IC 12-15-15

Chapter 15. Payment to Hospitals; General

IC 12-15-15-1

Services at hospitals licensed under IC 16-21; rates established under rules

Sec. 1. Payment of a service provided in a hospital licensed under IC 16-21 shall be determined in accordance with a payment rate for the service that is established under rules adopted under IC 4-22-2 by the secretary in conjunction with the office.

As added by P.L.2-1992, SEC.9. Amended by P.L.27-1992, SEC.11; P.L.2-1993, SEC.93.

IC 12-15-15-1.1

Reimbursement to hospitals for inpatient hospital services; intergovernmental transfers; calculating Medicaid shortfall

Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount not to exceed one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of

inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in an amount not to exceed each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer or certification of expenditures is made under subsection (d).

(d) Subject to subsection (e):

(1) an intergovernmental transfer may be made by or on behalf of the hospital; or

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under this section. The office shall use the intergovernmental transfer to fund payments made under this section.

(e) A hospital that makes a certification of expenditures or makes or has an intergovernmental transfer made on the hospital's behalf under this section may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under subsection (b). The periods described in subsections (c) and (d) for the hospital or another entity to make an intergovernmental transfer or certification of expenditures are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified

under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

As added by P.L.126-1998, SEC.4. Amended by P.L.113-2000, SEC.2; P.L.283-2001, SEC.19; P.L.66-2002, SEC.5; P.L.120-2002, SEC.13; P.L.1-2003, SEC.56; P.L.255-2003, SEC.16; P.L.212-2007, SEC.1; P.L.218-2007, SEC.11; P.L.229-2011, SEC.128; P.L.205-2013, SEC.190.

IC 12-15-15-1.3

Reimbursement to hospitals for outpatient hospital services; intergovernmental transfers; calculating Medicaid shortfall

Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the

office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount not to exceed one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in an amount not to exceed each hospital's Medicaid shortfall as defined in subsection (f).

(c) A hospital is not eligible for a payment described in this section unless:

(1) an intergovernmental transfer is made by the hospital or on behalf of the hospital; or

(2) the hospital or another entity certifies the hospital's expenditures as eligible for federal financial participation.

(d) Subject to subsection (e):

(1) an intergovernmental transfer may be made by or on behalf of the hospital; or

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under subsection (b). The office shall use the intergovernmental transfer to fund payments made under this section.

(e) A hospital that makes a certification of expenditures or makes or has an intergovernmental transfer made on the hospital's behalf under this section may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under subsection (b). The periods described in subsections (c) and (d) for the hospital or other entity to make an intergovernmental transfer or certification of expenditures are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under subsection (b) may not be delayed due to an administrative appeal or judicial review instituted

by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

As added by P.L.120-2002, SEC.14. Amended by P.L.255-2003, SEC.17; P.L.212-2007, SEC.2; P.L.218-2007, SEC.12; P.L.229-2011, SEC.129; P.L.205-2013, SEC.191.

IC 12-15-15-1.5

Additional reimbursements to certain hospitals; appeal of amount of distribution

Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) For a state fiscal year ending after June 30, 2003, and before July 1, 2007, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to

reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than sixty thousand (60,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the nonfederal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state and paid Medicaid fee for service and managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the nonfederal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals:

(i) on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days; or

(ii) other payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(c) As used in this subsection, "Medicaid supplemental payments" means Medicaid payments for hospitals that are in addition to Medicaid fee-for-service payments, Medicaid risk-based managed care payments, and Medicaid disproportionate share payments, and that are included in the Medicaid state plan, including Medicaid safety-net payments, and payments made under this section and sections 1.1, 1.3, 9, and 9.5 of this chapter. For a state fiscal year ending after June 30, 2007, in addition to the reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services reimbursable under this article and under the state Medicaid plan that were provided during the state fiscal year for all hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified in STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to all hospitals described in subsection (a). A calculation under this STEP excludes a payment made under the following:

(A) IC 12-15-16.

(B) IC 12-15-17.

(C) IC 12-15-19.

STEP THREE: The office shall calculate, under Medicare payment principles, a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) As used in this clause, "Medicaid inpatient days" are the hospital's in-state paid Medicaid fee for service and risk-based managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office. Subject to the availability of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent care trust fund under IC 12-15-20-2(8)(G) to serve as the nonfederal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be

paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis, based on the hospitals' Medicaid inpatient days or in accordance with another payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(B) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid as described in clauses (C) and (D) to a hospital that is described in subsection (a) and that is described as eligible under this clause. A hospital is eligible for a payment under clause (C) only if the hospital:

(i) has less than sixty thousand (60,000) Medicaid inpatient days annually;

(ii) was eligible for Medicaid disproportionate share hospital payments in the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The payment amount under clause (C) for an eligible hospital is subject to the availability of the nonfederal share of the hospital's payment being provided by the hospital or on behalf of the hospital.

(C) For state fiscal years ending after June 30, 2007, but before July 1, 2009, payments to eligible hospitals described in clause (B) shall be made as follows:

(i) The payment to an eligible hospital that merged two (2) hospitals under a single Medicaid provider number effective January 1, 2004, shall equal one hundred percent (100%) of the hospital's hospital-specific limit for the state fiscal year ending June 30, 2005, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(ii) The payment to an eligible hospital described in clause (B) other than a hospital described in item (i) shall equal one hundred percent (100%) of the hospital's hospital specific limit for the state fiscal year ending June 30, 2004, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(D) For state fiscal years beginning after June 30, 2009, payments to an eligible hospital described in clause (B) shall be made in a manner determined by the office.

(E) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A) and clauses (C) or (D), the remaining amount may be paid as described in clause (F) to a hospital described in subsection (a) that is described as eligible under this clause. A hospital is eligible for a payment for a state fiscal year under clause (F) if the hospital:

(i) is eligible to receive Medicaid disproportionate share payments for the state fiscal year for which the Medicaid disproportionate share payment is attributable under IC 12-15-19-2.1, for a state fiscal year ending after June 30, 2007; and

(ii) does not receive a payment under clauses (C) or (D) for the state fiscal year.

A payment to a hospital under this clause is subject to the availability of nonfederal matching funds.

(F) Payments to eligible hospitals described in clause (E) shall be made:

(i) to best use federal matching funds available for hospitals that are eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(ii) by using a methodology that allocates available funding under this clause, Medicaid supplemental payments, and payments under IC 12-15-19-2.1, in a manner in which all hospitals eligible under clause (E) receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for Medicaid disproportionate share payments and ensures that payments for eligible hospitals are equitable.

(G) If the Centers for Medicare and Medicaid Services does not approve the payment methodologies in clauses (A) through (F), the office may implement alternative payment methodologies that are eligible for federal financial participation to implement a program consistent with the payments for hospitals described in clauses (A) through (F).

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsections (b) or (c). The distribution to other hospitals under STEP FIVE of subsection (b) or (c) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) or (c) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends

calculated by the office.

As added by P.L.255-2003, SEC.18. Amended by P.L.212-2007, SEC.3; P.L.218-2007, SEC.13; P.L.3-2008, SEC.92; P.L.229-2011, SEC.130; P.L.205-2013, SEC.192.

IC 12-15-15-1.6

Alternative payment methodology for payments to hospitals

Sec. 1.6. (a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that payments made under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter will not be approved for federal financial participation. This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) If the office determines that payments made under section 1.5(b) STEP FIVE (A) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (A) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.

(c) If the office determines that payments made under section 1.5(b) STEP FIVE (B) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (B) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (B) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.

(d) If the office determines that payments made under section 1.5(b) STEP FIVE (C) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (C) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of

this chapter for that state fiscal year.

(e) If the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that payments made under subsection (b), (c), or (d) will not be approved for federal financial participation, the office shall use the funds that would have served as the nonfederal share of these payments for a state fiscal year to serve as the nonfederal share of a payment program for hospitals to be established by the office. The payment program must distribute payments to hospitals for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.

As added by P.L.78-2004, SEC.4. Amended by P.L.229-2011, SEC.131; P.L.205-2013, SEC.193.

IC 12-15-15-2

Rates adopted for hospital licensed under IC 16-21; prospective or retrospective application

Sec. 2. The rates adopted under this chapter for a hospital licensed under IC 16-21 may be the following:

(1) Prospective.

(2) Retroactive.

(3) A combination of prospective and retroactive.

As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.94.

IC 12-15-15-2.5

Payment for physician services in emergency department

Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.

(e) This section does not apply to a person enrolled in the Medicaid risk-based managed care program.

As added by P.L.153-1995, SEC.10. Amended by P.L.119-1997,

SEC.5; P.L.245-1999, SEC.1; P.L.223-2001, SEC.10.

IC 12-15-15-3
Services provided at hospitals operating under IC 16-24-1; prospective payment rate

Sec. 3. Payment of a service provided in a hospital operating under IC 16-24-1 shall be determined in accordance with a prospective payment rate for the service.
As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.95.

IC 12-15-15-4
Per diem rate for services provided in hospitals operating under IC 16-24-1

Sec. 4. The office shall establish a per diem rate for the service provided in a hospital operating under IC 16-24-1 under rules adopted under IC 4-22-2 by the secretary.
As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.96.

IC 12-15-15-4.5
Payment for HIV test; limitation

Sec. 4.5. Payment to a hospital for a test required under IC 16-41-6-4 must be in an amount equal to the hospital's actual cost of performing the test and may not reduce or replace the reimbursement of other services that are provided to the patient under the state Medicaid program. The total cost to the state may not be more than twenty-four thousand dollars ($24,000) in a state fiscal year.
As added by P.L.237-2003, SEC.2.

IC 12-15-15-5
Repealed

(Repealed by P.L.126-1998, SEC.22.)

IC 12-15-15-6
Fees in addition to infant delivery fees

Sec. 6. (a) In addition to a payment due to a hospital for the delivery of a newborn infant, the office shall tender a payment to the hospital for the hospital's collection, handling, and delivery of a specimen for testing under IC 16-41-17-2(a)(10).

(b) Payment to a hospital required under subsection (a) must be in an amount equal to the total of the following costs:

(1) The cost incurred by the hospital to collect, handle, and deliver the specimen obtained for testing under IC 16-41-17-2(a)(10).

(2) Any fee assessed against the hospital for a laboratory's testing of the specimen under IC 16-41-17-2(a)(10).

(3) Any newborn screening fee or other fee assessed against the hospital by the state department of health in connection with the testing of the specimen under IC 16-41-17-2(a)(10).

As added by P.L.149-2001, SEC.2.

IC 12-15-15-8
Repealed
(Repealed by P.L.126-1998, SEC.21.)

IC 12-15-15-9
Attribution of payable claim to county; amount of payment on payable claims; conditions on payments; funds available for payments

Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) For each state fiscal year ending after June 30, 2003, and before July 1, 2007, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under subsection (c).

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5.

STEP FOUR: For each hospital identified in STEP ONE, with

respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5. Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5.

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007.

(e) A hospital's payment under subsection (c) or (d) is in the form of a Medicaid supplemental payment. The amount of a hospital's Medicaid supplemental payment is subject to the availability of funding for the non-federal share of the payment under subsection (f). The office shall make the payments under subsection (c) and (d) before December 15 that next succeeds the end of the state fiscal year.

(f) The non-federal share of a payment to a hospital under subsection (c) or (d) is funded from the funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5.

(g) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

(h) Any county's funds identified in subsection (g) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(i) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

(j) For purposes of subsection (c):

(1) the amount of a payable claim is an amount equal to the

amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(k) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

As added by P.L.126-1998, SEC.5. Amended by P.L.113-2000, SEC.3; P.L.283-2001, SEC.20; P.L.1-2002, SEC.52; P.L.120-2002, SEC.15; P.L.1-2003, SEC.57; P.L.255-2003, SEC.19; P.L.78-2004, SEC.5; P.L.212-2007, SEC.4; P.L.218-2007, SEC.14; P.L.229-2011, SEC.132; P.L.205-2013, SEC.194.

IC 12-15-15-9.5

Attribution of payable claim to county; funds available for payments; limitation on payments

Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

This section does not apply during the period that the office is assessing a hospital fee authorized by IC 16-21-10.

(b) For each state fiscal year ending after June 30, 2003, but before July 1, 2007, a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under subsection (c).

(c) Subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division

and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007.

(e) A hospital's payment under subsection (c) or (d) is in the form of a Medicaid supplemental payment. The amount of the hospital's add-on payment is subject to the availability of funding for the

nonfederal share of the payment under subsection (f). The office shall make the payments under subsection (c) or (d) before December 15 that next succeeds the end of the state fiscal year.

(f) The nonfederal share of a payment to a hospital under subsection (c) or (d) is derived from funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 and not expended under section 9 of this chapter.

(g) Except as provided in subsection (h), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(h) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(i) Any funds transferred to the Medicaid indigent care trust fund under IC 12-16-7.5-4.5 remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8).

(j) For purposes of subsection (c):

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

As added by P.L.255-2003, SEC.20. Amended by P.L.78-2004, SEC.6; P.L.212-2007, SEC.5; P.L.218-2007, SEC.15; P.L.3-2008, SEC.93; P.L.229-2011, SEC.133; P.L.205-2013, SEC.195.

IC 12-15-15-9.6

Limitation on total amount of payments

Sec. 9.6. For state fiscal years beginning after June 30, 2007, the total amount of payments to hospitals under sections 9 and 9.5 of this chapter may not exceed the amount paid to hospitals under sections 9 and 9.5 of this chapter for the state fiscal year ending June 30, 2007.

As added by P.L.255-2003, SEC.21. Amended by P.L.212-2007, SEC.6; P.L.218-2007, SEC.16.

IC 12-15-15-9.8
Repealed
(Repealed by P.L.212-2007, SEC.31; P.L.218-2007, SEC.52.)

IC 12-15-15-10
Payments to providers under Medicaid disproportionate share provider program
Sec. 10. (a) This section applies to a hospital that:
(1) is licensed under IC 16-21; and
(2) qualifies as a provider under IC 12-15-16, IC 12-15-17, or IC 12-15-19 of the Medicaid disproportionate share provider program.
(b) The office may, after consulting with affected providers, do one (1) or more of the following:
(1) Establish a nominal charge hospital payment program.
(2) Establish any other permissible payment program.
(c) A program expanded or established under this section is subject to the availability of:
(1) intergovernmental transfers;
(2) funds certified as being eligible for federal financial participation; or
(3) other permissible sources of non-federal share dollars.
(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.
(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.
As added by P.L.113-2000, SEC.4. Amended by P.L.66-2002, SEC.6; P.L.212-2007, SEC.7; P.L.218-2007, SEC.17.

IC 12-15-15-11
Nominal charge hospitals
Sec. 11. Hospitals licensed under IC 16-21 that are established and operated under IC 16-22, IC 16-22-8, or IC 16-23 are nominal charge hospitals for purposes of the Medicaid program.
As added by P.L.283-2001, SEC.21.