Fee Schedule Rates for Free Standing Clinic Services, Ambulatory Surgical Centers, and Outpatient Hospital Services are the same for governmental and private providers except as otherwise noted in the Plan. The agency's fee schedule rates were set on various dates and are in effect for services provided on or after April 1, 2010. All rates and effective dates are published on the agency's website at www.indianamedicaid.com.

CLINIC SERVICES

FREE STANDING CLINIC SERVICES

The Office of Medicaid Policy and Planning (OMPP), in accordance with 42 CFR 447.325, will not pay more than the prevailing charges in the locality for comparable services under comparable circumstances. Freestanding clinic services are reimbursed on a fee for service basis according to the Indiana Medicaid fee schedule rates.

The rates paid to freestanding renal dialysis clinics for services provided on or after July 1, 2011 are subject to a 5% reduction. The 5% rate reduction will remain in effect through December 31, 2013.

AMBULATORY SURGICAL CENTERS

As applicable, services provided by free-standing Ambulatory Surgical Centers (ASC) are reimbursed in accordance with outpatient hospital services as described below.

OUTPATIENT HOSPITAL SERVICES

The reimbursement methodology for all covered outpatient hospital services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(a) Reimbursement for outpatient surgical procedures performed in a hospital or provider-based ambulatory surgical center will be based on the Indiana Medicaid statewide allowed amounts for that service. Surgical procedures shall be classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology and shall be paid a rate established for each ASC payment group. The Office of Medicaid Policy and Planning will classify outpatient surgical procedures not classified into an ASC group by Medicare into one of the nine (9) ASC groups designated by Medicare, or additional payment groups.

(b) Payments for provider-based emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(c) Payments for provider-based non-emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(d) The fixed fees for laboratory procedures are based on the Medicare fee schedule amounts and are paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule amounts for the technical component of radiology services.

(e) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., will be based on the 2003 Indiana Medicaid statewide fee schedule amounts for services provided on or after April 1, 2004.

(f) Payments will not be made for outpatient hospital services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

The established rates for hospital outpatient reimbursement shall be reviewed annually by the Office of Medicaid Policy and Planning and adjusted no more frequently than every second year and in accordance with this section to ensure that revisions contain appropriate incentives for provision of primary and preventive care.

Outpatient Hospital Services

The rates paid to outpatient hospital providers for services provided on and after January 1, 2010, and in accordance with methods described in Attachment 4.19-B in the Outpatient Hospital Services section, excluding ambulatory surgical center services, are subject to a 5% reduction. The 5% rate reduction will remain in effect through December 31, 2013. The rates paid to outpatient hospital providers, excluding ambulatory surgical center services, for services provided on and after January 1, 2014 through June 30, 2015 are subject to a 3% reduction.

Notwithstanding the preceding paragraph, for the period beginning July 1, 2011, Indiana outpatient hospital rates are subject to an outpatient hospital adjustment factor. The outpatient 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.

For the period of July 1, 2011 through June 30, 2013, the outpatient hospital adjustment factor is 3.50, for the period beginning July 1, 2013 **through July 31, 2014**, the outpatient hospital adjustment factor is 3.20, **and for the period beginning August 1, 2014, the outpatient hospital adjustment factor is 2.7,** for:

- Acute care hospitals licensed under IC 16-21, except for those specified below
- Psychiatric institutions licensed under IC 12-25

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

- Long term care hospitals
- Freestanding rehabilitation hospitals
- Out-of-state hospitals
- Clinical laboratory services

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 Outpatient 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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's rates are published at the State's website, www.indianamedicaid.com.

Freestanding Birthing Center Services

Covered freestanding birthing center services provided on or after February 1, 2012, shall be reimbursed in accordance with this section.

(1) Payment of a facility delivery fee shall be made to the birthing center for facility services. The facility delivery fee is a global fee that includes all services and supplies relating to the delivery. The facility delivery fee is an equivalent daily rate of the inpatient DRG base payment, as of June 30, 2011, for an uncomplicated delivery.

(2) Payment of a facility labor management fee shall be made to the facility for those situations when the patient is transferred to a hospital before the delivery. The facility labor management fee is 1/3 of the facility delivery fee.

(3) Payment for the professional services of physicians and certified nurse midwives shall be made apart from the facility delivery fee and facility labor management fee in accordance with the established reimbursement methodology for physicians and certified nurse midwife services as indicated in Attachment 4.19B Page 1, Section I.A of the State Plan.

Other Provider-Preventable Conditions

Effective for services provided on or after July 1, 2012, the State identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for non-payment under Section 4.19B:

(1) wrong surgical or other invasive procedure performed on a patient;

(2) surgical or other invasive procedure performed on the wrong body part;

(3) surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the State provides:

(1) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) That reductions in provider payment may be limited to the extent that the following apply:

    (a) The identified PPC would otherwise result in an increase in payment.

    (b) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.

(3) Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

MEDICAID OUTPATIENT 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 share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less that 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 outpatient 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 outpatient 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, outpatient safety-net hospitals, meeting the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid outpatient 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 outpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive outpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "outpatient 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 .

(2) For the Eligibility Periods beginning after June 30, 2001, an outpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid outpatient safety-net payment adjustment in the amount of 100% of the outpatient safety-net amount, will continue to receive Medicaid outpatient safety-net payment adjustments in the amount of 100% of the outpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid outpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid outpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid outpatient safety-net 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 outpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid outpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, outpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(a) licensed under IC 16-21,

(b) meeting the office's Medicaid outpatient safety-net criteria for the current Eligibility Period, and

(c) which did not meet the office's Medicaid outpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid outpatient safety-net payment adjustments equal to 33 1/3% of their outpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

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

(b) meeting the office's Medicaid outpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6 If the amount available to pay the outpatient 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.

This new payment methodology will only apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.
† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.

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 hospital under Indiana Code 16-22-2, or 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 outpatient Medicaid services, 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 DSH payments.

"Medicaid Services" are those outpatient 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, 2000, 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 service under Medicare payment principles.

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

(3) Notwithstanding the foregoing, subject to the applicable payment limits under 42 CFR 447.321, the office may enter into agreements with hospitals, individually or in combination, to permit hospitals to receive lesser or greater payment 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 (1) above an amount less than what the hospital would have otherwise received under the formula set forth in (1).

Outpatient Hospital Medicaid Upper Payment Limit Test

As required by 42 CFR 447.321, the office will compute an upper payment limit test on an annual basis. Aggregate payments to categories of facilities may not exceed 100 percent of a reasonable estimate of what would have been paid using Medicare payment principles.

The office will estimate Medicare payments using the Medicare Ambulatory Payment Classification (APC) for hospitals under 42 CFR 419. The upper payment limit test will use Medicare payment rates and policies in effect for the period of the upper payment limit test. Hospitals will be categorized by their organizational type under 42 CFR 447.321, including privately owned and operated, non-state government owned or operated, and state owned or operated facilities. In computing estimated Medicare payments, the office will include estimated Medicare payments for allowable bad debt under 42 CFR 413.80. Estimated Medicare payments for outpatient graduate medical education will not be considered under the outpatient upper payment limit test.

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 statewide 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 state-wide PRTF prospective per diem rate 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 rate 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 rate 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 rate 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 rate and in accordance with the reimbursement policies described in 405 IAC 5-25.

(4) All costs utilized to determine the statewide prospective per diem rate 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 rate 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 rate 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.

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 outpatient Medicaid supplemental amount for each state fiscal year ending after June 30, 2003, which shall not exceed the outpatient upper payment limit in accordance 42 CFR 447.321.

II. Outpatient Supplemental Payment Pool

The office will calculate an Outpatient Supplemental Payment Pool for each state fiscal year ending after June 30, 2003. This Outpatient Supplemental Payment Pool will include the outpatient 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 outpatient 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 447.321. The Outpatient Supplemental Payment Pool will be equal to the amount of the outpatient Medicaid supplemental amount.

III. Payment Methodology

For each state fiscal year ending after June 30, 2003, the Outpatient 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 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 Outpatient 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 amount of the amount remaining in the Outpatient 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 Outpatient 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 Outpatient 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 payment limitations as described in 42 CFR 447.321. 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).

MEDICAID HOSPITAL REIMBURSEMENT ADD-ON PAYMENT METHODOLOGY TO COMPENSATE HOSPITALS THAT DELIVER HOSPITAL CARE FOR THE INDIGENT PROGRAM SERVICE

In order to be eligible for and to receive a payment under the Indiana Hospital Care for the Indigent Care (HCI) program, a hospital must (1) be enrolled in and be providing services to patients enrolled in the Indiana Medicaid program during the state fiscal year for which payment is being made; and (2) have an audited cost report from the most recent common state fiscal year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year, unless extenuating circumstances exist. Hospitals that are no longer accepting Medicaid and HCI patients shall not receive payment under this section. Reimbursement under this program will be in the form of Medicaid add-on payments. The Medicaid add-on payments will provide additional reimbursement to eligible hospitals for the Medicaid-covered hospital services the hospitals provide to Medicaid enrollees. The amount and availability of the add-on payments will be limited by the upper payment limit imposed under 42 C.F.R. §§ 447.321, the amount of services rendered to Medicaid and HCI patients, and the rates for outpatient hospital services as stated in Attachment 4.19-B, Page 2 of this state plan. The add-on payments will be calculated and paid using the formula set forth below.

An eligible hospital for HCI purposes is defined as an acute care hospital licensed under Indiana Code 16-21, as defined and interpreted in the disproportionate share payment section of the Indiana Medicaid state plan amendment, and as defined and interpreted under the prior Medicaid HCI add-on payment methodology.

PAYMENT FORMULA

In accordance with I.C. 12-15-15-9.6, for each state fiscal year beginning July 1, 2003 and thereafter, the total Medicaid HCI add-on payments to hospitals for a state fiscal year shall not exceed an amount equal to all amounts transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund, including amounts attributable to each county's *ad valorem* HCI property tax levy, for a state fiscal year. A Medicaid add-on payment due to an eligible hospital must be based on a formula that provides additional Medicaid reimbursement for outpatient hospital services the hospital provides to Medicaid enrollees. The amount and availability of a Medicaid add-on payment for a hospital will be limited by the upper payment limits imposed under 42 CFR § 447.321. Variations in the amount of Medicaid add-on payments paid to eligible hospitals will be based upon the amount of outpatient hospital services an eligible hospital provides to Medicaid enrollees, the hospital's HCI patient case-load, and the amount of funds, including a county's *ad valorem* HCI property tax levy, transferred to the state hospital care for the indigent fund by each county to which one or more of the eligible hospital's HCI claims are attributed.

STEP 1: For each eligible hospital, the Office of Medicaid Policy and Planning ("office") shall identify the outpatient hospital services the hospital provided to Medicaid enrollees during the state fiscal year.

STEP 2: For each eligible hospital, the office shall calculate the amount of Medicaid reimbursement paid to the hospital for covered outpatient hospital services the hospital provided to Medicaid enrollees identified in STEP 1.

STEP 3: For each eligible hospital, the office shall calculate an amount equal to the amount calculated under STEP 3F of the following formula:

STEP 3A: Identify:

(1) Each eligible hospital that provided necessary emergency medical care during the state fiscal year to an individual who qualifies under IC 12-16-3.5 et seq. and the rules promulgated thereunder, and;

(2) the county of residence of the individual or, if the individual was not a resident of Indiana or the individual's Indiana county of residence cannot be ascertained, the county where the onset of the medical condition that necessitated the individual's emergency medical care occurred.

STEP 3B: For each county identified in (2) of STEP 3A, identify:

(1) each eligible hospital that provided care described in (1) of STEP 3A attributed to the county during the state fiscal year; and

(2) the total amount (using the office's fee for service reimbursement rates) of all eligible hospital episodes of care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3C: For each county identified in (2) of STEP 3A, identify the amount of the county's HCI funds, including its HCI *ad valorem* property taxes, transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3D: For each eligible hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, calculate the hospital's percentage share of the county's HCI funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount (using the office's fee for service reimbursement rates) of the hospital's care described in (1) of STEP 3A attributed to the county during the state fiscal year, calculated as a percentage of the total amount (using the office's fee for service reimbursement rates) of all hospital care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3E: For each hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, multiply the hospital's percentage share calculated under STEP 3D by the amount of the county's HCI funds transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3F: Determine the sum of all amounts calculated under STEP 3E for each eligible hospital identified in (1) of STEP 3A with respect to each county identified in (2) of STEP 3A.

STEP 4: Subject to STEP 5 and STEP 6, the office shall pay to each eligible hospital a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 3F and, in doing so, shall allocate the amount of the payment to each of the Medicaid covered hospital services identified for the hospital under STEP 1.

STEP 5: The office's allocation of a payment described in STEP 4 for a hospital's Medicaid-covered outpatient service shall be limited to an amount not to exceed either (1) the amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2, does not exceed the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

STEP 6: For any eligible hospital: (1) which receives a payment under STEP 4 that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limits under 42 CFR § 447.321, the office shall calculate an amount equal to the amount calculated for the hospital under STEP 6H below:

STEP 6A: Identify each county whose transfer of HCI funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) in STEP 3A above attributed to the county during the state fiscal year.

STEP 6B: For each county identified in STEP 6A, calculate the difference between the amount of HCI funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) of STEP 3A above attributed to the county during the state fiscal year.

STEP 6C: Calculate the sum of the amounts calculated for the counties under STEP 6(B).

STEP 6D: Identify each hospital: (1) which receives a payment under STEP 4 above that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limit under 42 CFR § 447.321.

STEP 6E: Calculate for each hospital identified in STEP 6D the difference between the hospital's payment under STEP 4 above and the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year.

STEP 6F: Calculate the sum of the amounts calculated for each of the hospitals under STEP 6E.

STEP 6G: For each hospital identified in STEP 6D, calculate the hospital's percentage share of the amount calculated under STEP 6F. Each hospital's percentage share is based on the amount calculated for the hospital under STEP 6E calculated as a percentage of the sum calculated under STEP 6F.

STEP 6H: For each hospital identified in STEP 6D, multiply the hospital's percentage share calculated under STEP 6G by the sum calculated under STEP 6C.

STEP 7: Subject to STEP 8, the office shall pay to each eligible hospital identified in STEP 6 a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 6H and, in doing so, shall allocate the amount of the payment to each of the hospital services identified for the hospital under STEP 1.

STEP 8: The office's allocation of a payment described in STEP 7 for a hospital's Medicaid-covered outpatient service shall be limited to an amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2 and STEP 4, does not exceed either (1) the amount of the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

Total non-federal share of payments to hospitals under this program for each state fiscal year may not exceed the amount equal to the product calculated when the amount transferred to the Medicaid indigent care trust fund by counties is multiplied by the state Medicaid medical assistance percentage for the state fiscal year for which the payments are made.

In the event there are insufficient state matching funds to pay each hospital the amounts calculated, the amount paid to each hospital will be reduced proportionate to the amount of the deficiency of funds. Payments shall be made prior to December 15 that next succeeds the end of the state fiscal year.

EFFECTIVE DATE Subject to approval by CMS, these payments are to be effective on July 1, 2003.