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State/Territory Name: IN

State Plan Amendment (SPA) #: 19-0004

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 S2-26-12
Baltimore, Maryland 21244-1850

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

Financial Management Group

September 11, 2019

Allison Taylor, Medicaid Director
Family Social Services Administration
402 West Washington, Room W461
Indianapolis, IN 46204

RE: State Plan Amendment (SPA) 19-0004

Dear Ms. Taylor:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 19-0004. This amendment proposes to continue the three percent (3%) reduction that is currently set to expire on June 30, 2019, for inpatient hospital service.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July, 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

cc:
Fredrick Sebree
Tom Caughey

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: 19-004

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: July 1, 2019

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 440.10

7. FEDERAL BUDGET IMPACT (*thousands*):
a. FFY 2019 $ (775)
b. FFY 2020 $ (3,084)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A Page 1 H.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A Page 1 H.3

10. SUBJECT OF AMENDMENT:
This State Plan amendment makes conforming changes to the State Plan to extend the current three percent (3%) rate reduction for inpatient hospital services that is currently set to expire on June 30, 2019. This rate reduction will be extended for the period July 1, 2019 through June 30, 2021. As this amendment is an extension of the current rate reduction, there is no fiscal impact associated with this amendment.

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 [redacted]

14. TITLE: Medicaid Director

15. DATE SUBMITTED:

16. RETURN TO:
Allison Taylor
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Amy Owens, Federal Relations Lead

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: SEP 11 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

The rates paid to providers in accordance with methods described in the preceding pages of Attachment 4.19-A for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 5% reduction for services on and after January 1, 2010. The 5% rate reduction will remain in effect through December 31, 2013. Medicaid payments for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 3% reduction for services on and after January 1, 2014 through June 30, 2021.

Notwithstanding the preceding paragraph, for the period beginning July 1, 2011, Indiana hospital rates are subject to a hospital adjustment factor. The hospital adjustment factors will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits.

A test will be made following the close of each state fiscal year to assure that annual inpatient payments do not exceed total inpatient billed charges for the fiscal year. Payments in excess of billed charges will be recovered. As permitted by 42 CFR 447.271(b), nominal charge hospitals identified in IC 12-15-15-11 are not subject to the inpatient charge limitation above.

The following sections of the State Plan do not apply for the period beginning July 1, 2011:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Inpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals.
- High Volume Outlier Payment Adjustment

The agency's rates are published in provider bulletins which are accessible through the agency's website, www.indianamedicaid.com.