behavioral health care services by the staff of the FQHC
- Provision of behavioral health services limited to patients 18 years of age and older
- Full integration of medical records, billing, and other data relating to primary and behavioral health care services
- Ongoing monitoring of the integration plan through data collection and evaluation

The Office and DMHA will develop performance measures to monitor the effectiveness of the integration plan. Performance measures will address the extent to which operational goals are met and will be based on the following objectives:

1. Increase the proportion of the adults screened in a primary care setting for identification of behavioral health needs;
2. For adults found in need of behavioral health services, increase the proportion of individuals assessed for level and type of service needs using a standardized assessment process in the primary care setting;
3. For adults needing a low to moderate level of behavioral health services, increase the numbers that receive these services in primary care settings;
4. For adults receiving behavioral health services in a primary care setting, demonstrate improved clinical outcomes following treatment.

Performance measures will be established based on an FQHC's specific integration plan, its experience related to each of the above objectives, and its capacity to provide behavioral health services.

Reimbursement under the alternative payment methodology will consist of two components:

1. An adjustment to the FQHC's Prospective Payment System (PPS) rate
2. Performance incentive payments limited to an established annual amount for each participating FQHC

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The rate adjustment will be determined by the Office as an add-on to the FQHC's existing PPS rate of no more than the budgeted cost per encounter for delivery of the new services based on an approved integration plan and budget. After the adjusted PPS rate is set, it will be updated in the same manner as the PPS rates for other FQHCs.

Performance incentive payments will be available up to a maximum amount established for each FQHC based on the FQHC's integration plan, utilization data, and the extent to which the integration plan addresses the State's goals. The maximum amount of performance payments that may be distributed annually to each FQHC with an approved integration plan will be established by the Office prior to implementation of the plan. The maximum annual amount available for an FQHC's performance payments will not exceed 8.5% of the provider's gross cost for Medicaid as reported on their most recent Medicaid cost report on file with the Office as of the date the alternative payment methodology (APM) agreement between OMPP and the FQHC is approved. Once established, the maximum annual performance payment amount for an FQHC will remain constant for the duration of the approved integration plan. Actual performance payments will be tied to the FQHC's achievement of the objectives as determined through specific measures established by the Office and DMHA, and agreed to by the FQHC. Performance payments will be paid no more often than quarterly.

The Office and the FQHC must agree in writing to the alternative payment methodology. The alternative payment methodology must provide payment in an amount which is at least equal to reimbursement under the Indiana Medicaid Prospective Payment System (PPS) for FQHCs.

The Office will provide for a supplemental payment for FQHCs furnishing services pursuant to a contract between the clinic and a managed care entity. The supplemental payments will be calculated based on the provider's rate determined under the alternative payment methodology, as adjusted for inflation using the Medicare Economic Index (MEI) and any change in the scope of service, multiplied by the number of valid FQHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four (4) months. The provider is responsible for submitting the managed care claims to the Office or its contractor for calculation of the supplemental payment.

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**Reimbursement to nursing facilities for residents who elect to receive Hospice Care:**

An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents receiving routine or continuous care services in a certified nursing facility. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Indiana Medicaid would have paid to the nursing facility for any resident for those dates of service on which the recipient was a resident of that facility.

Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

The additional amount for room and board is not available for recipients receiving inpatient respite care or general inpatient care.

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