The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES
COUNTY TUBERCULOSIS HOSPITALS

A hospital defined and licensed as a County Tuberculosis hospital shall be entitled to Medicaid payment for authorized Medicaid services provided to eligible persons, in accordance with Medicare reasonable cost recognition principles using an all-inclusive **prospective** payment rate for such services. Such hospitals shall be limited to Medicaid reimbursement representing recognition of and payment for the lower of the following: (a) the reasonable cost of services delivered as developed through the applicable **prospective** reasonable cost principles applicable to Title XVIII, or (b) the customary charges to the general public. The upper limits for Medicaid payment of inpatient services to hospitals shall not exceed in the aggregate, the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

The Indiana Medicaid program prohibits hospitals from charging the Medicaid program for items or services furnished to Medicaid recipients which are more expensive than those determined to be necessary in the efficient delivery of health services.

The Medicare reasonable cost recognition principles used to establish an all-inclusive prospective payment rate for County Tuberculosis Hospitals involves a comprehensive audit of the hospital's 1991 Medicaid cost report (base year), organizing the facility's costs into logical cost groupings for allocation to major cost centers and eliminating excessive and unallowable costs. This step down method of capturing costs in described in detail in the CFR at 42 CFR 413.24 (d)(1). After arriving at allowable costs including ancillaries, those costs are divided by Medicaid inpatient days to arrive at an all-inclusive daily per diem. This 1991 rate is then inflated to the midpoint of the year for which it is used prospectively by the hospital using the DRI-MCGRAW HILL HOSPITAL MARKETBASKET INDEX.

REIMBURSEMENT FOR INPATIENT HOSPITALS SERVICES

DEFINITIONS

"Allowable costs" means Medicare allowable costs as defined by 42 USC 1395 (f).

"All patient refined DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

"Base amount," means the rate per Medicaid stay that is multiplied by the relative weight to determine the DRG rate.

"Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

"Capital costs" are costs associated with the capital costs of the facility. The term includes, but is not limited to, the following:

(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

"Children's hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "children's hospital"; or
(2) furnishes services to inpatients who are predominately individuals under eighteen (18) years of age, as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under eighteen (18) years of age.

"Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. This amount may be changed at the time DRG relative weights are adjusted.

"Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays using similar resources. Classification is made using the all patient refined (APR) DRG grouper.

"Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge, unless one (1) of the units is paid according to the level-of-care approach.

"DRG daily rate," means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the DRG average length of stay.

"DRG rate," means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

"Free-standing" hospital does not mean a wing or specialized unit within a general acute care hospital.

"Inpatient" means a Medicaid patient who was admitted to a medical facility on the recommendation of a physician and who received room, board and professional services in the facility.

"Inpatient hospital facility" means a general acute care hospital, a mental health institution, a state mental health institution or a rehabilitation inpatient facility properly licensed as a hospital in accordance with appropriate Indiana Code.

"Less than one-day stay" means a medical stay of less than twenty-four (24) hours.

"Level-of-care case" means a medical stay that includes psychiatric cases, rehabilitation cases, certain burn cases and long term care hospital admissions.

"Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure.

"Long term care hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "long term hospital"; or
(2) has an average inpatient length of stay greater than twenty-five (25) days, as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.

"Marginal cost factor" means a percentage applied to the difference between the cost per stay and the outlier threshold for purposes of the cost outlier computation.

"Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day. The term does not include any portion of an outpatient service that occurs within three days of an admission as an inpatient for a related condition.

"Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

"Medical education costs" means that costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

"Office" means the Office of Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

"Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

"Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

"Principal diagnosis" means the diagnosis, as described by the International Classifications of Diseases, current version, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

"Readmission" means that a patent is admitted into the hospital following a previous hospital admission and discharge for a related condition as defined by the office.

"Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in the providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient form one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

PROSPECTIVE REIMBURSEMENT METHODOLOGY

The purpose of this section is to establish a prospective reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective.

system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Prospective payment shall constitute full reimbursement unless otherwise indicated herein or as indicated in provider manuals and update bulletins. There shall be no year-end cost settlement payments.

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient refined DRG grouper. The DRG rate is equal to the relative weight multiplied by the base amount.

Payment of inpatient stays reimbursed according to the DRG methodology shall be equal to the lower of billed charges or the sum of the DRG rate, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the lower of billed charges or the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Relative weights will be reviewed periodically by the office and adjusted no more often than annually using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine wither an adjustment to the relative weights will be made. DRG average length of stay values will be revised when relative weights are adjusted. The office shall include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission will not be eligible for outpatient reimbursement under Attachment 4.19B. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

A base amount is the rate per Medicaid stay. DRG base amounts will be reviewed periodically by the office and adjusted no more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.
The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjustment cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred and twenty percent (120%) of the statewide base amount for DRG services.

Level-of-care rates are per diem rates. Level-of-care rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. The office shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

Effective August 1, 2020, Level-of-Care cases are categorized by DRG number, as defined and grouped using the all patient refined DRG grouper and published on the agency's website, https://www.in.gov/medicaid/providers/669.htm . These DRG numbers represent burn, psychiatric, and rehabilitative care. The office may assign a LOC DRG number for long term care hospital admissions.

In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must operate a burn intensive care unit.

The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

The office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of a long-term care hospital to be eligible for the separate level-of-care rate.

Add-On Payments

Capital payment rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

- Depreciation
- Interest
- Property Taxes
- Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital payment rates will be calculated using a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data.

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. The capital payment amount is calculated as follows:

- for stays reimbursed under the DRG methodology, capital payment is equal to the product of the per diem capital rate and the average length of stay for the assigned DRG. Capital payments shall be pro-rated for a transferring or transferee facility to a maximum of the average length of stay.
- For stays reimbursed under the level-of-care methodology, capital payment is equal to the product of the per diem capital rate for each covered day of care.

The office shall not set separate capital per diem rates for different categories of facilities, except as specifically noted in this plan.

Medical Education rates shall be prospective, hospital-specific per diem amounts. Medical education payment amounts are calculated as follows:

- for stays reimbursed under the DRG methodology medical education payments are equal to the product of the medical education per diem rate and the average length of stay assigned to the DRG. Medical education rates for a transferring or transferee facility shall be pro-rated not to exceed the average length of stay.

- for stays reimbursed under the level-of-care methodology, medical education payments are equal to the medical education per diem rate for each covered day of care.

Medical education rates are facility-specific rates based on medical education costs per day multiplied by the number of residents reported by the facility. No more often than every second year, the office will use the most recent cost report data to determine a cost per day that more accurately reflects the cost of efficiently providing hospital services as it relates to operating a medical education program. The number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor.

Medical Education payments will be available to hospitals only so long as they continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program. For hospitals establishing new medical education programs, the medical education per diem will not be effective prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data cost report data.

A Medicaid stay that exceeds a predetermined threshold, defined as the greater of: (1) twice the DRG rate or (2) the outlier threshold, is a cost outlier case. The calculation for outlier payment amounts is made as follows:

(1) Multiplying the overall facility cost-to-charge ratio by submitted charges. The outlier payment is equal to the marginal cost factor multiplied by the difference between the prospective cost per stay and the greater of the DRG rate or the outlier threshold amount.

(2) Day outliers as required under Section 1902(s) of the Social Security act are provided for through implementation of the DRG/LOC per diem, which is designed to account for unpredictable and lengthy hospital admissions.

Outlier thresholds will be revised as necessary when DRG relative weights are adjusted. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology, except for burn cases that exceed the established threshold.

Other Payment Policies

Readmissions for a related condition as defined by the office within three (3) calendar days after discharge will be treated as the same admission for payment purposes. Readmissions that occur after three (3) calendar days will be treated as separate stays for payment purposes but will be subject to medical review.

Special payment policies shall apply to transfer cases. The transferring hospital and the transferee, or receiving, hospital are paid the sum of the following:

(1) A DRG daily rate for each Medicaid day of the recipient's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided.
(2) The capital per diem rate.
(3) The medical education per diem rate.

Transferring hospitals will not receive separate reimbursement for Medicaid patients subsequent to their return from a transferee hospital if the patient is readmitted to the transferring hospital 30 or fewer days from the original admission. Additional costs incurred as a result of the patient's return from a transferee hospital are eligible for cost outlier reimbursement. The office may establish a separate outlier threshold or marginal cost factor for such cases. Transferring hospitals will receive separate reimbursement for Medicaid patients subsequent to their return from a transferee hospital if the patient is readmitted to the transferring hospital more than 30 days after the original admission.

Each facility that submits an Indiana Medicaid cost report will receive a cost-to-charge ratio. The cost-to-charge ratio will be computed from claims data and will be used to determine applicable cost outlier payments. Facilities with less than 30 Medicaid claims annually will be given the statewide median cost-to-charge ratio.

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 medial cost-to-charge ratio to determine applicable cost outlier payments, computed in accordance with the outlier provisions of this plan.

Effective July 1, 2023, through July 1, 2025, reimbursement for inpatient hospital services provided by a children's hospital located in a state bordering Indiana will be reimbursed at a rate that is 130% of the Medicaid reimbursement rate. The increase does not apply to the capital per-diem or the medical education per-diem (if applicable). To be eligible, the children's hospital must be located in Illinois, Kentucky, Michigan, or Ohio. Additionally, the children's hospital must be either:

1) A freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age; or

2) A facility located within a freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age.

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.

(2) For the Eligibility Periods beginning after June 30, 2001, an inpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid inpatient safety-net payment adjustment in the amount of 100% of the inpatient safety-net amount, will continue to receive Medicaid inpatient safety-net payment adjustments in the amount of 100% of the inpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid inpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid inpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid inpatient 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 inpatient 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 inpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid inpatient 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 inpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid inpatient 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, inpatient 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 inpatient safety-net criteria for the current Eligibility Period, and
(c) which did not meet the office's Medicaid inpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid inpatient safety-net payment adjustments equal to 33 1/3% of their inpatient 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 inpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(a) meeting the office's Medicaid inpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or
(b) meeting the office's Medicaid inpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6) 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.

*This new payment methodology will 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.

Hospital-Acquired Conditions

This section applies to payment for inpatient stays reimbursed according to the DRG methodology. This section applies to all inpatient hospital facility reimbursement provisions, including Medicaid supplemental payments; Medicaid enhanced payments and Medicaid disproportionate share hospital payments.

The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a hospital acquired condition that was not present on the date of admission. If a hospital acquired condition is not present on the date of admission, the discharge will be assigned to a DRG as though the hospital acquired condition was not present.

Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

For purposes of this section, a "hospital acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and in effect on the date of admission.

Effective for services provided on or after July 1, 2012, this section applies to all inpatient stays reimbursed according to the DRG and level-of-care methodologies. A hospital-acquired condition (or "health care-acquired condition") means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and 42 CFR 447.26(b) and in effect on the date of admission.

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 4.19A: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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, 2021.

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 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.