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State: INDIANA

State Plan Amendment (SPA) #: 21-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

January 27, 2023

Allison Taylor, Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204

RE: TN 21-0006

Dear Ms. Taylor:

We have reviewed the proposed Indiana State Plan Amendment (SPA) to Attachment 4.19-B IN 21-0006, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 15, 2021. This plan amendment updates the reimbursement methodology for Medicaid reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to reimburse COVID-19 vaccine administration.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2021. 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 Debi Benson at 1-312-886-0360 or Deborah.Benson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 21-0006

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, 2021

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 § 405.24.69

7. FEDERAL BUDGET IMPACT (*thousands*):
a. FFY 2021 $135
b. FFY 2022 $500

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Page 2a.1
Attachment 4.19B Page 3d.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Page 2a.1
Attachment 4.19B Page 3d.1

10. SUBJECT OF AMENDMENT:
This State Plan amendment updates the reimbursement methodology for Medicaid reimbursement for FQHCs and RHCs to reimburse COVID-19 vaccine administration separately from the prospective payment system.

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: Allison Taylor

14. TITLE: Medicaid Director

15. DATE SUBMITTED: September 15, 2021

16. RETURN TO:
Allison Taylor
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
ATTN: Amy Owens, Government Relations Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **September 15, 2021**

18. DATE APPROVED: January 27, 2023

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **July 1, 2021**

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: **Todd McMillion**

22. TITLE: **Director, Division of Reimbursement Review**

23. REMARKS:

FORM HCFA-179 (07-92)

into account any increase or decrease in the scope of such services furnished by the center or clinic during the provider's fiscal year 2000, and increased by the percentage increase in the most current quarterly historical MEI (as defined in section 1842(I)(3)) applicable to primary care services (as defined in section 1842(I)(4)) for that fiscal year. This Prospective Payment System rate will be increased annually beginning January 1, 2002 by the percentage increase in the MEI and adjusted to take into account any increase or decrease in the scope of such services furnished by the RHC.

Until 1999 and 2000 cost reports are finalized and received by the office, Indiana Medicaid will provide for payment using an interim prospective payment rate to Rural Health Clinics in the following manner:

> The interim PPS rate will be established from rates paid during years 1999 and 2000. These amounts will be indexed (inflated) for MEI for each year and then a simple average of these two inflated amounts will be the rate paid.

In compliance with Section 702(b)(aa)(6)(B), a reconciliation back to January 1, 2001 will be performed to reconcile the interim PPS rate to the final PPS rate.

The establishment of an initial year rate for new providers certified after January 1, 2001, shall be determined in accordance with Section 702(b)(aa)(4) of BIPA 2000, taking into consideration geographic location, Medicaid utilization and similarity of services. In the absence of comparable data, the new clinic may be required to submit historical data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described in the paragraph above. Rural Health Clinics will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to Rural Health Clinics for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. Rural Health Clinics will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit

The office will provide for a supplemental payment for Rural Health Clinics furnishing services pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), in accordance with Section 702(b)(aa)(5), effective for services provided on or after January 1, 2001. The supplemental payments will be calculated based on the provider's base rate, as adjusted for MEI and any change in the scope of service, multiplied by the number of valid RHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four months. The provider is responsible for submitting the managed care claims to the office or its contractor for calculation of the supplemental payment.

> Field audits may be conducted annually on a selected number of Rural Health Clinics.

rate will take into account productions screens and applicable limits, (based on the provider's fiscal years ending 1999 and 2000) which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the provider's fiscal year 2001, and increased by the percentage increase in the most current quarterly historical MEI (as defined in section 1842(I)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year. This Prospective Payment System rate will be increased annually beginning January 1, 2002 by the percentage increase in the MEI and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC.

In the event a final settlement has not been reached on the provider's 1999 and 2000 FQHC cost reports by December 31, 2001, the alternative methodology may be extended for a period of not more than 180 days. If cost reports have not been finalized after a period of not more than 180 days, an interim prospective payment system rate equal to the most recent rate on file will be used to reimburse FQHC services until such time that the cost reports are final. This interim PPS rate will be adjusted annually beginning January 1, 2003 by the MEI.

In conformance with Section 702(b)(aa)(6)(B) of BIPA, a reconciliation will be performed to ensure that each center or clinic received reimbursement for such services in an amount that is at least equal to the amount that would have been paid under the Prospective Payment System described in Section 702(b)(aa) of BIPA.

The establishment of an initial year rate for new providers certified after January 1, 2001, shall be determined in accordance with Section 702(b)(aa)(4) of BIPA 2000, taking into consideration geographic location, Medicaid utilization and similarity of services. In the absence of comparable data, the new clinic may be required to submit historical cost data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described above. Federally Qualified Health Centers will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to FQHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHCs will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit.

The office will provide for a supplemental payment for FQHCs furnishing services pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), in accordance with Section 702(b)(aa)(5), effective for services provided on or after January 1, 2002. The supplemental payments will be calculated based on the provider's base rate, as adjusted for MEI and any change in scope of service, multiplied by the number of valid FQHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four months. The provider is responsible for submitting the managed care claims to the Office or its contractor for calculation of the supplemental payment.

Field audits may be conducted annually on a selected number of Federally Qualified Health Centers.