

HOME HEALTH SERVICES

Home health agencies will be reimbursed for covered services provided to Medicaid members through standard, statewide fee schedule rates, as follows:

- (1) one overhead rate per provider visit, per member, per day; plus
- (2) the staffing rate multiplied by the number of billing units spent in the performance of billable patient care activities;

to equal the total payment per visit.

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.

The staffing and overhead billing units for HHA services are as follows:

Home Health Service	Billing unit
Overhead	One unit per provider visit per member per day
Registered Nurse (RN)	Hourly
Licensed Practical Nurse (LPN)	Hourly
Home Health Aide	Hourly
Physical Therapist	15-minute increments
Occupational Therapist	15-minute increments
Speech Pathologist	15-minute increments

Medicaid fee schedule rates effective July 1, 2017 were determined using data from provider cost reports.

All fee schedule rates are available through the agency's website at www.indianamedicaid.com. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health care.

HOME HEALTH CARE SERVICES - TELEHEALTH MONITORING

Approved telehealth services are reimbursed separately from other HHA services. The unit of reimbursement for home health telehealth is one calendar day.

(1) The provider may bill a one-time amount of \$14.45 per beneficiary for an initial face-to-face visit necessary to train the beneficiary to appropriately operate the telehealth equipment.

(2) The Provider may bill the daily rate of \$9.84 for each day the telehealth monitoring equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

Rates for telehealth monitoring services shall not be adjusted annually.

All equipment and software cost associated with the telehealth monitoring services must be separately identified on the provider's annual cost report so that it may be removed from the calculation of overhead costs.

This page intentionally left blank.

This page intentionally left blank.

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.

All fee schedules are available through the agency's website at www.indianamedicaid.com. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health care. The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date.

HOME HEALTH CARE SERVICES – TELEHEALTH MONITORING

Approved telehealth monitoring services are reimbursed separately from other HHA services. The unit of reimbursement for home health telehealth is one calendar day.

(1) The provider may bill a one-time amount of \$14.45 per beneficiary for an initial face-to-face visit necessary to train the beneficiary to appropriately operate the telehealth equipment.

(2) The Provider may bill the daily rate of \$9.84 for each day the telehealth monitoring equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

Rates for telehealth monitoring services shall not be adjusted annually.

All equipment and software cost associated with the telehealth monitoring services must be separately identified on the provider's annual cost report so that it may be removed from the calculation of overhead costs.

TN: 13-011

Supersedes

TN: New

Approval Date: 5/14/14

Effective Date: 10/1/14

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. For medical supplies provided on or after July 1, 2013 through January 31, 2021, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on July 1, 2013. If this amount is not available, the Medicaid allowable shall be 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 (0.75). If this amount is not available, then
- (4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after February 1, 2021 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on January 31, 2021. If this amount is not available, the Medicaid allowable shall be:

- (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 manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
- (3) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
- (4) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after January 1, 2024, the Medicaid rate will be reviewed annually, taking into account the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount that takes effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary.

For medical supplies Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable amount for the purchase price shall be the lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10).

For medical supplies without Medicare fee schedule rates, reimbursement 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.

For medical supplies without an established fee schedule rate, the Medicaid allowable amount shall be:

- (1) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
- (2) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then

- (3) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after February 1, 2021 that are subject to Section 1903 (i)(27) of the Social Security Act, the Medicaid allowable shall be the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount effective as of January 1 of each year and updated on an annual basis, if available. For medical supplies that are subject to Section 1903 (i)(27) of the Social Security Act and Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be the lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10).

All reimbursement for medical supplies provided on or after July 1, 2011 thru December 31, 2013 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.

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.

Incontinence Supplies

Reimbursement for incontinence supplies (including diapers, briefs, catheters, trays, tape, gloves and ostomy/colostomy supplies) is based on the contract price established through competitive bidding in accordance with section 1915(a)(I)(B) of the Act and regulations at 42 CFR 431.54(d).

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. For ME provided on or after July 1, 2013 through January 31, 2021, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2013. 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 (0.75). If this amount is not available, then
- (4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after February 1, 2021 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on January 31, 2021. If this amount is not available, the Medicaid allowable shall be:

- (1) The Indiana Medicare fee schedule amount, 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 (0.75). If this amount is not available, then
- (3) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
- (4) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after January 1, 2024, the Medicaid rate will be reviewed annually, taking into account the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount that takes effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary.

For ME that Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be:

- (1) The lowest non-zero Indiana Medicare rental rate divided by one-and-one-half-tenths (0.15) for power wheelchairs, or
- (2) The lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10) for all other capped rental ME.

For ME without Medicare fee schedule rates, reimbursement 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.

For ME without an established fee schedule rate, the Medicaid allowable amount shall be:

- (1) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
- (2) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
- (3) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after February 1, 2021 that is subject to Section 1903 (i)(27) of the Social Security Act, the Medicaid allowable shall be the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount effective as of January 1 of each year and updated on an annual basis, if available. For ME that is subject to Section 1903 (i)(27) of the Social Security Act and Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be:

- (1) The lowest non-zero Indiana Medicare rental rate divided by one-and-one-half-tenths (0.15) for power wheelchairs, or
- (2) The lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10) for all other capped rental ME.

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. For hearing aids provided on or after July 1, 2011 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. For hearing aids provided on or after January 1, 2024, the Medicaid rate will be reviewed and adjusted at such time as Medicare-based rates for ME are adjusted, taking into account the level of Medicare fee schedule changes. For hearing aids without a fee schedule rate, 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 thru December 31, 2013, 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.

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 <https://www.in.gov/medicaid/>

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

TN# 10-002
Supersedes
TN# 07-003

Approval Date: MAY 17 2010

Effective Date: April 1, 2010

rate will take into account productions screens and applicable limits, (based on the provider's fiscal years ending 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. Federally Qualified Health Centers will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to FQHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHCs 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 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 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.

TN: 22-0014

Supersedes

TN: 21-006

Approval Date: February 28, 2023

Effective Date: 11/1/22

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

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.

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.

TN # 97-009

Supersedes

TN # -Approval Date 11/25/97Effective Date 7/1/97