

TARGETED CASE MANAGEMENT

1. HIV Infected Individuals

Reimbursement for case management services shall be on a fee-for-service basis.

The rate will be established by the Medicaid agency. A survey process will be utilized to establish an equitable rate. Service organizations throughout the State (urban and rural) that currently provide specialized case management services to HIV positive persons will be surveyed. The Medicaid agency will formulate a rate based on the results of this survey process. Organizations surveyed will be limited to those currently providing similar services as defined in this plan and whose case managers possess similar qualifications to those enumerated in Supplement 1 to Attachment 3.1-A.

The unit of service shall be a quarter hour segment.

2. Pregnant Women

Reimbursement for case management services for pregnant women shall be on a fee-for-service basis. The rate shall be established by the Medicaid agency based on actual costs of basic case management services from data collected from pilot projects conducted by the I.U. School of Nursing in urban and rural settings. These projects are providing services similar to those described in this plan and employ case managers possessing similar qualifications to those enumerated in Supplement 1 to Attachment 3.1-A. The cost figures provided by the projects are based on salary and benefits divided by the average amount of time spent providing case management services to each recipient. The average cost per recipient is divided into discrete components of care (i.e., initial assessment, reassessment, postpartum assessment) and reimbursed separately as an incentive to initiate services as early as possible in the pregnancy.

Mileage will be reimbursed at the rate per mile allowed by the State Legislature for State employees.

3. Persons Identified as Seriously Mentally Ill or Seriously Emotionally Disturbed

Payments will be based upon the lower of the provider's submitted charge or the Medicaid maximum allowance for the procedure billed. Maximum allowances are established by the Division of Mental Health based upon a review of like charges by similar providers throughout the State.

4. Low Functioning Severely and Persistently Mentally Ill Adults Needing Assertive Community Treatment (ACT)

Reimbursement for Assertive Community Treatment (ACT) services shall be on a fee-for-service basis.

The fee-for-service payment for Assertive Community Treatment services shall be established by the Medicaid Agency based on the operational expenses of a certified Assertive Community Treatment Team, as reported by the Division of Mental Health and Addiction (DMHA). DMHA will survey certified ACT teams that currently provide ACT services to low functioning seriously and persistently mentally ill adults to collect provider operational expenses. The operational expense cost figures provided by DMHA will be based on salary and benefits of ACT Team members and OMPP will divide the operational expenses by the average amount of time spent providing ACT services to each eligible recipient to establish the rate.

The unit of service will be per daily Assertive Community Treatment (ACT) Team meeting when the ACT enrollee's case is discussed, documented, and coordinated. Therefore, the unit of service equals one 24-hour business day.

5. Individuals with Developmental Disabilities

Reimbursement for case management services for individuals with developmental disabilities shall be on a fee-for-service basis. The rate is the current rate for case management services under the Medicaid HCBS waivers that serve individuals with developmental disabilities.

6. Case Management for Elderly or Disabled Individuals Diverted/Deinstitutionalized from Nursing Facilities

Reimbursement for case management services for the targeted population is paid on a fee-for-service basis. The rate is the current rate for case management services under the Medicaid HCBS waivers that serve elderly or disabled individuals with nursing facility level of care.

Transportation

Payment will be based upon the lower of the provider's submitted charge or the maximum allowed rate established by the State for the service billed. Maximum allowed rates are based on analysis of market rates paid for transportation services in Indiana and in Medicaid Programs in other comparable states. Reimbursement for covered transportation services will be as follows:

Taxi Services: Lower of metered or zoned rate or maximum.

Commercial Ambulatory Services (non-taxis): Base rate + mileage payments beyond a specified number of miles.

Non-Ambulatory Services: Base rate + mileage payments beyond a specified number of miles.

Ambulance Services: Loading fee + mileage payments.

A supplemental payment will be made to a provider for ambulance transportation services. The supplemental payments will be made on a quarterly basis, in an amount which, when combined with other payments under the plan, does not exceed the providers' usual charges. For purposes of this payment, usual charges, for the State Fiscal Year beginning July 1, 2003, will be defined as follows:

- a. The average of the following amounts: amounts billed to cash paying patients; the amounts billed to patients covered by indemnity insurers with which the provider has no contractual arrangement; and fee-for-service rates it contractually agrees to accept from any payor, including any discounted fee-for-service rates negotiated with managed care plans.
- b. Amounts not included in the average are charges for services provided to uninsured patients free of charge or at a substantially reduced rate, capitated payments, rates offered under hybrid fee-for-service arrangements whereby more than 10% of the individual's or entity's maximum potential compensation could be paid in the form of a bonus and/or withhold payment; and fees set by Medicare, State health care programs, and other Federal health care programs.

Usual charges will be determined by a study of ambulance providers' charges conducted by OMPP. For each SFY thereafter, each provider's usual charges will be based on the previous year's usual charges increased by the Medicare Ambulance Inflation Factor.

TN No. 03-018
Supersedes
TN No. 94-009

Approval Date _____

Effective Date July 2, 2003

The payment will be made only for ambulance services, and neither for non-ambulatory services nor commercial ambulatory services. The payment will be equal to the amount under STEP SIX below, which is calculated as follows:

STEP ONE: The Office of Medicaid Policy and Planning (Office) shall identify Medicaid providers that received reimbursement for ambulance transportation during the quarter.

STEP TWO: For each Medicaid provider described in STEP ONE, the Office shall identify the ambulance transportation services for which the Medicaid provider was reimbursed.

STEP THREE: For each Medicaid provider described in STEP ONE, the Office shall calculate the reimbursement paid to the Medicaid provider for the ambulance transportation services identified under STEP TWO.

STEP FOUR: For each Medicaid provider described in STEP ONE, the office shall calculate the Medicaid provider's usual charges for each of the Medicaid provider's services identified under STEP TWO.

STEP FIVE: For each Medicaid provider described in STEP ONE, the Office shall subtract an amount equal to the reimbursement calculation for each of the ambulance transportation services under STEP THREE from an amount equal to the amount calculated for each of the ambulance transportation services under STEP FOUR.

STEP SIX: For each Medicaid provider described in STEP ONE, the Office shall calculate the sum of each of the amounts calculated for each ambulance transportation services under STEP FIVE.

In the event that available funds eligible for federal financial participation are insufficient to provide the full state share for a provider's payment as calculated using the steps above, the payment will be reduced in proportion to that deficiency.

Reimbursement is also available for oxygen used during ambulance transport and waiting time for certain trips.

Community Mental Health Rehabilitation Services

Payment will be based upon the lower of the provider's submitted charge or the OMPP maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State.

TN No. 03-018

Supersedes

TN No. new

Approval Date _____

Effective Date July 2, 2003

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS
OUTPATIENT HOSPITAL SERVICES

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers which serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

- (A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.
- (B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the department of mental health." This group of providers is commonly referred to as state hospitals.
- (C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.

TN# 92-09
Supersedes:
TN # 91-7

Approval Date 6/26/92

Effective 7-1-91

(D) "Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital, State Mental Health Institution, or Private Psychiatric Institution:

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana; or

(2) whose low income utilization rate exceeds twenty-five percent (25%); and

(i) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Provision (i) does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer nonemergency obstetric services as of December 21, 1987.

(E) "Significant Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital, State Mental Health Institution or Private Psychiatric Institution which meets all criteria outlined in (D)(2) above.

(F) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days and hospital care for the indigent program inpatient days in a cost reporting period; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period.

where inpatient days includes days provided by an acute care subprovider of the provider and also includes inpatient days attributable to Medicaid beneficiaries from other states.

TN# 92-09
Supersedes:
TN # 91-7

Approval Date 6/26/92 Effective 7-1-91

(G) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in a cost reporting period; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include the Medicaid Inpatient Utilization Rates of providers who are determined to be Significant Disproportionate Share Hospitals and who are receiving significant disproportionate share payments.

(H) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following for a cost reporting period:

(i) the total Medicaid inpatient revenues paid to the provider; plus

(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for inpatient services (including cash subsidies) in the same cost reporting period; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment or third party or personal resources in a cost reporting period; and

(B) the denominator is the total amount of charges for inpatient services in the same cost reporting period.

The numerator in clause (2)(A) shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan.

III. PAYMENT ADJUSTMENTS

A. Outpatient Disproportionate Share Adjustment

Disproportionate Share Hospitals that are operating as Acute Care Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment for outpatient services calculated against the regular outpatient claims payments equal to:

The provider's Medicaid inpatient utilization rate less one (1) standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times ninety five percent (95%) plus two and one-half percent (2.5%).

Disproportionate share payment adjustments for outpatient services shall only be made from revenues contained in the Medicaid Indigent Care Trust Fund.

B. Outpatient Significant Disproportionate Share Adjustment

Significant Disproportionate Share Hospitals that are operating as Acute Care Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustment to which they are entitled, a disproportionate share payment adjustment for outpatient services calculated against the regular outpatient claims payment equal to:

The provider's Medicaid inpatient utilization rate less one (1) standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times ninety five percent (95%) plus two and one-half percent (2.5%), plus

The percentage add-on specified for significant disproportionate share providers at 42 U.S.C. 1385ww(d) (5) (F) (iii) which for the period 7-1-90 through 9-30-91 is 30% and for the period 10-1-91 forward until the next legislated change, is 35%.

TN # 92-09
Supersedes:
TN # 91-7

Approval Date

6/26/92

Effective

7-1-91

Significant Disproportionate Share Payment adjustments for outpatient services shall only be made from revenues contained in the Medicaid Indigent Care Trust Fund.

IV. OUTPATIENT DISPROPORTIONATE SHARE
PAYMENT ADJUSTMENT EXAMPLES

Example 1--Hospital qualifies as a regular disproportionate share hospital

Facts-----Hospital's Medicaid inpatient utilization rate = 28%

One Standard Deviation from the Statewide Mean
Medicaid Inpatient Utilization rate = 15%

Disproportionate Share Payment formula "The provider's Medicaid inpatient utilization rate less one standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times 95% plus 2.5%"

Medicaid inpatient claim reimbursement \$1000.00

Solution-----28% minus 15% = 13.00%
13% times .95 = 12.35%
12.35% plus 2.5% = 14.85%
14.85% times \$1000 = \$148.50 disp. share payment

Example 2--Same hospital qualifies additionally as a significantly disproportionate share hospital

Facts-----Same as those in example 1 (add the following)

Date of inpatient claim 10-10-91

Inpatient Significant Disproportionate Share adjustment percentage is 35%

Solution---35.00% times \$1000 = \$350.00 sig. disp. share payment
from example 1 above \$148.50 disp. share payment
\$498.50 total disp. share payment

TN # 92-09
Supersedes:
TN # 91-7

Approval Date 6/26/92 Effective 7-1-91

State: Indiana

Attachment 4.19B
Page 6e

V. EFFECTIVE DATE

Subject to approval by HCFA, these payment adjustments are to be effective for services provided on or after July 1, 1991. All appropriate assurances required by federal regulations are being submitted with this Medicaid state plan amendment.

TN # 92-09 Approval Date 6/26/92 Effective 7-1-91
Supersedes:
TN # 91-7

State: Indiana

Attachment 4.19B

Page 7

Rule 19 Ownership and Control Disclosures**405 IAC 1-19-1 Information to be disclosed**

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

- (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.
- (2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.
- (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
 - (A) keep copies of all these requests and the responses to them;
 - (B) make them available to the office upon request; and
 - (C) advise the office when there is no response to a request.
- (4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) the office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

TN: 03-002

Supersedes:

None

JUL 21 2003

Approval Date: _____

Effective: May 17, 2003