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State/Territory Name: IN

State Plan Amendment (SPA) #: 13-006

This file contains the following documents in the order listed:

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

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

FEB 2 0 2014

Mr. Joseph Moser
Director of Medicaid
Office of Medicaid Policy and Planning (OMPP)
402 West Washington, Room W374
Indianapolis, IN 46204

RE: Indiana State Plan Amendment (SPA) 13-006

Dear Mr. Moser:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-006. Effective for services on or after July 1, 2013, this amendment extends the 5% reduction in Medicaid reimbursement for services in an inpatient hospital setting for the period of 7/1/13 through 12/31/13 and changes the reduction to 3% for the period of 1/1/14 through 6/30/15. Additionally, this amendment clarifies that out-of-state hospitals that submit an Indiana Medicaid hospital cost report will receive a cost-to-charge ratio for purposes of calculating diagnosis related grouping (DRG) or level of care (LOC) reimbursement; also clarifies that the facility-specific per diem medical education rate for an out-of-state provider shall not exceed the highest in-state medical education per diem rate; modifies disproportionate share hospital (DSH) payment methodology to provide for additional payments, to municipal and private acute care hospitals, if there is remaining room remaining under applicable DSH limits after current DSH payments have been made.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 13-006 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

Cindy Mann
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-006

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $17,489 Thousands
b. FFY 2015 $23,510 Thousands

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Page 1G.1
Attachment 4.19-A, Page 1H
Attachment 4.19-A, Page 1H.3
Attachment 4.19-A, Page 6.1(a)
Attachment 4.19-A, Page 6.1(b)
Attachment 4.19-A, Page 6.1(c)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Page 1G.1
Attachment 4.19-A, Page 1H
Attachment 4.19-A, Page 1H.3
Attachment 4.19-A, Page 6.1(a)
Attachment 4.19-A, Page 6.1(b)

10. SUBJECT OF AMENDMENT:
1.) Extends the five percent (5%) reduction in Medicaid reimbursement for services provided in an inpatient hospital setting with dates of service from July 1, 2011 through December 31, 2013 and changes the reduction from 5% to 3% effective for the period January 1, 2014 through June 30, 2015. 2.) Changes cost-to-charge ratios and medical education rates for out-of-state hospitals effective July 1, 2013. 3) Modifies Hospital Assessment Fee reimbursement methodology.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Patricia Casanova

14. TITLE: Director of Medicaid

15. DATE SUBMITTED: 6-27-13

16. RETURN TO:
Patricia Casanova
Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Audie Gilmer, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 20 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy + Financial Mgt CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

Special payment policies shall apply to less than twenty-four (24) hour stays. For less than twenty-four (24) hour stays, hospitals will be paid under the outpatient reimbursement methodology as described in Attachment 4.19B.

Out-of-state hospitals receive the same DRG and level-of-care payments that are made for the same service to instate facilities computed in accordance with this plan. Each out-of-state hospital that submits an Indiana Medicaid hospital cost report will receive a cost-to-charge ratio. All other out-of-state facilities will use a statewide median cost-to-charge ratio to determine applicable cost outlier payments, computed in accordance with the outlier provisions of this plan.

Payments for services to an out-of-state provider will be negotiated on a case-by-case basis to obtain the lowest possible rate, not to exceed 100% of the provider's reasonable and customary charges, and may differ from the aforementioned out-of-state hospital reimbursement policy only when such payments are required because the services are not available in-state or are necessary due to unique medical circumstances requiring care that is available only from a limited number of qualified providers.

To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3), effective July 25, 1997, through 405 IAC 5-5-2(a)(4), effective July 25, 1997, or have a

minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement. The facility-specific per diem medical education rate for an out-of-state provider shall not exceed the highest in-state medical education per diem rate.

To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3), effective July 25, 1997, through 405 IAC 5-5-2(a)(4), effective July 25, 1997, or have a minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount.

MEDICAID INPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital," for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

(A) For the state fiscal years ending on or after June 30, 2000*, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid inpatient services provided by the hospital during the hospital's fiscal year, and

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

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection (A) of this section, subject to the provisions of subsection (B) of this section.

(B) If the amount available to pay the inpatient safety-net 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.

(C) (1) For the Eligibility Period** beginning July 1, 2001, inpatient safety-net hospitals, which meet both the above definition of "safety-net hospital" and the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid inpatient safety-net 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 inpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive inpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "inpatient safety-net amount"). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable.

The rates paid to providers in accordance with methods described in the preceding pages of Attachment 4.19-A for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 5% reduction for services on and after January 1, 2010. The 5% rate reduction will remain in effect through December 31, 2013. Medicaid payments for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 3% reduction for services on and after January 1, 2014 through June 30, 2015

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

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

The initial hospital adjustment factor for the DRG Base rate is 3.00.
The initial hospital adjustment factor for Psych Level of Care rates is 2.20.
The initial hospital adjustment factor for acute care hospital Rehab Level of Care rates is 3.00.
The initial hospital adjustment factor for Burn Level of Care rates is 1.00.

The adjustment factors above apply to acute care hospitals licensed under IC 16-21, except for those specified below, and psychiatric institutions licensed under IC 12-25.

For the period of July 1, 2011 through December 31, 2013, the hospital adjustment factor is 0.95, and for the period of January 1, 2014 through June 30, 2015, the hospital adjustment factor is 0.97, for:

- Long term care hospitals
- Out-of-state hospitals
- Freestanding Rehabilitation hospitals.

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

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

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

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

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 Indiana 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.