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**Targeted Case Management**

7. Targeted case management (TCM) for individuals who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level as defined by the Centers for Disease Control and Prevention (CDC)

***Reimbursement Methodology:***

***Rate(s):***
***The rate for reimbursement of lead case management services is a fee-for-service rate. The statewide rate was derived by using the average cost of salary, fringe benefits, for employed and contracted registered nurse and social worker case managers. The cost rate of 8% includes the indirect costs and transportation.***

***Unit Definition:***
***A unit of service is equivalent to fifteen (15) minutes. Minutes of service provided to a specific individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of Targeted Case Management provided during the day for a specific individual divided by fifteen minutes plus one additional unit if the remaining number of minutes is eight or greater.***

***Claims Payment Process:***
***Providers will submit claims to the Local Health Departments (LHD). The LHD will submit claims, via the Medicaid Management Information System (MMIS) claims processing system, for adjudication. Providers of TCM may not bill more than 26, 15-minute units per recipient, per rolling twelve (12) month period of time. If additional units of TCM are medically necessary, the provider must submit a prior authorization request for additional units of service.***

The State developed fee schedule rates are the same for both governmental and private providers of targeted case management services. The State developed fee schedule rate for environmental lead investigations is effective for services provided on or after June 18, 2009. All rates are published on *www.indianamedicaid.com.*

Transportation

Payment will be based upon the lower of the provider's submitted charge or the fee schedule rate established by the State for the service billed. Base rate is defined as the allowed payment amount for a one-way trip, not including mileage. Mileage payments are made for loaded miles, defined as the number of miles the Medicaid member is transported in the vehicle. Reimbursement for covered transportation services will be as follows:

Non-emergency Ground Transportation:

A non-emergency medical transportation (NEMT) broker is reimbursed a monthly capitated payment for each Indiana Medicaid FPS member.

Meals and Lodging: Meals and lodging reimbursement is based on the rate established by the Indiana State Legislature paid to Indiana state employees for travel-related expenses.

For dates of service on or after January 1, 2024, the office shall pay for the transportation services not covered by the emergency transportation section below at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana, if available, that takes effect January 1 of the calendar year preceding the Medicaid rate effective date.

3. If the Medicare urban rate for Indiana is not available, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate in effect for that date of service, adjusted for inflation as determined by the office.

Emergency Transportation:

Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is calculated based upon a survey of billed charges statewide utilization data.

For dates of service on or after July 1, 2023, Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana as of each January 1, if available.

For dates of service on or after January 1, 2024, Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana, if available, that takes effect January 1 of the calendar year preceding the Medicaid rate effective date.

3. If the Medicare urban rate for Indiana is not available, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate in effect for that date of service, adjusted for inflation as determined by the office. For procedure code A0225, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate for procedure code A0427.

Payments for Government Ambulance Transportation Services

Qualified in-state government ambulance transportation service providers are reimbursed for the actual incurred costs of providing ambulance services to eligible Medicaid beneficiaries. Each provider must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid ambulance transportation services. The CMS approved Medicaid cost report form 2552-10 or the non-hospital government ambulance cost report form is due from ambulance providers five months after the end of the provider's fiscal year. An initial settlement will be processed within eighteen months of receiving an approved cost report. A final settlement will be processed within twenty-four months of receiving the approved cost report. The payments will be paid to each provider in an amount based on the provider's reconciled costs for providing ambulance transportation services to Medicaid recipients, less amounts already paid to the provider for ambulance transportation services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods approved by the office. Government providers are required to comply with cost allocation principles found in OMB Circular A-87. In instances where cost allocation principles in OMB A-87 conflict with CMS 15-1, government providers must always use the OMB A-87 principles. For purposes of these payments, effective for services provided on or after January 1, 2011, costs shall be calculated as follows:

A. For hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent hospital cost report on file with the office. Hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

B. For non-hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent CMS-approved cost report on file with the office. Non-hospital-based governmental transportation providers will submit the Indiana Medicaid Freestanding Governmental Ambulance Provider Cost Report that is prepared in accordance with a cost reporting methodology developed by the office that complies with OMB Circular A-87 and utilizes the Federal Transit Administration (FTA) Uniform System of Accounts, or other accounting system determined to be appropriate by the office. Cost reports must also comply with Medicare reasonable cost principles. Non-hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

Payments will be the amounts calculated under Step Four of the following formula:

Step One: Determine the amount of each provider's charges and Medicaid reimbursement for claims incurred during the provider's fiscal year and adjudicated to a paid status through the MMIS.

Step Two: Determine the amount of each provider's reconciled costs for the provider's fiscal year for providing ambulance transportation services for Medicaid eligible persons. Cost for the provider's fiscal year will be calculated by multiplying the provider's charges identified in Step One by the cost-to-charge ratio from the cost report on file with the office corresponding to the fiscal year under consideration.

Step Three: Subtract the Medicaid reimbursement amount determined in Step One from the cost calculated in Step Two. If Medicaid reimbursement exceeds cost calculated in Step Two, an overpayment has been made. The office will recover the overpayment in compliance with the requirements of section 1903(d)(2) of the Social Security Act.

Step Four: If the amount calculated in Step Three is greater than zero, the provider will receive a payment equal to the amount calculated in Step Three multiplied by the Federal Medical Assistance Percentage (FMAP) rate for Indiana in effect at the time of the payment.

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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Mental Health Rehabilitation Services. The agency's fee schedule rate was set as of 7-1-2010 and is effective for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

Item 9D. Rehabilitation

1. Psychosocial Rehabilitation Services

Psychosocial rehabilitation services in a clubhouse setting provided on or after August 15, 2016 shall be reimbursed according to this section.

Payment for psychosocial rehabilitation services will be based on a blended payment rate that includes the Medicaid covered services that are components of psychosocial rehabilitation. The Medicaid covered psychosocial rehabilitation service components are: Individual Skills Training and Development and Group Skills Training and Development.

The psychosocial rehabilitation services blended payment rate is based on established individual Medicaid rehabilitation payment rates for the Medicaid covered service components, weighted to reflect utilization of these services in the psychosocial rehabilitation model. The rate does not include costs related to room and board or other unallowable facility costs.

The state will review the rate annually and rebase as necessary to assure the rates are economic and efficient. Providers will maintain data relating to the provision of covered psychosocial rehabilitation services, including the date of service, beneficiary information, and the nature and volume of services. Utilization information comprised of these data elements was used in the development of the rate and will be used by the state in the periodic review of the rate. The state will monitor the provision of covered psychosocial rehabilitation services under the blended rate to ensure that beneficiaries receive the quantity and intensity of services required to meet their psychosocial rehabilitative needs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of psychosocial rehabilitation services. The agency's rates, as of August 15, 2016, are published at the State's website, www.indianamedicaid.com.

Item 9D. Rehabilitation

2. Opioid Treatment Services

Opioid treatment services provided by an Opioid Treatment Program (OTP) on or after July 1, 2023 shall be reimbursed according to this section.

Payment for opioid treatment services will be based on 100% of Medicare payment rates. Services considered opioid treatment services are: U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medication, the dispensing and administration of MAT medications, toxicology testing, individual and group therapy, intake activities, and periodic assessments.

Payment for these services is to be reimbursed via an applicable weekly reimbursement bundle utilized by Medicare or may be separately reimbursable when not all service components of the weekly bundle have been administered. Additionally, other services not defined as OTP services may be reimbursable by an opioid treatment program provider if deemed appropriate by the Office of Medicaid Policy and Planning (OMPP).

The state will review the rate annually and rebase as necessary to assure the rate is economic and efficient and in accordance with Medicare payment. Providers will maintain data relating to the provision of covered opioid treatment services, including the date of service, beneficiary information, and the nature and volume of services. The state will monitor the provision of covered opioid treatment services to ensure that beneficiaries receive the quantity and intensity of services required to meet their opioid treatment service needs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of opioid treatment services.

Item 13D. Rehabilitation

**Intensive Outpatient Treatment (IOT)**

Payment for IOT will be based on blended payment rates that are for the Medicaid covered services found on Addendum 3.1-A Item 13.d Rehabilitative Services for Intensive Outpatient Treatment (IOT). The Medicaid covered service components are:

- Individual/Family Therapy; Group Therapy;
- Skills Training;
- Medication Training and Support;
- Peer Recovery Services; and
- Care Coordination

IOT blended payment rates are based on established individual Medicaid payment rates for the Medicaid covered service components, adjusted to reflect utilization of these services in the IOT model. The rates do not include costs related to room and board or other unallowable facility costs.

The state will periodically monitor the actual provision of IOT services paid under a blended rate to ensure that the beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the blended rate.

Effective for dates of service on or after January 1, 2024, rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of IOT services. The agency's rates are published at the State's website, in.gov/Medicaid.

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.

(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.

(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 indiviuals 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%.

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

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**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**

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**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**

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## 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.

**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.

**Diagnostic Services**

**Environmental Lead Investigations**

Reimbursement is provided for a one-time, on-site environmental lead investigation of a child's home or primary residence for a child with elevated blood lead level. This environmental lead investigation will be provided by a licensed risk assessor or licensed lead inspector, certified by a local health department. These services must be provided through coordination with the local health department (LHD).

Medicaid fees paid by other states and providers' costs (when available) will be considered when establishing a rate. ***Except as otherwise noted in the plan, the State developed fee schedule rates are the same for both governmental and private contracted providers of lead investigation services. The State developed fee schedule rate for environmental lead investigations is effective for services provided on or after June 18, 2009. All rates are published on www.indianamedicaid.com.***

Limitations on reimbursement:

Medicaid reimbursement for an environmental lead investigation ***is available for a licensed risk assessor's or inspector's time and activities performed during the one-time on-site investigation of the poisoned child's home or primary residence. The reimbursement rate includes the time associated with collection of specimens and associated paperwork. Medicaid reimbursement is not available for the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis.***

***Initial Comprehensive Environmental Lead Investigation may include the following:***

***(A) Visual assessment of the probable contaminated site,***
***(B) Interview of the occupants,***
***(C) Dust examination,***
***(D) On-site X-ray fluorescence (XRF) analysis of lead paint content, and***
***(E) Collection of soil sample.***

All Environmental Lead Investigations include the following:

Assessment of lead hazards from any structural source by a licensed risk assessor or inspector to include:

(A) A complete assessment including recommendations to mitigate identified lead hazards.

(B) A written report to the family and the owner if the family does not own the site of contamination.

Identification of lead hazards from any nonstructural sources by licensed risk assessors or inspector to include:

(A) Identification and evaluation of nonstructural exposure sources within the individual's environment.

(B) Presentation of the environmental investigation results, including recommendations for reducing or eliminating exposure.

A written report must be provided to the family, owner of the contaminated site, and Local Health Department.