TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #17-130(F)

DIGEST

Amends 405 IAC 1-4.2-4 to extend through June 30, 2019, the three percent rate reduction for covered home health agency (HHA) services that is currently set to expire on June 30, 2017. Amends 405 IAC 1-8-3 to extend through June 30, 2019, the three percent rate reduction for covered outpatient hospital services that is currently set to expire on June 30, 2017. Amends 405 IAC 1-10.5-6 to extend through June 30, 2019, the three percent rate reduction for covered inpatient hospital services that is currently set to expire on June 30, 2017. Amends 405 IAC 1-14.6-26 to extend through June 30, 2019, the three percent reduction for covered nursing facilities that is currently set to expire on June 30, 2017. Effective 30 days after filing with the Publisher.

405 IAC 1-4.2-4; 405 IAC 1-8-3; 405 IAC 1-10.5-6; 405 IAC 1-14.6-26

SECTION 1. 405 IAC 1-4.2-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-4 Home health care services; reimbursement methodology

Authority: IC 12-15
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 4. (a) HHAs will be reimbursed for covered services provided to Medicaid members through standard, statewide rates, computed as:

(1) one (1) overhead cost rate per HHA, per member, 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.

(b) 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 HHA total patient-related costs submitted by HHAs on forms prescribed by the office, less direct staffing and benefit costs, divided by the total number of HHA visits during the Medicaid reporting period for that HHA. The result of this calculation is an overhead cost per visit for each HHA.

(2) Array all HHAs 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.

(c) 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.

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

(1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHAs on forms prescribed by the office, divided by the total number of HHA 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 HHA and discipline.

(2) Array all HHAs 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.

(e) All HHAs must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all HHA personnel.

(f) Medicare-certified HHAs 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 HHAs are required to submit a Medicaid cost report on forms prescribed by the office and the latest fiscal year end financial statements.

(g) 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 HHA's cost from the most recent completed year will be adjusted for inflation using the Center for Medicare & Medicaid Services Home Health Agency Market Basket index as published quarterly by Global Insight. 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.

(h) The semivariable cost will be removed from the overhead cost calculated in accordance with subsection (b) and added to the staffing cost calculated in accordance with subsection (c), based on hours worked.

(i) Field audits will be conducted yearly on a selected number of HHAs. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.

(j) Financial and statistical documentation may be requested by the office. 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.
Failure to submit requested documentation within thirty (30) days of the date of the request may result in the imposition of the sanctions described in section 3.1(c) and 3.1(d) of this rule and sanctions set forth in IC 12-15-22-1.

(k) Retroactive repayment will be required when any of the following occur:
(1) A field audit identifies overpayment by Medicaid.
(2) The HHA knowingly receives overpayment of a Medicaid claim from the office. In this event, the HHA must:
(A) complete appropriate Medicaid billing adjustment forms; and
(B) reimburse the office for the amount of the overpayment.

(l) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, ~~2017,~~ **2019,** by three percent (3%) for home health services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA; filed May 23, 2017, 1:43 p.m.: 20170621-IR-405170130FRA)

SECTION 2. 405 IAC 1-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-3 Reimbursement methodology

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The reimbursement methodology for all covered outpatient hospital and ambulatory surgical center services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(b) Surgical procedures shall be:
(1) classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology; and
(2) paid a rate established for each ASC payment group.
Outpatient surgeries that are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups or additional payment groups. Reimbursement will be based on the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003.

(c) Payments for emergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(d) Payments for nonemergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(e) Reimbursement for laboratory procedures is based on the Medicare fee schedule amounts.

(f) Reimbursement for the technical component of radiology procedures shall be based on the Medicaid physician fee schedule rates for the radiology services technical component.

(g) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., shall be equal to the Medicaid statewide fee schedule amounts in effect during state fiscal year 2003.

(h) Payments will not be made for outpatient hospital and ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

(i) The established rates for hospital outpatient and ambulatory surgical center reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section.

(j) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(k) Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, ~~2017~~, **2019,** by three percent (3%) for outpatient hospital services (excluding ambulatory surgical center reimbursement) that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 16, 2010, 3:35 p.m.: 20100915-IR-405100167FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Oct 6, 2016, 2:59 p.m.: 20161019-IR-405160452ACA; filed May 23, 2017, 1:43 p.m.: 20170621-IR-405170130FRA)

SECTION 3. 405 IAC 1-10.5-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-6 Rate reduction

Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 6. Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced, through June 30, ~~2017,~~ **2019,** by three percent (3%) for inpatient hospital services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-6; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed May 23, 2017, 1:43 p.m.: 20170621-IR-405170130FRA)

SECTION 4. 405 IAC 1-14.6-26 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-14.6-26 Rate reduction

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 26. Notwithstanding all other provisions of this rule, reimbursement rates shall be reduced by three percent (3%) per resident day, through June 30, ~~2017,~~ **2019,** for nursing facility services that have been calculated under this rule except for the following:

(1) The difference between:
  (A) the nursing facility quality rate add-on, as described in section 7(m) of this rule; and
  (B) the nursing home report card score rate add-on calculated using each facility's current nursing home report card score, and the nursing home report card score rate add-on parameters contained in 405 IAC 1-14.6-7(k) of LSA Document #10-183, posted as a final rule in the Indiana Register at 20101201-IR-405100183FRA, effective December 1, 2010.

(2) The difference between:
  (A) the quality assessment rate add-on, as described in section 24(a) of this rule; and
  (B) the quality assessment rate add-on calculated using the assessment rates in 405 IAC 1-14.6-24(a) of LSA Document #10-65, posted as a final rule in the Indiana Register at 20101201-IR-405100065FRA, effective December 1, 2010.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-26; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed May 23, 2017, 1:43 p.m.: 20170621-IR-405170130FRA)

LSA Document #17-130(F)
Notice of Intent: 20170308-IR-405170130NIA
Proposed Rule: 20170419-IR-405170130PRA
Hearing Held: May 11, 2017
Approved by Attorney General: May 18, 2017
Approved by Governor: May 23, 2017
Filed with Publisher: May 23, 2017, 1:43 p.m.
Documents Incorporated by Reference: None Received by Publisher
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Posted: 06/21/2017 by Legislative Services Agency
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