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State/Territory Name: IN

State Plan Amendment (SPA) #: 24-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

August 27, 2024

Cora Steinmetz
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
Attn: Madison May-Gruthusen, Federal Relations Lead

RE: TN 24-0005

Dear Director Steinmetz,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Indiana State Plan Amendment (SPA) to Attachment 4.19-B TN: #24-0005, which was submitted to CMS on June 26, 2024. This plan amendment proposes to makes changes to the SPA to revise the Medicaid reimbursement for physician services which will be reimbursed utilizing the Medicare payment policies for practitioner payment reductions and site-of-service payment reductions under the Medicare physician fee schedule.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of April 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or via email at matthew.klein@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0005

2. STATE: IN

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 438.5(b)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page 1b
Attachment 4.19-B Page 1c

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page 1b
Attachment 4.19-B Page 1c

9. SUBJECT OF AMENDMENT

This SPA equalizes Indiana Medicaid rates across all managed care programs.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Cora Steinmetz

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 26, 2024

15. RETURN TO
Cora Steinmetz
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
Attn: Madison May-Gruthusen, Federal Relations Lead

FOR CMS USE ONLY

16. DATE RECEIVED
June 26, 2024

17. DATE APPROVED
August 27, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

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

1. Reimbursement for services provided by physicians, clinical and independently practicing psychologists, 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 Medicaid RBRVS physician fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at sixteen percent (16%) of the Medicaid RBRVS physician amount for the procedure and cosurgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure. Assistant at surgery services provided by physician assistants and advanced practice registered nurses will be reimbursed at thirteen and six tenths percent (13.6%) of the Medicaid RBRVS physician amount for the procedure.

3. Reimbursement for all services is subject to the global surgery and multiple endoscopy policies 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 a non-office setting that are normally provided in a physician's office will be subject to the facility practice expense relative value unit policy as defined by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

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 below, will be equal to the lower of:
   ·the submitted charge for the procedure, or
   ·the established Medicaid RBRVS physician fee schedule amount for the procedure.
2. Outpatient mental health services provided by:
   a licensed psychologist will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure, and 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 eighty-five percent (85%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

3. Services provided on or after February 1, 2015 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 Medicaid RBRVS physician fee schedule amount for that procedure. Services provided on or after April 1, 2024 by advance practice nurses will be reimbursed at eighty-five percent (85%) of the Medicaid RBRVS physician fee schedule amount for that procedure. State developed fee schedule rates are the same for both public and private providers of these services.

4. Services provided for dates of service on or after July 1, 2018 by a certified community health worker and supervised by a physician, health services provider in psychology, advanced practice nurse, physician assistant, dentist, podiatrist, or chiropractor shall be reimbursed at fifty percent (50%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and privately employed providers. All rates are published at in.gov/Medicaid.

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

1. Certified registered nurse anesthetists (CRNAs) that are medically directed and anesthesiologist assistants (AAs) are reimbursed at 50% of the allowable physician rate. Certified registered nurse anesthetists (CRNAs) that are not medically directed are reimbursed at 100% of the allowable physician rate.

2. Physician assistants are reimbursed at 85% of the allowable physician rate.

3. Outpatient mental health services provided by:

   A licensed school psychologist, a licensed clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, a licensed clinical addiction 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 Medicaid RBRVS physician fee schedule amount for that procedure.

V. Laboratory services

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. The Medicaid lab fee schedule will be reviewed annually, taking into account the Medicare lab fee schedule rates published by CMS that take effect January 1 of each calendar year and adjusted as necessary. For procedures without Medicare fee schedule values, 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.