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State/Territory Name: Indiana

State Plan Amendment (SPA) #: 15-0009

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

March 9, 2017

Joe Moser, Director
Family Social Services Administration
Office of Medicaid Policy and Planning
402 West Washington, Room W374
Indianapolis, IN 46204

ATTN: Tim Hawkins

RE: Transmittal Number (TN) 15-0009

Dear Mr. Moser:

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

TN 15-0009:

- This state plan amendment modifies the reimbursement methodology for faculty physician access-to-care payment adjustments to comply with federal requirements and to extend the payment adjustments to eligible faculty physicians and eligible practitioners employed by or affiliated with eligible health institutions.
- Effective Date: April 1, 2015

If you have any questions, please have a member of your staff contact Jennifer Maslowski at (217) 492-4120 or by email at jennifer.maslowski@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: 15-009

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
04/01/2015

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 USC 1396(a)(30); 42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 ($17,563)
b. FFY 2016 ($35,168)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B, Page 1c.1
Attachment 4.19B, Page 1c.2
Attachment 4.19B, Page 1c.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, Page 1c.1
Attachment 4.19B, Page 1c.2
Attachment 4.19B, Page 1c.3

10. SUBJECT OF AMENDMENT: This State Plan amendment modifies the existing Medicaid reimbursement methodology for faculty physician access-to-care payment adjustments to comply with new federal requirements and to extend the payment adjustments to eligible faculty physicians and eligible practitioners employed by or affiliated with eligible health institutions. The new payment methodology will make these payments on a periodic basis, for services provided by eligible faculty physicians and eligible practitioners, in an amount, which when combined with other payments under the Plan, will not exceed the average commercial rate as a percentage of Medicare. Supplemental payments will include performance-based adjustments.

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: 06/30/2015

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 30, 2015

18. DATE APPROVED: March 9, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

V. Access to Care Adjustments for Services Provided by Medical School Faculty Physicians and Practitioners

1. Beginning April 1, 2015, the office will make adjustments to payments, as necessary, for services provided by eligible physicians and practitioners to Medicaid recipients in order to maintain adequate access to primary and specialty physician and practitioner services as required by 42 USC 1396a(a)(30) and 42 CFR 447.204 and to compensate eligible physicians and practitioners for their additional costs incurred in providing services to Medicaid patients. The office will make adjustments to payments ("Medicaid Payment Adjustments") as follows:

   a. Medicaid Payment Adjustments to eligible physicians and practitioners

      (1) Medicaid Payment Adjustments will be made by the office to eligible physicians and practitioners. To be an eligible physician or practitioner, the physician or practitioner must be:
         i. A faculty physician with an in-state medical school or one of the following types of practitioners:
            a. Certified Registered Nurse Anesthetist
            b. Nurse Practitioner
            c. Physician Assistant
            d. Certified Nurse Midwife
            e. Clinical Social Worker
            f. Clinical Psychologist
            g. Optometrist
         ii. Licensed by the State of Indiana;
         iii. An enrolled Indiana Medicaid provider; and
         iv. Employed by or affiliated with an eligible health institution.

      Eligible health institutions are: (a) Indiana University Health, Inc. and its affiliates and (b) Health and Hospital Corporation of Marion County and its affiliates.

      (2) Subject to 42 CFR 447.10 and (3) below, Medicaid Payment Adjustments will be made quarterly by the office, with an annual reconciliation, in an amount not to exceed the difference between Indiana Medicaid RBRVS fee schedule for eligible physicians and practitioners and in accordance with state plan attachment 4.19-B page 1, 1a, 1a.1, 1b and 1c for practitioners, and the Enhanced Payment, as defined in b.(4) below. Eligible physicians and practitioners who receive Medicaid payments as authorized by attachment 4.19-B, Page 1c.4b through d in the state plan shall also receive these Medicaid Payment Adjustments provided they meet the office's applicable performance standards as discussed in (3) below. Eligible practitioners will also be required to meet the office's performance standards.

      (3) The amounts of the Medicaid Payment Adjustments to eligible physicians and practitioners are subject to the office's performance standards. The office may adjust the eligible physician and practitioner Medicaid Payment Adjustments based upon the office's review and the eligible physicians' and practitioners' satisfaction of the office's performance standards in order to ensure access to care for Medicaid recipients. An annual review will be conducted to measure and evaluate whether eligible physicians and practitioners have met performance standards. The results of the annual review will be applied to the quarterly payments for the following calendar year. No less than annually, the office will report the results of the annual review to CMS.

b. Medicaid Payment Adjustment Calculation

(1) Calculate the Average Commercial Rate: For each procedure code for which the payment adjustments will be made ("eligible procedure codes"), compute the average commercial rate by CPT Code, and modifier if applicable, including patient share amounts, by the top five payers during the defined base period.

(2) Calculate the Medicaid Payment Ceiling: Multiply the Average Commercial Rate as determined in Paragraph (1) above, by the number of times each eligible procedure code, and modifier if applicable, was paid in the base period for Medicaid beneficiaries, to eligible physicians and practitioners, as reported in the claims data. Calculate the Total Medicaid Payment Ceiling by summing the product of each eligible procedure code.

(3) Calculate the Average Commercial Rate as a Percentage of Medicare, for all eligible physicians and practitioners

i. Calculate Total Medicare Payments: Multiply the Medicare non-facility rate per procedure code by the number of times each eligible procedure code, and modifier if applicable, was paid for Medicaid beneficiaries during the base period as reported in the claims data. Add the product for all eligible procedure codes, to equal the Total Medicare Payments.

ii. Divide the Medicaid Payment Ceiling by Total Medicare Payments. This ratio expresses the Average Commercial Rate as a Percentage of Medicare.

iii. The Average Commercial Rate as a Percentage of Medicare will be rebased/updated at least every three (3) years.

(4) Determination of Medicaid Payment Adjustment for each eligible physician or practitioner

i. Determine the Enhanced Payment:
For Eligible Physicians and Practitioners: Multiply the Average Commercial Rate as a Percentage of Medicare by the Medicare rate for each eligible procedure code, and modifier if applicable. Sum the product for all eligible procedure codes to equal the Enhanced Payment.

ii. Determine the Medicaid Payment Adjustment Prior to Application of Performance Standards: the Medicaid Payment Adjustment Prior to Application of Performance Standards, for eligible physicians and practitioners, shall equal the Enhanced Payment less all Medicaid payments for eligible procedure codes paid in the applicable period for Medicaid beneficiaries to eligible physicians and practitioners, as reported in the claims data.

iii. The Medicaid Payment Adjustment is calculated by multiplying the Medicaid Payment Adjustment Prior to Application of Performance Standards by the applicable factor for the eligible physician or practitioner's achievement of the performance standards as averaged by respective group practice.

iv. Performance standards as established by the office and effective beginning April 1, 2015, are described in the following table.

Performance Metric	Performance Target	Data and Monitoring
1. Percent of new patients seen in clinics in less than 7 days.	≥ 35%	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
2. Median lag time for clinic visits in all specialties.	≥ 55% of new patients seen within 3 weeks of request	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
3. Median time for patient to see a provider in the Emergency Department.	≤ 40 minutes	• All hospital emergency department facilities of the eligible institutions. • Data as reported to Medicare.gov for Hospital Compare per satisfaction survey schedule with auditing / data checks as necessary.
4. Patient Satisfaction: Patients who reported YES, they would definitely recommend the hospital or clinic.	≥ 70%	• All physician group practices, emergency departments, and outpatient clinics of eligible institutions. • Data as reported to Medicare.gov for Hospital Compare and Physician Compare per satisfaction survey schedule with auditing / data checks as necessary.