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State/Territory Name: IN

State Plan Amendment (SPA) #: 15-023

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

NOV 03 2015

Mr. Joseph Moser, Director of Medicaid
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street, Room W461
Indianapolis, IN 46204-2739

ATTN: Amber Swartzell, State Plan Coordinator

Dear Mr. Moser:

Effective July 1, 2015, this amendment increases Medicaid reimbursement to intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD) by 3% from the methodology in effect on December 31, 2013. OMPP was directed by the Indiana General Assembly to make this change (House Enrolled Act 100 I, Sections 128 and 129 (2015)). Since there was a 3 % rate reduction in place on December 31, 2013 (pursuant to SPA T.N. #13-005), the net effect of a 3% increase to rates that have been reduced by 3%, is a reduction of nine-tenths of one percent (.09%) of the original Medicaid rate.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-0023 is approved effective July 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Fredrick Sebree at (217) 492-4122 or via email at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Timothy Hill [redacted]
Director

Enclosures

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

1. TRANSMITTAL NUMBER: 15-023

2. STATE: Indiana

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
July 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 447.253

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $555.5 (thousands)
b. FFY 2016 $2212.8 (thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D, page 111
Attachment 4.19D, page 119

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, page 111
Attachment 4.19D, page 119

10. SUBJECT OF AMENDMENT:
This State Plan amendment increases Medicaid reimbursement to intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD) by 3% from the methodology in effect on December 31, 2013.

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: 8/19/2015

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:

18. DATE APPROVED: NOV 03 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMC

23. REMARKS:

FORM HCFA-179 (07-92)

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day.

(d) All ICFs/IID that are licensed as a CRMNF will be paid at a per diem rate of six hundred thirty-nine dollars and eighteen cents ($639.18) per resident day.

This per diem rate is available only upon certification as a Medicaid ICF/IID and licensure by the division of disability and rehabilitative services. ICFs/IID that are licensed as CRMNFs are not subject to other rate adjustments identified in this rule except for 405 IAC 1-12-27 and will not receive a base rate nor be subject to the base rate reporting requirements at section 5 of this rule.

405 IAC 1-12-27 Rate Reduction

Sec. 27. Effective July 1, 2015, per diem Medicaid rates paid to nonstate owned intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and community residential facilities for the developmentally disabled (CRFs/DD) shall be reduced by nine-tenths of one percent (.09%) per Medicaid resident per day for services that have been calculated under this rule.