Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Indiana

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor--

☒ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Office of Medicaid Policy and Planning
(Designated Single State Agency)

Date: 10/16/91

James M. Verdin
(Signature)

ASST. SEC. MEDICAID POLICY AND PLANNING
(Title)

TN No. 91-16
Supersedes TN No. 78-5
Approval Date 3-13-92 Effective Date 1-1-92

HCFA ID: 7982E

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 a recission SPA to CMS. Indiana Medicaid policy will provide detail on which requirements are amended.

The following provisions are to be end dated as of June 1, 2020:
Section D6: Drug Benefit, 90 day fills of maintenance drugs.

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 October 21, 2020:
Section D5: Telehealth IATV technology requirement

The following provisions are to be end dated as of December 31, 2020:
Section G: Therapeutic leave for individuals with IID/IDD living in intermediate care facilities.

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 D2 and E1b: The reimbursement and coverage for treat/no transport is effective for dates of service through 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 1/18/21.
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.

The following provisions are to be end dated as of July 10, 2021:
Section D5: Remaining telehealth provisions

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

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

a. __X___ 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. __X___ 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. __X___ 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 inconsistences 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. _x___ The agency makes the following adjustments to benefits currently covered in the state plan:

42 CFR 440.130(c) Preventative Benefit: Beginning March 1, 2020 and through June 30, 2021, Indiana Medicaid will provide coverage when care is provided by certified paramedics or emergency medical technicians in response to an emergency call to a member's home or on a scene, when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. This is referred to as treat/no transport and is provided under the preventive services benefit at 42 CFR 440.130(c). The response must originate through a 9-1-1 call. Services provided are recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law and administered by a paramedic licensed by the Indiana emergency medical services commission or an emergency medical technician certified by the Indiana emergency medical services commission.

3. ___X__ 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. __X___ 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. __X__ 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. __X___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Indiana Medicaid will remove the technology requirement that providers must use an "IATV" technology, a specification which is end-dated for October 21, 2020. Indiana Medicaid will remove the face-to-face requirement to allow for other telemedicine communication types such as phone and voice-only communication. Additionally, Indiana Medicaid will remove the following limitations for telemedicine from the Medicaid State Plan and allow reimbursement for these services/providers when delivered via telemedicine: long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled; audiological services; optical or optometric services (effective March 01, 2020, end-dated October 21, 2020); podiatric services; physical therapy services. The telemedicine limitations in the Medicaid State Plan will remain as follows: surgical services; home health providers and services; radiological services; laboratory services; anesthesia services; chiropractic services; care coordination services without the member present, unless this type of service is covered as part of the member's benefit plan or package; DME and HME providers; transportation services; and provider to provider consultations.

Drug Benefit:

6. __X___ 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.
Until 6/1/2020, Indiana will allow 90 day fills of maintenance drugs to decrease the need for individuals to visit pharmacies.

7. __X___ 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. __X___ 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. __x__ 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. __X__ 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 in 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 during COVID-19 vaccine-only visits.

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 during COVID-19 vaccine-only visits 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 only for the COVID-19 vaccine-only visits. If the COVID-19 vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will receive their provider-specific PPS rate. FQHCs/RHCs may not receive a supplement payment under this APM and a PPS payment for encounters that include the COVID-19 vaccine administration.

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/RHCs will receive payment for COVID-19 vaccine administration fees using an APM that pays the FQHCs and RHCs at the Medicare rate as a supplemental payment in addition to (but billed separately from) the PPS rate. Payments will be made on a per claim basis for each dose of the COVID-19 vaccine administered to Medicaid members. (This will include any boosters and annual boosters that will be implemented.)

The supplemental payments under the APM are only for the COVID-19 vaccine-only visits. If the COVID-19 vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will receive their provider-specific PPS rate. FQHCs/RHCs may not receive a supplement payment under this APM and a PPS payment for encounters that include the COVID-19 vaccine administration.

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. _x_ 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. _x_ 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. ___x__ 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

Hospitalizations Indiana Medicaid removes the requirement for automatic discharge of individuals with intellectual or developmental disabilities (IID/IDD) from intermediate care facilities (ICFs) who are hospitalized more than 30 days. Therapeutic Leave of Absence Modifies the current limit of 60 calendar days of leave to 180 calendar days for only therapeutic reasons through December 31, 2020. Reimburse providers at the bed-hold rate for the duration of the extended leave periods. Removes the requirement for a physician's order for these leaves. Indiana Medicaid will reimburse CLIA certified pharmacy providers for COVID-19 tests, included under their certification, ordered by pharmacists employed by the facility, and administered by qualified pharmacists, pharmacist interns, and pharmacy technicians.

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.

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:

Describe shorter period here.

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

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

a. __x___ 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. __x___ 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.

Include name of the optional eligibility group and applicable income and resource standard.

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. __X___ 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 inconsistences 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. ___X__ 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). The State suspends all cost sharing.

2. ___X__ The agency suspends enrollment fees, premiums and similar charges for:

    a. __X___ 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:

Please describe.

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 –

State/Territory: Indiana

Effective date (enter date of change): _____

Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Please list all that apply.

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

Please describe criteria.

b. Payments are increased through:

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

Please describe.

ii. ____ 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): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

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;

Describe telehealth payment variation.

    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:

Please describe.

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.

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

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

a. __X___ 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. __X___ 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 inconsistences 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. __x__ 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. __X__ 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. __x__ 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. __x__ 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. ___x__ 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

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