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State/Territory Name: Indiana

State Plan Amendment (SPA) #: 22-0011

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



December 9, 2022

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
401 W. Washington Street, Room W374
Indianapolis, IN 46204

Re: Indiana State Plan Amendment (SPA) 22-0011

Dear Ms. Taylor:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 22-0011. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Indiana requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers of the requirements related to SPA submission timelines and public notice apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Indiana's Medicaid SPA Transmittal Number 22-0011 is approved effective March 1, 2020. This SPA supersedes Transmittal Number 21-0002.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Mai Le-Yuen at 312.353.2853 or by email at mai.le-yuen@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Indiana and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2022.12.09
09:12 28 -05'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 2</u> — <u>0 0</u> <u>1 1</u>	2. STATE <u>IN</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE March 1, 2020
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5. FEDERAL STATUTE/REGULATION CITATION Section 1135 of the Social Security Act; Title XIX of the Act	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2020</u> \$ <u>58,480</u> b. FFY <u>2021</u> \$ <u>158,190</u>
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7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Section 7 - 7.4 Medicaid Disaster Relief SPA	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Section 7 - 7.4 Medicaid Disaster Relief SPA
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9. SUBJECT OF AMENDMENT
This State Plan Amendment will correct FQHC/RHC payment methodology language from the previous Disaster Relief SPA (TN 21-0002)

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 S 	15. RETURN TO Allison Taylor 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
12. TYPED NAME Allison Taylor	
13. TITLE Medicaid Director	
14. DATE SUBMITTED September 20th, 2022	

FOR CMS USE ONLY

16. DATE RECEIVED 9/20/2022	17. DATE APPROVED December 9, 2022
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL March 1, 2020	19. SIGNATURE OF APPROVING OFFICIAL Alissa M. Deboy -S <small>Digitally signed by Alissa M. Deboy -S Date: 2022.12.09 09:12:53 -05'00'</small>
20. TYPED NAME OF APPROVING OFFICIAL Alissa Mooney DeBoy	21. TITLE OF APPROVING OFFICIAL On Behalf of Anne Marie Costello, Deputy Director, CMCS

22. REMARKS

Section 7 – General Provisions**7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Indiana reserves the right to terminate any of the emergency provisions in this amendment prior to the end of the emergency period through submission of an updated SPA to CMS. Indiana Medicaid policy will provide detail on which requirements are amended.

The following provisions are to be end dated as of August 31, 2020:

Section E2: Home Health COVID expense reimbursement is available through August 31, 2021.

The following provisions are to be end dated as of February 28, 2021:

Section E4: In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred for dates of service through February 28, 2021.

The following provisions are to be end dated as of March 31, 2021:

Section E1: 4.2% per diem rate increase for Nursing Facilities for states of service through March 31, 2021.

Section E3: Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members. Assisted living providers have through July 31, 2021 to request reimbursement for COVID-19 related expenses incurred for dates of service prior to March 31, 2021.

The following provisions are to be end dated as of June 30, 2021:

Section E1: 3% per diem rate increase for Nursing facilities for dates of service between April 1, 2021 and June 30, 2021.

Section E5: Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 12/1/20

Section E6: Indiana Medicaid will pay for COVID vaccine administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

Section E7: Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency

is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. The agency uses a simplified paper application.
 - b. The agency uses a simplified online application.
 - c. The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. The agency suspends enrollment fees, premiums and similar charges for:
- a. All beneficiaries
 - b. The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

The reimbursement for treat/no transport (billed with procedure code A0998) was set at \$76.71 for the duration of the public health emergency. This rate is equivalent to Indiana Medicaid’s fee for service reimbursement for CPT code 99203, a level 3 new patient E/M

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

1. Nursing facilities

2. Home Health Agencies
3. Assisted Living Providers
4. Emergency Medical Services (EMS)
5. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
6. COVID-19 Vaccine Administration
7. COVID-19 Treatment Payments

a. X Payment increases are targeted based on the following criteria:

1. **Nursing Facilities**

A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

Two additional add-on payments will be calculated and paid to qualifying nursing facility providers. Providers that have attested to being "COVID-19 Ready" in accordance with Indiana Department of Health (IDOH) criteria will receive a temporary 2% rate increase for the period beginning 5/1/2020 and ending 8/31/2020. The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.
2. A \$115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The \$115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. **Home Health Agencies**

Home Health agencies applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of fee for service members between March 1, 2020 and August 31, 2020 up to 4.2% of their paid fee for service claims for services provided March 1, 2019 through August 31, 2019.

3. **Assisted Living Providers**

Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members for dates of service from March 1, 2020 through March 31, 2021 subject to a 3% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

4. **Emergency Medical Services (EMS)**

In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred March 1, 2020 through February 28, 2021 subject to a 4.2% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

5. **FQHCs and RHCs**

Effective with dates of service December 1, 2020 through the end of the public health emergency, the Indiana Medicaid will pay only Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that agree to accept this alternate payment methodology (APM), the Medicare Rate for the administration of the COVID-19 vaccine. This payment will be a supplemental payment in addition to (but billed separately from) the prospective payment system (PPS) rate. Payments under the APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs. This APM was developed to support FQHCs/RHCs, as a key COVID-19 vaccine provider. Payments under this APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs as the PPS cost base did not include these costs.

Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees using an alternate payment method (APM) that pays at the Medicare rate, in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 12/1/2020. Indiana Medicaid opted to pay at the Medicare rate to encourage the administration of the COVID-19 vaccine to Medicaid members. Payment will be made to FQHCs/RHCs on a per claim basis for each dose of vaccine administered. (This will include any booster or annual boosters that will be implemented)

The supplemental payments under the APM are for all COVID vaccine administration services. The payment to FQHC/RHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHC/RHCs 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.

-6. COVID-19 Vaccine Administration

Indiana Medicaid will pay for the COVID-19 Vaccine Administration fees at a higher rate than the rate methodology in the Indiana State Plan.

In addition, FQHCs and RHCs will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to FQHC/RHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHC/RHCs 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.

7. COVID-19 Treatment Payments

Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

- ii. x (1, 2, 3, 4, 5, 6, 7) An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

x (6, 7) Up to the Medicare payments for equivalent services.

X (1, 2, 3, 4, 5, 6, 7) By the following factors:

Nursing Facilities

1. A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.

2. A \$115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The \$115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. Home Health Agencies

For dates of service from March 1, 2020 through August 31, 2020 Home Health agencies will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

3. Assisted Living Providers

For dates of service from February 2020 through March 2021 Assisted Living providers will be reimbursed the lesser of their reported COVID-19 related expenses or 3% of Medicaid revenues paid during the relief period.

4. Emergency Medical Services (EMS)

For dates of service March 1, 2020 through February 28, 2021 in state Emergency Medical Services will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

5. FQHCs and RHCs

The COVID vaccine administration fee will be reimbursed in addition to (but billed separately from) the Medicaid PPS rate. For dates of service from 1/18/21 - 2/20/21, the vaccine administration will be \$16.94 for the first dose in the two-dose series and \$28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be \$15.83 and \$26.11 (respectively). For dates of service on or after 3/17/21, the vaccine administration fee will be \$37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca).

6. COVID-19 Vaccine Administration

For dates of service from 12/12/20 (Pfizer vaccine) and 12/18/20 (Moderna vaccine) through 2/20/21, the vaccine administration will be \$16.94 for the first dose in the two-dose series and \$28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be \$15.83 and \$26.11 (respectively). For dates of service on or after 3/17/21, the vaccine administration fee will be \$37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca). The \$16.94 and \$28.39 were the nationwide rates and all other rates are Indiana Medicare's specific rates from the CMS physician fee schedule.

7. COVID-19 Treatment Payments

For dates of service from 11/10/20 (bamlanivimab treatment manufactured by Eli Lilly: procedure code M0239) and 11/21/20 (casirivimab and imdevimab treatment manufactured by Regeneron: procedure code M0243) through 12/31/21, the COVID treatment administration fee will be \$309.60. For dates of service from 1/21/21 through 5/5/21, the treatment administration fee will be \$278.98 when billed on a professional claim. For dates of service on or after 5/6/21, the treatment administration fee will be \$403.66. The \$309.60 rate was the nationwide COVID treatment administration rate and \$279.98 \$403.66 are Indiana Medicare's specific rates from the 2021 CMS physician fee schedule. Outpatient reimbursement for COVID treatment administration followed Indiana Medicaid's state plan outpatient reimbursement methodology for dates of service on or after 1/1/21.

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. Are not otherwise paid under the Medicaid state plan;
 - b. Differ from payments for the same services when provided face to face;
 - c. Differ from current state plan provisions governing reimbursement for telehealth;
-
- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
 - i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

- ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

- 4. Other payment changes:

Effective for dates of service on or after March 1, 2020, EMS providers transporting COVID-19 positive or symptomatic individuals will be trips scheduled as and reimbursed as basic life support (BLS), unless the individual meets medical necessity for advanced life support (ALS).

Section F – Post-Eligibility Treatment of Income

- 1. The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. The individual’s total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount: _____
- 2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this

information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.