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State/Territory Name: Indiana

State Plan Amendment (SPA) #: IN-15-0006

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

June 27, 2016

Joe Moser, Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, Indiana 46204

ATTN: Tim Hawkins

RE: Indiana TN #15-0006; 75 percent of Medicare physician increase

Dear Mr. Moser:

Enclosed for your records is an approved copy of the following state plan amendment (SPA).

Transmittal #15-0006:

- This SPA modifies the Medicaid reimbursement methodology for physician services by revising the payment rate so that the aggregate Medicaid reimbursement to physicians is at least 75 percent of the Medicare reimbursement for the same service, in accordance with the Healthy Indiana Plan 2.0 §1115 waiver special terms and conditions.
- Effective Date: February 1, 2015

The Centers for Medicare & Medicaid Services (CMS) notes that the approval of Indiana SPA 15-0006 includes the approval of Attachment 4.19-B Page 1c.1. The CMS is approving Attachment 4.19-B, page 1c.1 in recognition of the state's submission of SPA 15-0009 which addresses reimbursement methodology issues that were raised during the review of this SPA. With the submission of SPA 15-0009, the state amended page 1c.1 to address these issues. As a result, and per our agreement, Attachment 4.19-B page 1c.1 as found in SPA 15-0006 is now approvable.

If you have any questions, please have a member of your staff contact Tannisse Joyce at 312-886-5121 or by email at tannisse.joyce@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Tim Hawkins, OMPP
Kelly Flynn, OMPP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-006 REVISED

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR § 440.50

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 62,660.00 (Thousands)
b. FFY 2016 $85,220.00 (Thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 – B pages 1, 1a, 1a.1, 1b, 1c, and 1c.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 – B pages 1, 1a, 1a.1, 1b, 1c, 1c.1

10. SUBJECT OF AMENDMENT:
This amendment modifies the Medicaid reimbursement methodology for physician services by revising the payment rates so that the aggregate Medicaid reimbursement to physicians is equivalent to at least 75% of Medicare reimbursement for the same service. The State is making these changes in accordance with the Healthy Indiana Plan 2.0 section 1115 waiver recently approved by the Centers for Medicare and Medicaid Services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph Moser

14. TITLE: Medicaid Director

15. DATE SUBMITTED: ~~06/29/2015~~ 3/26/15

16. RETURN TO:
Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: ~~Amber Swartzell~~ Kelly Flynn, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/26/15

18. DATE APPROVED: 6/27/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 2/1/15

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

REIMBURSEMENT FOR SERVICES PROVIDED BY PHYSICIANS, LIMITED LICENSE PRACTITIONERS, AND NON-PHYSICIAN PRACTITIONERS

I. A. Summary of the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology

All services provided by physicians, limited license practitioners, and non-physician practitioners will be reimbursed according to a statewide fee schedule based on a Resource-Based Relative Value Scale (RBRVS). This includes services provided by:

Physicians and Limited License Practitioners

- doctors of medicine,
- osteopaths,
- physician or primary care group practices,
- optometrists,
- podiatrists,
- dentists who are oral surgeons,
- chiropractors, and
- health service providers in psychology.

Non-Physician Practitioners

- audiologists,
- physical, occupational, respiratory, and speech therapists,
- licensed psychologists,
- independent laboratory or radiology providers,
- advance practice nurses,
- dentists who are not oral surgeons.

Other Licensed Practitioners

- physician assistants,
- licensed independent practice school psychologist,
- licensed clinical social worker,
- licensed martial and family therapist,
- licensed mental health counselor,
- person holding a master's degree in social work, marital and family therapy, or mental health counseling,
- certified registered nurse anesthetists, and
- anesthesiologist assistants

All Other Licensed Practitioners are required to work under the direct supervision of a physician. All Other Licensed Practitioners, except CRNAs, must bill under the supervising physician's provider number.
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 were set on various dates and are effective for services provided on or after January 1, 2011. All rates and effective dates are published on the agency's website at www.indianamedicaid.com.

Effective for services provided on or after February 1, 2015, the components of the RBRVS methodology used to develop the fee schedule include the July 2014 Medicare Physician Fee Schedule (MPFS) non-facility Relative Value Units (RVUs), the 2014 MPFS Geographic Practice Index (GPCI) for Indiana, and the 2014 MPFS conversion factor. The RVUs are adjusted using the following 2014 Medicare locality GPCI values to reflect work, practice, and malpractice costs in Indiana: Work: 1.000, Practice Expense: 0.922, Malpractice: 0.615.

To determine the payment rate for each procedure under the RBRVS fee schedule, the Indiana-specific RVU for each procedure is multiplied by the conversion factor according to the following calculation: Payment Amount = (Indiana RVU x Indiana Medicaid Conversion Factor). For services prior to February 1, 2015, the Indiana Medicaid conversion factor is $28.61, which was developed using Indiana Medicaid claims data from fiscal year 1992 and specific policy assumptions relative to the Indiana Medicaid program. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversion factor is $26.8671, which equals 75% of the 2014 MPFS conversion factor of $35.8228. These rates are published at the State's website, www.indianamedicaid.com.

I. B. Summary of exceptions to the RBRVS reimbursement methodology

1. For procedures where no Medicare RVU exists, the RBRVS fee schedule amount was established using RVUs from other state Medicaid programs or developed specifically for the Indiana Medicaid program.

2. The Medicaid office developed RBRVS fee schedule amounts for certain maternity and primary care procedures to give special consideration to the importance of maternity and primary care services in the Indiana Medicaid program. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversion factor for maternity and antepatrum services is 100% of the 2014 MPFS conversion factor and applies to the following HCPCS codes: 59000 – 59350 and 59409 – 59871. The reimbursement rate for delivery HCPCS codes 59409 and 59514 is a single rate calculated based on the individual rates for these services as described above that are blended based on utilization. The reimbursement rates for antepartum HCPCS codes 59425 and 59426 are the rates calculated as described above, divided by the expected number of visits. The expected number of visits is 6 for 59425 and 10 for 59426.

3. The reimbursement rates for anesthesiology procedures were developed using the total base and time units for each procedure multiplied by the Indiana Medicaid conversion factor for anesthesiology, $13.88. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversation factor for anesthesiology procedures will be $16.26, which is 75% of the 2014 Medicare anesthesiology conversion factor for Indiana of $21.68. The calculation is: Anesthesia reimbursement rate = (Base Units + Time Units + Additional Units for age (if applicable) + Additional Units for physical status modifiers (as applicable)) x anesthesia conversion factor. Base units were assigned to all anesthesia CPT codes (00100 through 01999) based on the 2002 relative values as published by the American Society of Anesthesiologists. Effective for services provided on or after February 1, 2015, base units for anesthesia CPT codes (001000 through 01999) are based on the 2014 Medicare anesthesia base units. Additional base units are added for age and physical status as applicable. A member younger than one year old or older than 70 years old will receive one (1.0) additional base unit. Physical status modifier P3 (severe systemic disease) receives one (1.0) additional base unit, P4 (severe systemic disease that is a constant threat to life) receives two (2.0) additional base units, and P5 (moribund patient not expected to survive without operation) receives three (3.0) additional base units. If CPT code 99140 is billed to denote an emergency, two (2.0) additional base units are added for physical status modifiers P1 through P5. No additional base units are added for physical status modifier P6. Time

units are converted from the actual time reported on the claim at the rate of one unit for each 15 minute period or fraction thereof. Anesthesia time begins when the anesthesiologist begins preparing the patient for anesthesia care and ends when the anesthesiologist is no longer in personal attendance.

Medical direction of two, three, or four anesthesia procedures is reported using modifier QK and is reimbursed at 30% of the allowable physician rate. Separate reimbursement is not available for anesthesia administered by the same provider performing the surgical procedure.

4. The fee schedule amounts for services of dentists in calendar year 1994 were developed based on fiscal year 1992 charges and the percentage difference between physician and LLP submitted charges for fiscal year 1992 and RBRVS fee schedule amounts. Effective August 1, 1995, to determine the Medicaid allowable amount for which the 1992 charges are not available, Medicaid sets reimbursement rates for most dental procedures equal to 100% of the 75th percentile of the rates reported by the American Dental Association for the East North Central Region (ADA-ENC). The ADA-ENC-based rates may be adjusted annually for inflation, using the Consumer Price Index – Urban, Dental (CPI-UD). The Medicaid agency may set reimbursement for specific dental procedures using a different methodology in order to preserve access to the service. The current fee schedule, located at the State's website, www.indianamedicaid.com, is effective as of July 1, 1998.

   The five percent (5%) reduction in rates paid to providers in accordance with the methods described in Attachment 4.19-B for dental services provided on or after April 1, 2010 is extended through December 31, 2013. These rates are published at the State's website, www.indianamedicaid.com.

5. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversion factor for behavioral health procedures will be 28.6582, which equals 80% of the 2014 MPFS conversion factor of $35.8228. This methodology applies to the following HCPCS codes: 90785 – 90870, 96150 – 96155, and 99407 – 99408.

6. For telemedicine services provided through interactive television, a facility fee for the spoke site (the location where the patient is physically present) is reimbursed at the lesser of the provider's billed charge or the maximum allowance established by the Office of Medicaid Policy and Planning. The reimbursement rate is paid for one unit per encounter, and the maximum allowance is a state-wide rate based on Medicare's 2005 allowance for the spoke site service, which is $21.86.

   If a health care provider's presence at the spoke site is determined to be medically necessary by the provider at the hub site, separate reimbursement is available for the appropriate evaluation and management code for the service provided.

   The maximum allowance for reimbursement to the hub site (the location of the practitioner providing the consultation services) is based on specific Evaluation and Management (E&M) and End Stage Renal Disease codes and paid as if a traditional encounter were performed.

   Except as otherwise noted in the plan, state-developed fee schedule rates for telemedicine services are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 1, 2007 and is effective for services provided on or after that date. All rates are published at the State's website, www.indianamedicaid.com.

II. Application of reimbursement methodology for services provided by physicians and limited license practitioners (LLPs)

1. Reimbursement for services provided by physicians and limited license practitioners (LLPs), except for services described in subdivisions two (2) through six (6) below, will be equal to the lower of:

   ·the provider's submitted charges for the procedure, or
   ·the established RBRVS fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at twenty percent (20%) of the RBRVS fee schedule amount for the procedure and cosurgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure.

3. Reimbursement for all services is subject to the global surgery policy as defined by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

4. Reimbursement for services provided by physicians and LLPs is subject to the policy for supplies and services incident to other procedures as defined by the by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

5. Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections.

6. Reimbursement for services provided by physicians and LLPs is subject to the site-of-service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the RBRVS fee schedule amount for the procedure.

7. Payments for services to an out-of-state-provider will be negotiated on a case-by-case basis to obtain the lowest possible rate, not to exceed 100% of the provider's reasonable and customary charges, and may differ from the reimbursement methodology or amounts set out in the Indiana Administrative Code when such payments are required because the services are not available in-state or are necessary due to unique medical circumstances requiring care that is available only from a limited number of qualified providers.

III. Application of the RBRVS reimbursement methodology for services provided by non-physician practitioners (NPPs)

1. Reimbursement for services provided by non-physician practitioners (NPPs), except services described in subdivisions 2 and 3 below, will be equal to the lower of:

   ·the submitted charge for the procedure, or
   ·the established RBRVS fee schedule amount for the procedure.

2. Outpatient mental health services provided by:

   a licensed psychologist, or an advance practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing in a physician-directed outpatient mental health facility will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure.

The following HCPCS codes will be reimbursed using a conversion factor that is eighty percent (80%) of the 2014 MPFS conversion factor of $35.8228: 90785 – 90870, 96150 – 96155, and 99407 – 99408.

3. Services provided by independently practicing respiratory therapists (42 CFR 440.60), physical therapists' assistants (42 CFR 440.110) and advance practice nurses (42 CFR 440.166) will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure. State developed fee schedule rates are the same for both public and private providers of these services.

IV. Application of the RBRVS reimbursement methodology for services provided by other licensed practitioners

1. Certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AAs) are reimbursed at 60% of the allowable physician rate.

2. Outpatient mental health services provided by:

a licensed independent practice school psychologist, a licensed clinical social worker, a licensed martial and family therapist, a licensed mental health counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling in a physician-directed outpatient mental health facility will be reimbursed at seventy-five percent (75%) of the RBRVS fee schedule amount for that procedure.

The following HCPCS codes will be reimbursed using a conversion factor that is eighty percent (80%) of the 2014 MPFS conversion factor of $35.8228: 90785 – 90870, 96150 – 96155, and 99407 – 99408.

V. Laboratory services

1. For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement is based on the Medicare clinical laboratory fee schedule and is paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Medicaid clinical diagnostic laboratory fee schedules comply with Section 1903(i)(7) that limits Medicaid payments for clinical diagnostic lab services to the amount paid by Medicare for those services on a per test basis.

[Reserved for Future Use]

VI. Faculty Physician Access to Care Adjustments for Services Provided by Medical School Faculty Physicians

1. Beginning June 2, 2003, the office will make adjustments to payments, as necessary, for services provided by faculty physicians to Medicaid recipients in order to maintain adequate access to primary and specialty faculty physician services as required by 42 USC 1396(a)(30) and 42 CFR 447.204, and to compensate faculty physicians for their additional costs incurred in providing faculty physician services to Medicaid patients. The office will make adjustments to payments as follows:

    a. Subject to 42 CFR 447.10 and b. below, adjustments to payments for faculty physician services will be made quarterly by the office in an amount not to exceed the lesser of billed charges or an amount equal to the difference between:
        i. the amounts paid for services rendered to Medicaid recipients pursuant to the RBRVs fee schedule; and
        ii. the amounts that are the usual charges as defined in c. below, for the same services.

    b. The adjustments to payments for faculty physician services are subject to the following:
        i. In the event that sufficient funds are not available to provide the full amount of the state share for the adjustments, payments of the adjustments to the faculty physicians will be reduced proportionately; and
        ii. Beginning January 1, 2005, the amounts of the faculty physicians' payments will be subject to the office's performance standards. The office may adjust the faculty physicians' payments based upon the office's review and the faculty physicians' satisfaction of the office's performance standards, as stated in Section 2 below, in order to ensure adequate access to care for Medicaid recipients.

    c. "Usual charges" are defined as follows:

        i. For services rendered for the time period of June 2, 2003 through December 31, 2003, usual charges for faculty physician services to Medicaid patients will be an amount determined as follows:
            A. the average (as measured during the 2003 calendar year) 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 any fee-for-service rates the faculty physicians contractually agree 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.