DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, Section 1923 of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers that serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

(A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.

(B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the division of mental health." This group of providers is commonly referred to as state hospitals.

(C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.

(D) "Community Mental Health Center" has the following meaning: "a program of services approved by the division of mental health and organized for the purpose of providing multiple services for the mentally handicapped and operated by one of the following or combinations thereof:

(1) Any city, town, county or other political subdivision of this state; any agency of the state of Indiana or of the United States; and any political subdivision of another state; including but not limited to and without limiting the generality of the foregoing, hospitals owned or operated by units of government and building authorities organized for the purpose of constructing facilities to be leased to units of government;

(2) A corporation incorporated under the provisions of IC 1971, 23-7-1.1, the "Indiana General Not for Profit Corporation Act";

(3) A nonprofit corporation incorporated in another state; and

(4) A university of college.

(E) "Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital licensed under IC 16-21, the Indiana hospital licensure statute; a State Mental Health Institution under the administrative control and responsibility of the Director of the State Division of Mental Health; or a Private Psychiatric Institution licensed under IC 12-25, that qualifies as an inpatient hospital eligible for DSH payments as set out in the requirements in section 1923 of the Act,

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana, or,

(2) whose low income utilization rate exceeds twenty-five percent (25%).

No hospital may be a disproportionate share hospital unless the hospital:

(i) has a Medicaid utilization rate of at least one percent (1%); and
(ii) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision, (ii), does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer non-emergency obstetric services as of December 21, 1987.

For state fiscal years ending after June 30, 1997, eafch hospital's eligibility for disproportionate share payments under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report for the individual hospital is on file with the office.

(F) "Historical disproportionate share provider" has the following meaning:

An acute care hospital licensed under IC 16-21 which was eligible for a disproportionate share hospital payment for the state fiscal year ending on June 30, 1998, and which is eligible for a disproportionate share hospital payment in the year for which payments are being calculated.

(G) "Municipal Disproportionate Share Provider" has the following meaning: An acute care hospital licensed by the State of Indiana and established and operated under Indiana Code 16-22-2 or 16-23, that based on utilization and revenue date from the most recent year for which an audited cost report is on file with the office, has a Medicaid Inpatient Utilization Rate greater than one percent (1%). IC 16-22-2 and 16-23 are enabling statutes for county and city-county hospitals under Indiana law.

(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: A community health center designated as such by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients, and whose Medicaid Inpatient Utilization Rate, based on utilization and revenue data from the most recent year for which an audited cost report is on file with the office, is greater than one percent (1%). Indiana Code 12-29-1-7(b) provides for property tax funding by individual counties of community mental health centers situated in those counties.

(I) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days in the most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period, where inpatient days includes each day in which an individual (including newborns, Medicaid managed care beneficiaries, and Medicaid beneficiaries from other states) is an inpatient in the hospital, whether or not the individual is in a specialized ward (including acute care excluded unit distinct part subproviders of the provider) and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term "inpatient days" includes days attributable to Medicaid managed care recipients and Medicaid eligible patients. The term does not include days attributable to Medicaid patients between the ages of 21 and 65 in Institutions for Mental Disease.

(J) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in the most recent year for which audited cost reports are on file with the office; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include in the statistical database for the statewide mean calculation, the Medicaid Inpatient Utilization Rates of providers whose low income utilization rates exceed twenty-five percent (25%).

(K) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following:

(i) the total Medicaid patient revenues paid to the provider during the most recent year for which an audited cost report is on file with the office; plus

(ii) the amount of the cash subsidies received directly from state and local governments, during the most recent year for which an audited cost report is on file with the office, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for patient services (including cash subsidies) during the most recent year for which an audited cost report is on file with the office; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services during the most recent year for which an audited cost report is on file with the office that are attributable to care provided to individuals who have no source of payment or third party or personal resources, less the amount of any cash subsidies described in clause (K)(1)(A)(ii) above; and

(B) the denominator is the total amount of charges for inpatient services in the same cost reporting period.

The numerator in clause (2)(A) shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan.

(L) For purposes of eligibility, utilization rate and payment adjustment determinations for State fiscal years ending after June 30, 1997, "utilization and revenue data from the most recent year for which an audited cost report is one file" means utilization and revenue data from the most recent cost report which is on file for each individual provider as of June 30 of the state fiscal year immediately preceding the fiscal year for which the determination of eligibility of the calculation or rates or the calculation of payment adjustments is being made, and which has been audited prior to the date on which the determination or calculation is made.

(M) For purposes of calculating DSH eligibility, audited is defined as a targeted limited scope desk review where the data used for DSH calculations is thoroughly reviewed and adjusted where necessary.

(N) "Non-State Government-Owned or Operated Hospital" means a health care facility providing inpatient and outpatient hospital services that is (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

(O) "Eligibility Determination" means the office's targeted limited scope desk review of survey data, cost and claims reports, and documentation in order to determine (1) the criteria for qualification as a disproportionate share hospital under Section II(E); and (2) hospitals which satisfy that criteria.

(P)"Eligibility Period" means the state fiscal year(s) for which an Eligibility Determination applies and which ends immediately prior to the commencement of the state fiscal year for which the office next makes an Eligibility Determination. The duration of an Eligibility Period shall be at least two SFYs, but no more than four SFYs, in length.

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

Subject to Subsection H, Disproportionate Share Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment calculated in the following manner for SFY 2012 and thereafter:

In no instance will any Disproportionate Share Hospital payments exceed the hospital specific limit as defined in subsection B 1. The provisions in subsection B 1 are applicable for SFY 2012 and thereafter and also apply to DSH eligible freestanding psychiatric institutions licensed under IC 12-25. DSH payments that are retrospectively determined to exceed the hospital specific limit shall be recovered by the office. For DSH payments made on or after 7/1/2011, any DSH allotment recovered by the office may be redistributed to other DSH eligible hospitals in accordance with the payment order below, not to exceed any hospital's hospital specific limit. The amount of DSH redistribution payments is limited to the amount recouped by the office.

Any Disproportionate Share Hospital may decline all or part of the annual DSH payments by submitting documentation to the State indicating that it declines the DSH payments and the amount of DSH payments being declined.

1. Step One: Each Disproportionate Share Hospital receives a payment of $1,000, not to exceed the hospital's hospital specific limit.

2. Step Two: Municipal Disproportionate Share Providers established and operated under Indiana Code 16-22-2 or 16-23 receive payment amounts equal to the lower of the hospital's hospital specific limit for the payment year less any Step One amount received by that hospital; or the hospital's net 2009 supplemental payment amount.

3. Step Three: DSH eligible acute care hospitals licensed under IC 16-21 located in Lake County, Indiana receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any Step One amount received by that hospital.

4. Step Four: DSH eligible private acute care hospitals licensed under IC 16-21 and DSH eligible hospitals established and operated under Indiana Code 16-22-8 receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital under step one. If not enough DSH funds are available to pay all eligible hospitals in this group up to their respective hospital specific limits, the amount paid to each hospital will be reduced by the same percentage for all hospitals in the group.

5. Step Five: If there is DSH remaining after the above steps, DSH eligible freestanding psychiatric institutions licensed under IC 12-25 receive payment amounts equal to the institution's hospital specific limit for the payment year, less any payment received by the institution under step one. If not enough DSH funds are available to pay all eligible institutions in this group up to their respective hospital specific limits, the amount paid to each institution will be reduced by the same percentage for all institutions in the group. Institutions owned by the State of Indian are not eligible for payments from this pool.

Steps six and seven below apply to DSH payments for SFYs 2013 and thereafter.

6. Step Six: If there is DSH remaining after the above steps:
    a. a Municipal Disproportionate Share Provider established and operated under Indiana Code 16-22-2 or 16-23 receives a payment amount equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital for the payment year under step one and step two; and

    b. a private acute care hospital established and operated under Indiana Code 16-21-2 that:
        i. has a Medicaid inpatient utilization rate for the DSH eligibility period for the payment year that is at least equal to the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but does not equal or exceed one (1) standard deviation above the mean Medicaid inpatient utilization rate; and
        ii. satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d);

    receives a payment amount equal to the hospital's hospital specific limit for the payment year.

    If not enough DSH funds are available to pay all hospitals eligible under this step up to their respective hospital specific limits, the amount paid to each hospital under this step will be reduced by the same percentage for all hospitals eligible under this step.

7. Step Seven: If there is DSH remaining after the above steps, a private acute care hospital established and operated under Indiana Code 16-21-2 that:

    a. has a Medicaid inpatient utilization rate for the DSH eligibility period for the payment year that is less than the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but is at least greater than one percent (1%); and

    b. satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d);

    receives a payment amount equal to the hospital's hospital specific limit for the payment year.

    If not enough DSH funds are available to pay all hospitals eligible under this step up to their respective hospital specific limits, the amount paid to each hospital under this step will be reduced by the same percentage for all hospitals eligible under this step.

Disproportionate share hospital payments described in this section may be made on an interim basis throughout the year as determined by the office.

Interim DSH payments will be calculated using the payment methodology described above, based on the best available data at the time of the calculation. To determine the interim payment amount, the hospitals' calculated DSH payments will be multiplied by two percentages: 1) the ratio of the total DSH allotment for the payment year divided by the sum of all DSH eligible and appealing hospitals' hospital specific limits for that same year, not to exceed 1, and 2) the percentage of the state fiscal year that has been completed at the time of the payment. Partial payments to psychiatric hospitals will be limited to the amount paid in step 1.

The disproportionate share payment adjustment calculations described below and in subsections B 2 and C through G do not apply for SFY 2012 and thereafter.

(1) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars ($2,000,000) shall be distributed to all qualified private psychiatric DSH's licensed by the director of the state department of health to provide private institutional psychiatric care, whose Medicaid impatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana and/or whose low income utilization rate exceeds twenty-five percent (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each qualifying hospital's Medicaid inpatient utilization rate bears to the total of the Medicaid inpatient utilization rates of all hospitals in the pool as determined based on data form the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital. In no instance will any hospital in this pool be entitled to disproportionate share amounts that when added to the hospital's payments associated with Medicaid and uninsured care yield a combined total reimbursement that exceeds 100% of the hospital's allowable cost of delivering Medicaid and uninsured care. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered by the office.

(2) For each state fiscal year ending on or after June 30, 1995, a pool not exceeding one hundred ninety-one million dollars ($191,000,000) shall be distributed to all state mental health DSH's whose inpatient utilization rates are al least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana or whose low income utilization rate exceeds twenty-five percent (25%). The fund in this pool must be distributed to the qualifying hospitals in the proportion that each hospital's low income utilization rate, multiplied by total Medicaid days, bears to the product of the same factors of all hospital in the pool using data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital.

Disproportionate share payments described in this section shall be made on an interim basis throughout the year as determined by OMPP.

B. DSH Payments to Acute Care Hospitals Licensed Under IC 16-21

1. For the state fiscal years ending after June 30, 2000, the following payment methodology will be utilized for the distribution of payments to acute care hospitals licensed under IC 16-21:

   (1) The office will distribute disproportionate share payments to all qualifying acute care hospitals, in an aggregate sum which does not exceed the limits imposed by federal law and regulation, including the statewide allocation limits for disproportionate share payments imposed by 42 USC 1396r-4(f).

   (2) Each qualifying hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH payment provisions of the State Plan.

   (3) The hospital-specific limit for each hospital shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital to determine the hospital's hospital-specific limit.

2. (a) For the Eligibility Period beginning July 1, 2001, hospitals meeting the office's Medicaid disproportionate share provider criteria as described in Attachment 4.19A, Section II(E) of this Plan (the "office's Medicaid DSH criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid DSH criteria for the Eligibility Period ending on June 30, 2001, will receive disproportionate share payments equal to 100% of their individual hospital-specific limit. For later Eligibility Periods, hospitals receiving payment pursuant to this subsection (a) will be subject to (b), (c), (d) and (e) below, as applicable.

(b) For the Eligibility Periods beginning after June 30, 2001, a hospital, whether a historic disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid disproportionate share payment in the amount of 100% of its hospital-specific limit will continue to receive Medicaid disproportionate share payments in the amount of 100% of its hospital-specific limit for subsequent Eligibility Periods in which it meets the office's Medicaid DSH criteria unless the hospital has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period shall be subject to (c), (d), and (e) below, as applicable, for later Eligibility Periods.

(c) For the Eligibility Periods beginning after June 30, 2001, if a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid DSH criteria for any Eligibility Period, the hospital will receive Medicaid disproportionate share payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination by the office, if the hospital is able to meet the office's Medicaid DSH criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid disproportionate share payment will be calculated as set forth in (b), (d) or (e) of this section 2., as applicable.

(d) Except as set forth in (a) above, for Eligibility Periods beginning after June 30, 2001, hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(i) licensed under IC 16-21,

(ii) meeting the office's Medicaid DSH criteria for the current Eligibility Period, and

(iii) which did not meet the office's Medicaid DSH criteria for the prior Eligibility Period,

will receive disproportionate share payments equal to 33 1/3% of their individual hospital-specific limit.

(e) Except as set forth in (b) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(i) meeting the office's Medicaid DSH criteria for two consecutive Eligibility Periods will receive a disproportionate share payment equal to 66 2/3% of its hospital-specific limit; or

(ii) meeting the office's Medicaid DSH criteria for three (or more) consecutive Eligibility Periods will receive a disproportionate share payment equal to 100% of its hospital-specific limit.

(f) Except for payments to Non-State Government-Owned or Operated Hospitals, as defined on Attachment 4.19A, Page 17 of this plan, if the amount available to pay the disproportionate share amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

The OMPP may, however, adjust the disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. Each eligible hospital may receive an additional disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

The office may also, before the end of a state fiscal year, make a partial payment to one or more qualifying hospitals, if:

(1) sufficient funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51;

(2) the partial disproportionate share payment to each hospital does not exceed the limits provided by federal law and regulations; and

(3) no hospital qualifying for a disproportionate share payment for the same state fiscal year for which a partial payment is made will receive a net disproportionate share payment for that state fiscal year in an amount less than the amount the hospital would have received if no partial payment had been made before the end of the fiscal year.

C. Contributions by State of Indiana to the Medicaid Indigent Care Trust Fund

The office shall, in each state fiscal year, provide, for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under Section II.E. of this plan, sufficient funds, other than funds transferred by other governmental units to the Medicaid indigent care trust fund, that equal an amount equal to twenty-six million dollars ($26,000,000) minus the product of twenty-six million dollars ($26,000,000) multiplied by the federal medical assistance percentage.

D. Municipal Disproportionate Share Payment Adjustments

For each state fiscal year ending on or after June 30, 1998, OMPP will make municipal disproportionate share payments to qualifying municipal disproportionate share hospitals as follows:

A pool not exceeding the sum of the hospital specific limits for all qualifying hospitals shall be distributed to each qualifying hospital in an amount which equals to the extent possible, but in no case exceeds, the hospital's hospital-specific limit provided under 42 U.S.C. 1396r-4(g). Each hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The hospital-specific limit for each hospital, in each state fiscal year, shall be determined by the office taking into account data provided by the hospital that is considered reliable by the office, based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a municipal disproportionate share hospital to determine the hospital's hospital-specific limit.

The OMPP may, however, adjust the municipal disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional municipal disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible hospital may receive an additional municipal disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

For the state fiscal year ending June 30, 2000, the total municipal disproportionate share payments available to qualifying municipal disproportionate share hospitals shall be twenty-two million dollars ($22,000,000), except, as provided in Section III.G. of this plan.

E. Community Mental Health Center Disproportionate Share Payment Adjustments.

For each state fiscal year ending after June 30, 1997, OMPP will make community mental health center disproportionate share payments to qualifying community mental health centers as follows:

Each qualifying community mental health center shall receive an amount determined by subtracting the amount paid to the community mental health center during the state fiscal year by the county treasurer of the county in which the community mental health center is located, as authorized by the county executive and appropriated by the county fiscal body, or funds received by the community mental health center from other county sources, from an amount consisting of the foregoing amount divided by the state medical assistance percentage applicable to the state fiscal year.

The OMPP may, however, adjust the community mental health center disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional community mental health center disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible community mental health center may receive an additional community mental health center disproportionate share payment adjustment, if:

(1) funds are made available by one or more counties which have been certified as expenditures eligible for financial participation under 42 U.S.C. 1396(w)(6)(A) and 42 CFR 433.51;

(2) the total disproportionate share payments to each individual community mental health center do not exceed the institution specific limit provided under 42 U.S.C. 1396r-4(g); and

(3) the total disproportionate share payments to community mental health centers do not result in total disproportionate share payments in excess of the state limit on such expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h).

The office shall assist a county treasurer in making the certification described in III.E.(1) above.

The institution specific limit for a state fiscal year shall be determined by the office taking into account data provided by the community mental health center that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a community mental health center to determine the institution specific limit.

The office may reduce, on a pro rata basis, payments due to community mental health centers under this section for a fiscal year if necessary to avoid exceeding the state limit on disproportionate share expenditures for institutions for mental diseases. Further, a payment under this provision may be recorded by the office from the community mental health center if federal financial participation is disallowed for the funds certified under IC 12-29-1-7(b) upon which such payment was based.

For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, the total community mental health center disproportionate share payments available under this section to qualifying community mental health center disproportionate share providers, is six million dollars ($6,000,000), except as provided in Section III.G. of this plan.

F. Hospital Specific Limit on Disproportionate Share Payments

1. Total disproportionate share payments to a provider shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital or other qualifying provider to determine the provider's hospital specific limit. Each hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan.

2. Notwithstanding the foregoing, for SFYs beginning after June 30, 2003 and to the extent permitted under Section 701(c) of the Benefits Improvement Act (BIPA) of 2000, Section 1(a)(6) of Public Law 106-554, a Non-State Government-Owned or Operated Hospital will receive a DSH payment which shall not exceed 175% of its hospital-specific limit. The amount paid to each hospital is contingent upon available room under Indiana's statewide disproportionate share allocation as limited by 42 USC 13964-4(f). If the amount of state matching funds available is not sufficient to pay each hospital its full amount as determined by the office, the amount paid to each hospital will be reduced proportionately.

G. State Limit on Disproportionate Share Payments

1. For the state fiscal year ending June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 USC 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental disease (as defined in 42 U.S.C. 13964-4(b)), the state shall pay providers as follows:

   (1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation. The total amount paid to the municipal disproportionate share providers under this plan for the state fiscal year ending June 30, 2000, may not exceed twenty-two million dollars ($22,000,000), except as provided elsewhere in this section.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under section II.(H) of this plan. The total paid to the qualified community mental health center disproportionate share providers under section 9(a) of this chapter, may not exceed six million dollars ($6,000,000) for the state fiscal year ending June 30, 2000, except as provided elsewhere in this section.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to acute care hospitals licensed under IC 16-21 and qualifying under section II.(E) of this plan.

2. For each state fiscal year beginning after June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

   (1) The state shall make municipal disproportionate share provider payments to providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to providers qualifying under Section II.(E) of this plan.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under Section II.(H) of this plan.

The dollar limitations imposed by this section on disproportionate share payments to municipal disproportionate share hospitals and community mental health center disproportionate share providers shall not be applicable in the event that additional disproportionate share expenditures are made under the provisions of this plan after the end of a federal fiscal year, relating back to a prior federal fiscal year. An eligible provider may receive an additional disproportionate share payment adjustment as authorized by this Plan, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to the individual provider, and all qualifying providers in the aggregate, to not exceed the limit provided by federal law and regulation.

H. Inpatient Disproportionate Share Payment Adjustments in the Event of a Reduced Federal DSH Allotment

a. For purposes of Subsection H:

i. The term "base disproportionate share payment program" shall mean the provisions for distributing disproportionate share payments set forth in Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid State Plan effective January 1, 2019.

ii. The term "CMS" shall mean the Centers for Medicare and Medicaid Services.

iii. The term "disproportionate share payment plan" shall mean the plan for distributing disproportionate share payments for the State Fiscal Year beginning July 1, 2020.

iv. The term "federal DSH allotment" shall mean the allotment of federal disproportionate share funds calculated for the State under 42 U.S.C. 1396r-4.

v. The term "reduced federal DSH allotment" shall mean a federal DSH allotment for the State for the Federal Fiscal Year beginning October 1, 2020, that, by operation of 42 U.S.C. 1396r-4(f)(7), is less than the federal DSH allotment for the State for the Federal Fiscal Year beginning October 1, 2018.

vi. The term "terminating event" shall mean federal legislation, including an amendment to 42 U.S.C. 1396r-4, a regulation issued by CMS or any other federal agency, any sub-regulatory policy or directive issued by CMS or other federal agency, or a judicial ruling, that is enacted or issued on or before March 30, 2021, that: (1) cancels, or postpones to a subsequent federal fiscal year, a reduced federal DSH allotment; and (2) does not cause the state to incur a reduced federal DSH allotment.

b. Subject to paragraph c, the disproportionate share payment plan for the State Fiscal Year beginning July 1, 2020 shall be as follows:

i. The disproportionate share payment paid to an acute care hospital that qualifies as:

(A) a municipal disproportionate share provider under Step Two of the base disproportionate share payment program;

(B) a disproportionate share provider under Step Three of the base disproportionate share payment program; or

(C) a disproportionate share provider under Step Four of the base disproportionate share payment program;

shall be reduced by the percentage described in subparagraph ii.

ii. The percentage reduction in disproportionate share payments described in subparagraph i shall be applied uniformly to all hospitals to which subparagraph i applies. The percentage of the reduction in disproportionate share payments described in subparagraph i shall be the percentage determined by the office to cause the total disproportionate share payments made under subparagraph i to maximize the expenditure of, without exceeding, the reduced federal DSH allotment.

c. If a terminating event occurs, paragraph b of Subsection H shall not apply to the disproportionate share payment plan for the State Fiscal Year beginning July 1, 2020. If a terminating event occurs, disproportionate share payments for the State Fiscal Year beginning July 1, 2020 shall be governed by the base disproportionate share payment program.

d. Subsection H shall only apply to disproportionate share payments for the State Fiscal Year beginning July 1, 2020.

State: Indiana

Attachment 4.19A

IV. DISPROPORTIONATE SHARE PAYMENT EXAMPLES

To illustrate the payment methodology proposed by TN _____ for disproportionate share payments, the following examples are displayed within this plan.

****

Example 1 - **Provider is an acute care hospital licensed under I.C. 16-21 that qualifies as a disproportionate share provider**

Facts— Hospital's Medicaid inpatient utilization rate = 28% and exceeds one standard deviation from the statewide mean Medicaid IUR which is 15%.

Hospital is determined to be a disproportionate share acute care hospital under Section II.(B) of this plan, that qualifies for a disproportionate share payment under section II.(E) of this plan. Hospital qualified as a disproportionate share provider in state fiscal year 1998 and continues to qualify as a disproportionate share provider in the state fiscal year for which a distribution is being made.

Hospital's hospital specific limit is $11,000,000.

The hospital's disproportionate share payment is equal to 100% of its hospital-specific limit, or .....**$11,000,000**.

****

Example 2 - Provider is a state mental health institution (state psychiatric hospital) that qualifies for DSH payments (for SFYE 6-97)

Facts— Hospital's low-income utilization rate = 40%. The provider meets the definition found at II(B) of the plan, and qualifies to participate in DSH basic pool (4) as described at Section III(A)(2) of this plan.

This pool had $191,000,000 available for distribution in the SFYE 6-95 and was adjusted for SFYE 6-96 by a ratio as provided for on page 7 of this plan resulting in a reduction of 5% of the 1995 pool amount to a new pool amount of $181,450,000 for FYE 6-96. This pool was again adjusted for SFYE 6-97 as provided for on page 7 of the plan by an increase of 12% from the SFY 6-96 base to $203,224,000 (181,450,000 x 112%).

The hospital's total inpatient days equal 1,000. The distribution factor is the low income utilization rate times the total inpatient days. (40 x 1000) = 40,000.

All qualifying hospital in the pool have a sum total distribution factor of 400,000. This hospital's percentage of the total distribution is 40,000/400,000 or 10%.

This hospital's distribution for DSH for SFYE 6-97 is set at $20,322,400. (203,224,000 x 10%).

The hospital has been determined to have a Medicaid shortfall and uncompensated charity care total, for the hospital's fiscal year ending in SFY 1997, of $13,400,000. The OBRA '93 hospital specific DSH limit for '97 is set at $13,400,000 (100% of the determined total).

The hospital receives **$13,400,000** rather than $20,322,400 based on the OBRA '93 DSH limit.

****

All disproportionate share payments made in accordance with these examples and under the provisions of this disproportionate share payment methodology will be made subject to all applicable federal DSH spending caps and any Indiana specific DSH caps, and specific provider payments will not exceed the individual provider's OBRA '93 calculated DSH payment limit. The "hospital's OBRA '93 calculated DSH payment limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The formula appears as follows:

DSH LIMIT = M + U

M = Cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan

U = Cost of services to uninsured patients, less any cash payments made by them

High Volume Outlier Payment Adjustment

I. General

In addition to regular claims payments and any other payment adjustments to which they are entitled, each in-state hospital may receive an additional inpatient Medicaid outlier payment adjustment, which shall not exceed the inpatient charge limitations pursuant to 42 CFR 447.271. Total payments to all hospitals will not exceed the applicable inpatient upper payment limit in accordance with 42 CFR 447.272. The outlier payment adjustment is available to in-state hospitals that have a high volume of inpatient hospital stays that qualify for outlier payments. Each hospital's percentage of the state's Medicaid fee-for-service inpatient outlier stays will be calculated annually, based on fee-for-service claims adjudicated through the MMIS to a paid status during the most recently completed state fiscal year. The outlier payment adjustment will be made annually after the office has computed the payment under this methodology. The outlier payment adjustment will be made prior to any hospital supplemental payment adjustments. The outlier payment adjustment is effective May 1, 2011 for each state fiscal year ending on or after June 30, 2011.

II. Eligibility Determination

Step One: Identify the total number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year.

Step Two: For each in-state hospital, identify the number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year. The current threshold amount is the greater of two times the DRG payment rate or the outlier threshold of $34,425.

Step Three: For each in-state hospital, calculate the number of claims identified in Step Two as a percentage of the total number of claims identified in Step One. This percentage is the hospital's percentage of the total number of outlier claims. To be eligible for the outlier payment adjustment, a hospital must provide more than fifteen percent (15%) of the state's Medicaid fee-for-service inpatient stays that qualify for outlier payment.

III. Payment Methodology

The outlier payment adjustment will be the difference between the hospital's total claim reimbursement for paid Medicaid fee-for-service inpatient claims qualifying for outlier payment and the costs of providing such services. For eligible hospitals, the outlier payment adjustment will be calculated using the following methodology:

Step One: For each eligible hospital, identify the Medicaid fee-for-service claims that qualify for outlier payment that were paid during the most recently completed state fiscal year.

Step Two: Calculate the total aggregate cost of the claims identified in Step One. Total cost is determined by multiplying routine units from the claim by routine per diems and by multiplying ancillary charges from the claim by ancillary cost-to-charge ratios. Routine per diems and ancillary cost-to-charge ratios will be obtained from the hospital's latest cost report on file with the office.

Step Three: Determine the total aggregate claim payments previously received for the claims identified in Step One, including Medicaid claim payments, non-Medicaid claim payments, such as third party liability (TPL) payments and Medicare payments, and spend-down.

Step Four: Subtract total aggregate claim payments in Step Three from total aggregate costs in Step Two. This difference is the outlier payment adjustment. If the payments in Step Three exceed the costs calculated in Step Two, no outlier payment adjustment will be made.

MUNICIPAL HOSPITAL PAYMENT ADJUSTMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A), Section 1903 (w)(3), and Section 1903 (w)(6) of the Act, the Indiana Medicaid program (the "Office") adopts the following definitions and methodologies to identify and make payment adjustments to Municipal Hospitals.

II. DEFINITIONS

"Non-State Government-Owned Or Operated Hospital" has the following meaning: a health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

"Municipal Hospital" has the following meaning: a non-state government-owned or operated health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental ~~county~~ hospital under Indiana Code 16-22-2, or ~~as a municipal hospital under~~ Indiana Code 16-23.

"Medicaid Payments" are all payments made to Municipal Hospitals by on or behalf of the Office pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code. This includes, but is not limited to, claim specific payments for inpatient Medicaid services, ~~and~~ non-claim specific additional Medicaid payments such as the Medicaid Hospital Care for the Indigent (HCI) add-on payments, and the payment adjustments provided for in this state plan amendment. This does not include the Disproportionate Share Hospital (DSH) payments made pursuant to Indiana Code 12-15-16 and 12-15-19, which contain the methodologies used to determine and distribute ~~the Basic Acute Care and Enhanced~~ DSH payments, ~~respectively.~~

"Medicaid Services" are those inpatient services provided by a Municipal Hospital that are reimbursable under the Medicaid program.

III. PAYMENT ADJUSTMENTS

A Municipal Hospital ("hospital") shall receive, in addition to its allowable regular Medicaid claims payments to which it is entitled, a payment adjustment calculated in the following manner:

(1) For each state fiscal year ending after June 30, 1997 and before June 30, 2002, reimbursement in the form of a single payment, equal to the difference between:

(a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year; and

(b) an amount equal to the lesser of the following:

(i) the hospital's customary charges for the services described in (a) above; or

(ii) a reasonable estimate by the Office of the amount that would have been paid for those services under Medicare payment principles.

(2) For each state fiscal year ending after June 30, 2002, reimbursement in the form of a single payment, equal to the difference between:

(a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year, and

(b) an amount equal to 100 percent of a reasonable estimate by the Office of the amount that would have been paid for those services under Medicare payment principles.

(3) The payment adjustment identified in (1) and (2) above shall be made after the close of the applicable state fiscal year.

(4) Notwithstanding the foregoing, subject to the applicable payment limits under 42 CFR 447.272, the office may enter into agreements with hospitals, individually or in combination, to permit hospitals to receive lesser or greater adjustments, made after the close of the applicable state fiscal year, up to, but not to exceed the difference between:

(a) The aggregate amount of Medicaid payments to all hospitals made pursuant to the Medicaid reimbursement provisions under Indiana Code 12-15, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by all hospitals during the state fiscal year; and

(b) The aggregate amount, as reasonably estimated by the office, that all hospitals would have been paid for those services under Medicare payment principles.

However, the office may not enter into an agreement with a hospital if, in doing so, another hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement, will receive under (2) above an amount less than what the hospital would have otherwise received under the formula set forth in (2).

EFFECTIVE DATE

Subject to approval by HCFA, these payment adjustments identified in 1 above, are to be effective on or after April 1, 1998. Payments being made beginning effective April 1, 1998 for SFYE June 30, 1998 and thereafter shall be paid by this methodology.

Payment adjustments up to 150 percent of a reasonable estimate of the amount that would be paid for services under Medicare payment principles (identified in 2 above) will only apply on or after April 1, 2001. For the state fiscal year ending on June 30, 2001, the state may adjust payments, under this section, to each Municipal Hospital eligible for such payment adjustment in an amount not to exceed one-fourth of the amount equal to 150 percent of a reasonable estimate of the amount that would be paid for services under Medicare payment principles. For state fiscal years ending after June 30, 2001, the state may reimburse, under this section, each Municipal Hospital eligible for a payment adjustment in an amount up to 150 percent of a reasonable estimate that would be paid for services under Medicare payment principles.

Supplemental Payments to Privately-owned Hospitals

I. General

A Privately-owned Hospital means an acute care hospital that is (i) licensed under IC 16-21, and (ii) Privately-owned and operated in accordance with 42 CFR 447.272(a)(3) and 42 CFR 447.321(a)(3). In addition to regular claims payments and any other payment adjustments to which they are entitled, each hospital that is a Privately-owned Hospital may receive an additional inpatient Medicaid supplemental amount for each state fiscal year ending after June 30, 2003, which shall not exceed the inpatient charge limitations pursuant to 42 CFR 447.271 and the applicable inpatient upper payment limit in accordance 42 CFR 447.272.

II. Inpatient Supplemental Payment Pool

The office will calculate a Inpatient Supplemental Payment Pool for each state fiscal year ending after June 30, 2003. This Inpatient Supplemental Payment Pool will include the inpatient Medicaid supplemental amount, which is an amount equal to the difference between the aggregate of actual Medicaid payments made to all Privately-owned Hospitals for Medicaid inpatient hospital services (excluding Medicaid disproportionate share payments made pursuant to IC 12-15-16, 12-15-17, and 12-15-19), and the office's reasonable estimate of the amount that would have been paid for those services using Medicare payment principles, subject to limits imposed by 42 CFR 447.271 and 42 CFR 447.272. The Inpatient Supplemental Payment Pool will be equal to the inpatient Medicaid supplemental amount.

III. Payment Methodology

For each state fiscal year ending after June 30, 2003, the Inpatient Supplemental Payment Pool will be established and distributed to Privately-owned Hospitals in the following manner:

(1) An amount equal to the lesser of (i) the amount of the Inpatient Supplemental Payment Pool; or (ii) five million dollars ($5,000, 000), will be paid to a Privately-owned Hospital that has in excess of seventy thousand (70,000) Medicaid inpatient days.

(2) Following the payment under (1) above, if there is an amount remaining in the Inpatient Supplemental Payment Pool after the payment under (1) above has been made, that remaining amount will be paid to all Privately-owned Hospitals on a pro rata basis based upon the number of each Privately-owned Hospital's Medicaid inpatient days. For purposes of this Section III (2) the non-federal share of such payments will not exceed the amount transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Privately-owned Hospitals with larger numbers of Medicaid inpatient days will receive a higher proportion of the amount remaining in the Inpatient Supplemental Payment Pool than Privately-Owned Hospitals having smaller numbers of Medicaid inpatient days. The amount of a payment shall be determined and distributed after the end of each state fiscal year.

(3) In the event the entirety of the aggregate Inpatient Supplemental Payment Pool is not distributed after the payments indicated in (1) and (2) above have been made, the remaining amount will be paid on a pro rata basis to any Privately-owned Hospital that enters into an agreement with the office for such payment, based on each Privately-owned Hospital's Medicaid weighted inpatient days. For Children's hospitals (as identified by the office), weighted Medicaid inpatient days will be calculated by taking Medicaid days and multiplying them by 120%, consistent with the Medicaid DRG add-on. In addition, all hospitals' Medicaid days (including Children's hospitals) will be weighted further by their Medicaid Case Mix. The amount(s) of a Privately-owned Hospital's payment(s) under this clause (3) will not exceed the amount of the remaining Inpatient Supplemental Payment Pool.

Adjustments

Notwithstanding III (2) above, the office may enter into an agreement with any Privately-owned Hospital whereby the Privately-owned Hospital waives payments described in III (2) above or accepts a lesser or greater amount than provided in III (2) above, subject to the hospital's charge and payment limitations as described in 42 CFR 447.271, and 42 CFR 447.272. However, the office may not enter into an agreement with a Privately-owned Hospital if, in doing so, another Privately-owned Hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement will receive an amount less than what the hospital would have otherwise received under the formula set forth in III (2).

State: Indiana

Attachment 4.19A
Page 19

Rule 19 Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

(A) keep copies of all these requests and the responses to them;

(B) make them available to the office upon request; and

(C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) the office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

Psychiatric Residential Treatment Facility Services

For purposes of this section, "Psychiatric residential treatment facility" (PRTF) means a PRTF licensed under *470 IAC 3-13* and meeting the requirements set forth in *405 IAC 5-20-3.1.*

Reimbursement for Medicaid-covered psychiatric residential treatment facility services is made in accordance with the following prospective reimbursement methodology. The prospective per diem shall constitute full reimbursement. There shall be no year-end cost settlement payments.

Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:

(1) PRTFs shall be reimbursed for services provided to Medicaid recipients based upon the lower of:

(A) the PRTF prospective per diem rates calculated by the Office or

(B) the usual and customary daily charges billed for the psychiatric treatment of eligible recipients

(2) The applicable PRTF payment per diem rates determined in section (1) shall provide reimbursement for all Medicaid-covered services provided in the psychiatric residential treatment facility except for those costs described in section (3). Providers will include, and rates will be determined using, only those allowable costs set out in Medicaid PRTF provider cost reporting instructions and update bulletins.

(3) The per diem rates determined in section (1) shall exclude costs incurred for pharmaceutical services and physician services provided to eligible recipients. Medicaid reimbursement for costs incurred for pharmaceutical services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rates and in accordance with the reimbursement policies described in *405 IAC 5-24.* Medicaid reimbursement for costs incurred for physician services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rates and in accordance with the reimbursement policies described in 405 IAC 5-25.

(4) All costs utilized to determine the prospective per diem rates in section (1)(A) shall be subject to reasonability standards as set forth in the *Medicare Provider Reimbursement Manual,* CMS-Pub. 15-1, Chapter 25.

(5) The per diem rates determined in section (1) shall exclude such costs unrelated to providing psychiatric residential services including, but not limited to the following:

(A) group education including elementary and secondary education
(B) advertising or marketing
(C) non-psychiatric specialty programs

(6) Medicaid reimbursement for Medicaid-covered psychiatric services provided to recipients residing in a psychiatric residential treatment facility shall be limited to the payments described in *405 IAC 1-21.* Medicaid reimbursement for Medicaid-covered services not related to the recipient's psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are performed at a location other than the PRTF.

(7) The established per diem rates for psychiatric residential treatment facilities shall be reviewed annually by the OMPP or its contractor by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.

PRTFs shall file a cost report annually using a uniform cost report form prescribed by the Office of Medicaid Planning and Policy (OMPP). The OMPP or its contractor may audit or review the cost reports as it deems necessary.