



M E D I C A I D B U L L E T I N

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**To: All Indiana Medicaid Acute Care Hospitals, Municipal County Hospitals, Community Mental Health Centers, State Psychiatric Hospitals, and Private Psychiatric Hospitals**

**Subject: Participation in the Indiana Medicaid Hospital Care for the Indigent (HCI) Payment, Municipal County Hospital Indiana Medicaid Shortfall Payment and Indiana Medicaid Disproportionate Share Hospital (DSH) Payment Programs**

## Overview

During the 1998 Indiana legislative session, legislation was introduced, passed, and enacted into law by Governor Frank O'Bannon that revised the Indiana Medicaid Hospital Care for the Indigent (HCI) and Disproportionate Share Hospital (DSH) payment programs and added the Municipal County Hospital Indiana Medicaid Shortfall Program. Specifically, *Indiana Public Law 126-1998* revised the DSH program to include two new and separate Enhanced DSH pools under Indiana Code (I.C.) 12-15-19-8 and 12-15-19-9. These two new and separate Enhanced DSH pools include the participation of municipal county hospitals and community mental health centers. *Indiana Public Law 126-1998* also added the Municipal County Hospital Indiana Medicaid Shortfall program to reimburse municipal county hospitals only.

Public notice of the intent to change the methods and standards for setting the Indiana Medicaid HCI and DSH payments and Municipal County Hospital Indiana Medicaid shortfall payment was provided in newspapers throughout the State of Indiana, county directors' offices throughout the State of Indiana, and in the Indiana Register, in accordance with the public notice requirements contained in *Section 447.205 of Title 42, Code of Federal Regulations and Section 4711 of the Balanced Budget Act (BBA) of 1997*.

In accordance with *I.C. 12-15-13-6*, this bulletin is to notify acute care hospitals, municipal county hospitals, community mental health centers, state psychiatric hospitals, and psychiatric hospitals that the Health Care Financing Administration (HCFA) has approved the Indiana State Plan Amendments associated with these payment programs. Therefore, and where appropriate, the Office of Medicaid Policy and Planning (OMPP) has revised the Indiana Medicaid HCI and DSH payment methodologies and added the Indiana Medicaid Shortfall payment process to the Indiana Medicaid program.

## New Indiana Medicaid Payment Programs

As a result of the new provisions contained in *Indiana Public Law 126-1998*, the current Indiana Medicaid Program includes the following payment programs:

1. The Hospital Care for the Indigent payment program
2. The Municipal County Hospital Indiana Medicaid Shortfall Payment program
3. The Enhanced DSH payment program.

The section of the Indiana Code (I.C.) for the prior Hospital Care for the Indigent payment methodology, *I.C. 12-15-15-8*, has been repealed. The new section, *I.C. 12-15-15-9*, which applies only to acute care hospitals, required the OMPP to develop a new payment methodology policy. The fundamental concept behind the new HCI payment program was to minimize “the difference between the aggregate amount paid under this section to all hospitals in a county for a state fiscal year and the amount of the county’s hospital care for the indigent property tax levy for that state fiscal year.”

The basic purpose of the new Municipal County Hospital Indiana Medicaid Shortfall Payment Program is to reimburse municipal county hospitals only for their Indiana Medicaid shortfall. While technically not considered a DSH payment, this payment is figured into the upper limit calculation for DSH cap purposes. This includes both the limit on the amount of DSH payment to the specific municipal county hospital under *42 U.S.C. Section 1396r-4(g)(1)* and the Indiana state-wide DSH cap under *42 U.S.C. Section 1396r-(4)(f)(2)*.

Within the Indiana Medicaid DSH payment program, there is the Basic program and the Enhanced program. The Basic DSH payment program is comprised of four separate pools consisting of the following:

1. \$8 million pool for acute care hospitals that qualify under *I.C. 12-15-16-1(a)(1)*
2. \$2 million pool for psychiatric hospitals and community mental health centers that qualify under either *I.C. 12-15-16-1(a)(1)* or *I(a)(2)*
3. A pool not to exceed \$191 million for state mental institutions that qualify under either *I.C. 12-15-16-1(a)(1)* or *I(a)(2)*
4. \$18 million pool for acute care hospitals that qualify under either *I.C. 12-15-16-1(a)(1)* or *I(a)(2)* and have at least 20,000 Medicaid inpatient days from the most recent common SFY

The new, revised Enhanced DSH payment program is comprised of three separate pools consisting of the following:

1. The Regular Enhanced DSH payment
2. The Municipal County Hospital Enhanced DSH payment
3. The CMHC Enhanced DSH payment

## **New Payment Flow**

Payments from these programs will be made in the following sequential order for a given state fiscal year (SFY):

1. The HCI payment
2. The Municipal County Hospital Indiana Medicaid Shortfall payment
3. The Basic DSH payment
4. The Regular Enhanced DSH payment
5. The Municipal County Hospital Enhanced DSH payment
6. The CMHC Enhanced DSH payment

## **General Conditions of Participation**

Other than the specific legal requirements contained in the Indiana Code provisions, prior to participating in any one of these programs, all acute care hospitals, municipal county hospitals, community mental health centers, state psychiatric hospitals, and psychiatric hospitals must meet the following general conditions:

1. Must be an Indiana hospital and have operated during the SFY for which payment is being determined

2. Must have an audited Medicaid cost report on file from the most recent common SFY, unless extenuating circumstances exist
3. Except for state and psychiatric hospitals and private, acute care hospitals, must have made an intergovernmental transfer (IGT) or, if a community mental health center, must have a county treasurer or auditor certify that “a payment under *I.C. 12-29-1-7(b)* or other county sources . . . represents expenditures that are eligible for federal financial participation.”
4. Must have submitted to the OMPP either the DSH survey document section II or an audited opinion certified by an independent certified public accounting firm or the State Budget Agency or the State Board of Accounts to determine each provider’s hospital specific limit (HSL) under *42 U.S.C. Section 1396r-4(g)(1)(A)* and compare with the Indiana state-wide DSH cap under *42 U.S.C. Section 1396r-4(f)(2)* and the Institutions for Mental Diseases (IMD) DSH cap under *42 U.S.C. Section 1396r-4(h)*.

## The Revised Medicaid HCI Payment Program

The section of the Indiana Code dealing with the prior Hospital Care for the Indigent payment methodology, *I.C. 12-15-15-8* was repealed. The new section, *I.C. 12-15-15-9*, which applies only to acute care hospitals, required the OMPP to develop a new payment methodology policy.

The fundamental concept behind the new Medicaid HCI payment program is to minimize “the difference between the aggregate amount paid under this section to all hospitals in a county for a state fiscal year and the amount of the county’s hospital care for the indigent property tax levy for that state fiscal year.” To the extent practical, the new payment methodology policy attempts to reduce the deficit for those counties that have a deficit between their SFY 97 HCI payments and current SFY HCI tax levy amount.

The new payment methodology policy uses each acute care hospital’s SFY 97 payments, each acute care hospital’s Medicaid inpatient days and each county’s HCI tax levy amount from the current SFY to derive at a payment for each acute care hospital. The Medicaid inpatient days of an acute care hospital are derived from the acute care hospital’s audited Medicaid cost report that is on file from the most recent common SFY and that is used to determine Basic DSH eligibility. For HCI payment purposes, the same Medicaid inpatient days are used for subsequent SFY’s, until the next DSH eligibility database is determined.

The new payment methodology policy was submitted in the September 1, 1999, October 1, 1999, November 1, 1999, and December 1, 1999, versions of the Indiana Register.

No intergovernmental transfers are needed to fund this program.

OMPP's hospital payment rate-setting contractor, Myers and Stauffer, will determine and notify each acute care hospital of its Medicaid inpatient days and HCI payment amount through written notification letters.

OMPP's fiscal agent contractor, EDS, will perform the payment function of the Medicaid HCI payment program through the weekly claims payment cycle as a non-claim expenditure.

Notification and payment should occur at or around the end of the SFY for which payment is being made.

## **The New Municipal County Hospital Indiana Medicaid Shortfall Payment Program**

The basic purpose of the new Municipal County Hospital Indiana Medicaid Shortfall Payment Program is to reimburse acute care, municipal county hospitals only for their Indiana Medicaid shortfall. Under this program, Indiana Medicaid shortfall is defined as the difference between the amount of reimbursement received from the Indiana Medicaid program and the lesser of the hospital's customary charges for performing Indiana Medicaid program services or, a reasonable estimate for performing Indiana Medicaid program services using Medicare payment principles.

Payment will be determined using the municipal county hospital's cost report that has been filed with the OMPP, the survey document or audited opinion submitted by the municipal county hospital and/or from Medicaid paid claims data. The municipal county hospital's cost report with a fiscal period ending in the SFY for which payment is to be made will be used to determine the amount of reimbursement. A Notice of Program Reimbursement (NPR) will be sent to each municipal county hospital notifying them of the amount of reimbursement. The NPR will provide a 15 day period to allow the municipal county hospital to appeal the amount determined to be reimbursed.

In accordance with *I.C. 12-15-15-1.1(a)*, as a condition of participation in this program, an IGT must be made in order to receive an Indiana Medicaid shortfall payment. An IGT is defined as a payment exchange

among or between different levels of government. According to *I.C. 12-15-15-1.1(d)*, a municipal county hospital may make the IGT after the close of each SFY in one of two methods:

1. The municipal county hospital may make an IGT.
2. The IGT may be made on behalf of the municipal county hospital by another entity.

Payment of the IGT needs to be made before the State's share of the Enhanced DSH payments are made under *I.C. 12-15-20-2(1)*. According to *I.C. 12-15-15-1.1(d)*, the IGT is 85 percent of the Indiana Medicaid shortfall payment amount.

OMPP's hospital payment rate-setting contractor will determine and notify each municipal county hospital of its Indiana Medicaid shortfall payment amount and the IGT amount through the NPR.

Please personally deliver or forward a cover letter, a copy of the NPR and the IGT check made payable to the "Treasurer of the State of Indiana." The cover letter should contain the following information:

- Your facility's name and address
- Your federal tax identification number
- The method of providing the transfer and/or payment
- The name of the representative who will be personally delivering it to FSSA – Financial Management

The check and cover letter should be personally delivered or sent by certified mail to:

Tilena Henry  
Family and Social Services Administration  
MS34  
P.O. Box 7128  
Office of Financial Management, E-442  
Indianapolis, IN 46207-7128.  
Telephone: (317) 233-6327, Fax: (317) 233-6572

If you fax this letter, please also mail the original.

FSSA-Financial Management will perform the payment function of the Indiana Medicaid Shortfall Payment Program.

Notification and payment should occur at or around the end of the SFY for which payment is being made.

## The Revised Indiana Medicaid Disproportionate Share (DSH) Payment Program

Within the Indiana Medicaid DSH payment program, there is the Basic program and the Enhanced program. The Basic DSH payment program is comprised of four separate pools consisting of the following:

1. \$8 million pool for acute care hospitals that qualify under *I.C. 12-15-16-1(a)(1)*
2. \$2 million pool for psychiatric hospitals and community mental health centers that qualify under either *I.C. 12-15-16-1(a)(1)* or *1(a)(2)*
3. A pool not to exceed \$191 million for state mental institutions that qualify under either *I.C. 12-15-16-1(a)(1)* and *1(a)(2)*
4. \$18 million pool for acute care hospitals that qualify under either *I.C. 12-15-16-1(a)(1)* or *1(a)(2)* and have at least 20,000 Medicaid inpatient days from the most recent common SFY to be eligible for payment

The new, revised Enhanced DSH payment program is comprised of three separate pools consisting of the following;

1. The Regular Enhanced DSH payment
2. The Municipal County Hospital Enhanced DSH payment
3. The CMHC Enhanced DSH payment

## The Basic DSH Program

Indiana Public Law 126-1998 did not significantly change the Basic DSH program. One of the changes to the program worth noting deals with the Basic Acute Care Hospital \$18 million DSH pool. The requirement of having at least 20,000 Medicaid inpatient days changed from an eligibility requirement to a qualification requirement.

All acute care hospitals, municipal county hospitals, community mental health centers, state psychiatric hospitals, and psychiatric hospitals (providers) will receive a Medicaid Statistical Report (MSR) from Myers and Stauffer when the cost reports have been audited and adjusted. Providers shall have 30 days to contest the audit adjustments.

*Note: The MSR should be reviewed thoroughly by all providers and responded to if they do not agree with the adjustments. The adjusted data is used not only to determine DSH eligibility, but also for the rebasing of the Diagnostic-Related Group (DRG)/Level-of-Care (LOC) Medicaid Inpatient rates and determining the Medicaid HCI payments.*

An audited Medicaid cost report on file from the most recent common SFY shall be used to determine DSH eligibility, unless extenuating circumstances exist. However, extenuating circumstances do not include comparing the utilization data of a provider from different fiscal years to derive the most advantageous days for eligibility purposes.

Along with the MSR, Myers and Stauffer will mail the DSH eligibility survey document sections I and II to all providers for the purpose of obtaining relevant data to determine DSH eligibility.

*Note: Where the DSH eligibility survey requests data and supporting documentation for categories such as Medicaid Out-of-State days, Risk-Based Managed Care (RBMC) days, Medicaid eligible zero paid days, and HCI days, survey reported numbers will not be used to determine DSH eligibility, unless the appropriate requested documentation is submitted for review.*

The DSH eligibility survey specifically indicates which data requires supporting documentation and the type of documentation required.

Thereafter, data reconciliation letters will be sent to providers showing the numbers reported for DSH eligibility determination as compared to any adjusted cost report numbers and verified provider information. Myers and Stauffer will work with the providers to resolve any contested differences. Providers will have 30 days to appeal their Medicaid inpatient and HCI days.



*Note: This will be the last opportunity to appeal the data that is contained in this data reconciliation letter [i.e., Medicaid inpatient days, Medicaid discharges, utilization rates (MIUR or LIUR) and HCI days].*

Providers shall receive letters notifying them of their DSH eligibility.

*Note: Providers will not be provided an opportunity to appeal the data that is contained in this DSH eligibility letter [i.e., Medicaid inpatient days, Medicaid discharges, utilization rates (MIUR or LIUR) and HCI days], unless a clerical error has occurred.*

As previously stated above, this data will be used not only to determine DSH eligibility, but also for the rebasing of the DRG/ LOC Medicaid Inpatient rates and determining the Medicaid HCI payments.

A provider can become eligible to receive a DSH payment under the Basic DSH program by one of the following ways:

1. Under the Medicaid Inpatient Utilization Rate (MIUR) calculation
2. Under the Low Income Utilization Rate (LIUR) calculation

A provider is eligible to receive a DSH payment under MIUR “if the provider’s Medicaid Inpatient Utilization Rate is at least one (1) standard deviation above the mean Medicaid Inpatient Utilization Rate for providers receiving Medicaid payments in Indiana.” A provider is eligible to receive a DSH payment under LIUR “if the provider’s Low Income Utilization Rate exceeds 25 percent .”

For CMHCs only, the following is the manner in which the Medicaid Rehabilitation Option (MRO) and Hoosier Assurance Plan (HAP) payments should be included within the LIUR calculation to determine DSH eligibility and calculation purposes only:

1. The gross (state and federal share) MRO payment amount that the CMHC receives from the Indiana Medicaid Program
2. The net HAP payment amount that the CMHC receives from the Indiana Department of Mental Health (IDMH)

Please see below the section on DSH Survey Document or Audited Opinion for how HAP payments should be treated within these documents.

After DSH eligibility is determined and the providers have been notified of their DSH eligibility status, those providers that have qualified for payment under the Basic DSH pools will receive a DSH distribution letter.

*Note: The data that is contained in this DSH distribution letter cannot be appealed [i.e., Medicaid inpatient days, Medicaid discharges, utilization rates (MIUR or LIUR) and HCI days], unless a clerical error has occurred.*

For state fiscal years ending June 30, 1998, and thereafter, the OMPP will change the methodology used to distribute funds for the Basic psychiatric and CMHC hospitals \$2 million DSH pool. This pool will be distributed to qualifying hospitals in the proportion that each qualifying hospital's Medicaid Day Utilization Rate bears to the total of the Medicaid Day Utilization Rates for all hospitals in the pool.

Basic DSH payments for each provider will be restricted to the amount of the provider's hospital specific limit. In order to determine a provider's hospital specific limit, the Indiana Medicaid program requires for providers to submit relevant portions of the DSH survey document or an audited opinion certified by an independent certified public accounting firm. Please see below the section on DSH Survey Document or Certified Audited Opinion.

If the Basic DSH payment calculated for a provider exceeds that provider's hospital specific limit, then the provider will not receive the amount in excess of the hospital specific limit, but the excess amount will be re-distributed to the remaining hospitals in the Basic DSH pool. This calculation will apply to all pools in the Basic DSH program.

No intergovernmental transfers are needed to fund the Basic DSH program.

Myers and Stauffer will determine and notify each provider of its Basic DSH eligibility and payment amounts through written notification letters.

EDS will perform the payment function of the Basic DSH payment program through the weekly claims payment cycle as a non-claim expenditure.

Notification and payment should occur on an interim basis throughout the year.

## The New, Revised Enhanced DSH Program

Indiana Public Law 126-1998 did significantly change the Enhanced DSH program. As previously stated, Indiana Public Law 126-1998 expanded the DSH program to include two new and separate Enhanced DSH pools under *I.C. 12-15-19-8* and *12-15-19-9*. These two new and separate Enhanced DSH pools include the participation of municipal county hospitals and community mental health centers. Therefore, the new, revised Enhanced DSH payment program is comprised of three separate pools consisting of the following:

1. The Regular Enhanced DSH payment
2. The Municipal County Hospital Enhanced DSH payment
3. The CMHC Enhanced DSH payment

The eligibility and qualification requirements for an Enhanced DSH payment have also changed. No longer are the providers that meet the Medicaid utilization data from SFY 1992 cost reports codified in statute only eligible for payment. To be eligible for any of the Enhanced DSH pools, the following general conditions of participation apply:

1. Must have operated during the SFY for which payment is being determined;
2. Must have an audited Medicaid cost report on file from the most recent common SFY, unless extenuating circumstances exist;
3. Except for private, acute care hospitals, must have made an IGT or, if a community mental health center, must have a county treasurer or auditor certify that “a payment under *I.C. 12-29-1-7(b)* or other county sources . . . represents expenditures that are eligible for federal financial participation.”; and
4. Must have submitted to OMPP either the DSH survey document section II or an audited opinion certified by an independent certified public accounting firm.

Other than the specific legal requirements contained in the Indiana Code (I.C.) provisions, the qualification requirements for the regular Enhanced DSH pool are different than the qualifications for the Municipal County Hospital Enhanced DSH and CMHC Enhanced DSH pools. To qualify for a DSH payment from the regular Enhanced pool, the provider needs to qualify under *either I.C. 12-15-16-1(a)(1)* or *1(a)(2)*. To qualify for a DSH payment under either the Municipal County Hospital Enhanced DSH pool or the CMHC Enhanced DSH pool, the provider needs to have a Medicaid utilization rate greater than one percent. The one percent Medicaid utilization rate is

determined from a provider's audited Medicaid cost report from the most recent common SFY or, if a preceding or subsequent audited Medicaid cost report is used based on extenuating circumstances.

Furthermore, eligibility, qualification and participation in one of these Enhanced DSH pools, precludes a provider from being eligible, qualifying and participating in the other two Enhanced DSH pools.

The measurement by which the Enhanced DSH payments are calculated has also been changed. Rather than using payment rates codified in statute to determine payments, the new measurement used to calculate payments for the three separate Enhanced DSH pools is the hospital specific limits of the Enhanced providers in their respective pool. Therefore, in order to determine a provider's hospital specific limit, the Indiana Medicaid program requires that providers submit relevant portions of the DSH survey document or an audited opinion certified by an independent certified public accounting firm or the State Board of Accounts.

Myers and Stauffer will determine and notify each provider of its Enhanced DSH eligibility and payment amounts through letters.

FSSA – Financial Management will perform the payment function for all Enhanced DSH payment programs.

Notification and payment should occur on an interim basis throughout the year.

## **The Revised Regular Enhanced DSH Pool**

The methodology to determine payments under the regular Enhanced DSH pool is espoused under *I.C. 12-15-19-1(b)*. According to *I.C. 12-15-19-1(b)*, “funds shall be distributed to qualifying hospitals in proportion to each qualifying hospital's percentage of the total net hospital specific limits of all qualifying hospitals. A hospital's net hospital specific limit is determined under STEP THREE of the following formula:

**STEP ONE:** Determine the hospital's hospital specific limit under subsection (d).

**STEP TWO:** Subtract basic disproportionate share payments received by the hospital under *I.C. 12-15-16-6* from the amount determined under STEP ONE.

**STEP THREE:** Subtract intergovernmental transfers paid by or on behalf of the hospital from the amount determined under STEP TWO.”

As previously stated, to qualify to receive a payment under this Enhanced DSH pool, the provider must qualify to receive a payment under either *I.C. 12-15-16-1(a)(1)* or *1(a)(2)*. However, eligibility, qualification and participation in one of these Enhanced DSH pools, precludes a provider from being eligible, qualifying and participating in the other two Enhanced DSH pools.

Other than the specific statutory transfer payments, the only entities that need to provide an IGT for the regular Enhanced DSH pool are the Health and Hospital Corporation of Marion County and the Indiana University Trustees. Private, acute care hospitals do not provide an IGT. Municipal county hospitals that participate under the regular Enhanced DSH pool may, but do not need to, provide an IGT in order to receive a DSH payment.

If the Indiana Medicaid program will exceed the Indiana state-wide cap under *42 U.S.C. Section 1396r-(f)(2)* when making payments under the regular Enhanced DSH pool, then the Indiana Medicaid program may pro-rate the payments to this Enhanced DSH pool in order to avoid exceeding the cap provision.

Please see sections on IGT and DSH Survey Document and Certified Audited Opinion.

Rather than providing an IGT, the OMPP is reviewing the possibility of allowing the state share match to be certified by the county treasurer, county auditor or hospital administrator via an affidavit, similar to the affidavit described in the section on the Certification of County Payments Eligible for Federal Financial Participation.

## **The New Municipal County Hospital Enhanced DSH Pool**

The methodology used to distribute a payment to qualifying providers under the Municipal County Hospital Enhanced DSH pool is the following:

STEP ONE: Determine the hospital's hospital specific limit (HSL).

STEP TWO: Subtract the gross Municipal County Hospital Indiana Medicaid Shortfall payment received by the hospital *under I.C. 12-15-15-1.1* from the amount determined under STEP ONE.

STEP THREE: Determine each hospital's net HSL and total of all hospital's net HSL.

STEP FOUR: Determine the state share of each hospital by multiplying each hospital's net HSL by the state's medical assistance percentage applicable.

STEP FIVE: Determine the federal share of each hospital by multiplying each hospital's net HSL by the federal medical assistance percentage applicable.

STEP SIX: Determine the amount due each hospital by multiplying the first \$100,000 by 50 percent and the remainder by 15 percent.

STEP SEVEN: Determine IGT of each hospital needed to fund the Municipal Enhanced DSH pool.

STEP EIGHT: Determine the total Municipal County Hospital Enhanced DSH payment due each hospital.

To qualify to receive a payment under this Enhanced DSH pool, the provider must be a municipal county hospital as defined in *I.C. 12-15-16-1(c)*. Eligibility, qualification and participation in one of these Enhanced DSH pools, precludes a provider from being eligible, qualifying and participating in the other two Enhanced DSH pools.

If the municipal county hospital chooses to participate in the Municipal County Hospital Enhanced DSH pool, then the municipal county hospital must provide an IGT in order to receive a payment through this Enhanced DSH pool. The municipal county hospital is not required to participate in the Municipal County Hospital Enhanced DSH; however, if the municipal county hospital chooses not to participate in this Enhanced DSH pool, then the municipal county hospital will not receive a payment through this Enhanced pool.

If the Indiana Medicaid program will exceed the Indiana state-wide cap under *42 U.S.C. Section 1396r-(f)(2)* when making payments under the Municipal County Hospital Enhanced DSH pool, then the Indiana Medicaid program may pro-rate the payments to this Enhanced DSH pool in order to avoid exceeding the cap provision.

Please see sections on IGT and DSH Survey Document Section II and Certified Audited Opinion.

Rather than providing an IGT, the OMPP is reviewing the possibility of allowing the state share match to be certified by the county treasurer, county auditor or hospital administrator via an affidavit, similar to the affidavit described in the section on the Certification of County Payments Eligible for Federal Financial Participation.

## The New Community Mental Health Center (CMHC) Enhanced DSH Pool

The methodology to determine payments under the CMHC Enhanced DSH pool is espoused under *I.C. 12-15-19-9(a)*. According to *I.C. 12-15-19-9(a)*, a CMHC provider shall receive an Enhanced DSH payment, “in an amount determined under STEP THREE of the following formula:

STEP ONE: Determine the amount paid to the community mental health center during the state fiscal year under *IC 12-29-1-7(b)* or from other county sources according to the county treasurer or auditor affidavit.

STEP TWO: Divide the amount determined under STEP ONE by a percentage equal to the state’s medical assistance percentage for the state fiscal year.

STEP THREE: Subtract the amount determined under STEP ONE from the sum determined under STEP TWO.”

While not specifically addressed, in order to comply with *42 U.S.C. 1396r-4(g)(1)(A)*, the Indiana Medicaid program will reduce the amount determined under STEP THREE by any Basic DSH payment and/or if the provider’s hospital specific limit is exceeded by the amount determined under STEP THREE.

Related to STEP ONE above, in order for a CMHC to be eligible to receive an Enhanced DSH payment, the county treasurer from the county in which the CMHC is located must first certify that a payment that a county makes under *I.C. 12-29-1-7(b)* or from other county sources to the CMHC “represents expenditures that are eligible for federal financial participation under *42 U.S.C. 1396(w)(6)(A)* and *42 CFR 433.51*.” The payments that represent expenditures that are eligible for federal financial participation must be derived from county property tax levy amounts. Please see below section on Certification of County Payments Eligible for Federal Financial Participation.

If the Indiana Medicaid program will exceed the Indiana state-wide cap under *42 U.S.C. Section 1396r-(f)(2)* or the IMD state-wide cap under *42 U.S.C. Section 1396r-4(h)* when making payments under the CMHC Enhanced DSH pool, then the Indiana Medicaid program may pro-rate the payments to this Enhanced DSH pool in order to avoid exceeding these cap provisions.

Please see sections on IGT and DSH Survey Document Section II and Certified Audited Opinion.

If federal financial participation is later disallowed for the funds certified under this section upon which the CMHC Enhanced DSH payment are based, then the CMHC Enhanced DSH payment must be recovered by the Indiana Medicaid program.

## Intergovernmental Transfer (IGT)

As previously stated, an IGT is defined as a payment exchange among or between different levels of government. The IGT is used as the revenue or funding source for a state's DSH program. In these instances, funds are transferred from state psychiatric facilities, university hospitals and county or metropolitan hospitals to the state Medicaid agency. By using these IGT's, the state Medicaid agency is able to draw down federal financial participation or federal funds when making DSH payments. Currently, the share of federal financial participation in Medicaid payments is approximately 60 percent and the share from the State is approximately 40 percent.

If you are a provider that must provide an IGT to the Indiana Medicaid program, OMPP cannot make your DSH payment until the IGT funds are received. When providing the IGT, the provider may either mail the IGT certified or, have a representative personally deliver it to Indiana Family and Social Services Administration (FSSA) - Financial Management. Make the check payable to "The Treasurer of the State of Indiana."

When providing the IGT, please notify FSSA – Financial Management by cover letter and by phone. In this cover letter, please provide the following:

- Your facility's name and address
- Your federal tax identification number
- The method of providing the transfer and/or payment
- The name of the representative who will be personally delivering it to FSSA – Financial Management

The check and cover letter should be personally delivered or sent by certified mail to:



Tilena Henry  
Family and Social Services Administration  
MS34  
P.O. Box 7128  
Office of Financial Management, E-442  
Indianapolis, IN 46207-7128  
Telephone: (317) 233-6327, Fax: (317) 233-6572.

If you fax this letter, please also mail the original.

Rather than providing an IGT, OMPP is reviewing the possibility of allowing the state share match to be certified by the county treasurer, county auditor or hospital administrator via an affidavit, similar to the affidavit described in the section on the Certification of County Payments Eligible for Federal Financial Participation.

## **Certification of County Payments Eligible for Federal Financial Participation**

For Community Mental Health Centers (CMHCs) only, in order to be eligible to receive an Enhanced DSH payment, the county treasurer or auditor from the county in which the CMHC is located must first certify that a payment that a county makes under *I.C. 12-29-1-7(b)* or from other county sources to the CMHC “represents expenditures that are eligible for federal financial participation under *42 U.S.C. Section 1396(w)(6)(A)* and *42 CFR 433.51*.”

OMPP believes an affidavit will provide the necessary format to certify that the payment made by a county represents expenditures that are eligible for federal financial participation. A copy of an affidavit may be obtained by contacting Jared Duzan or Kay Spear at Myers and Stauffer, or Bill Washienko at the OMPP. The addresses of each may be found on page 23 of this bulletin.

The CMHC may include the payments from counties within the catchment area. The payments that represent expenditures that are eligible for federal financial participation must be derived from county property tax levy amounts. The necessary signatures and information from each county treasurer or auditor must be provided before a DSH payment will be made.

After obtaining the necessary signatures and information that the affidavit requests, please either forward the affidavit by certified mail to Myers and Stauffer or the OMPP or, have the county treasurer or auditor send the affidavit by certified mail directly to Myers and

Stauffer, or the OMPP. Please accompany the affidavit with a cover letter indicating to what CMHC this affidavit applies.

If federal financial participation is later disallowed for the funds certified under this section upon which the CMHC Enhanced DSH payment was based, then the CMHC Enhanced DSH payment may be recovered by the Indiana Medicaid Program.

## **DSH Survey Document Section II and Certified Audited Opinion**

Federal law requires that each provider cannot receive a DSH payment that exceeds its hospital specific limit (HSL) and that in the aggregate, all DSH payments that the State of Indiana pays to providers cannot exceed the Indiana state-wide DSH cap. Therefore, data must be provided to OMPP by each provider to determine each provider's hospital specific limit (HSL) in order to comport with the cap provisions under *42 U.S.C. Section 1396r-4(f)(2)* and *Section 1396r-4(g)(1)(A)*.

Furthermore, since the new measurement to calculate payments for the three separate Enhanced DSH pools is the sum of the hospital specific limits of all of the Enhanced providers in their respective pool, the submission of either the DSH survey document section II or the certified audited opinion is necessary.

Therefore, the DSH survey document section II or the certified audited opinion must be provided before any provider can receive a DSH payment. In a letter dated, February 17, 1999, from OMPP's hospital payment rate-setting contractor, Myers and Stauffer, each provider was notified of a threshold amount that can be used by the provider to determine whether either the DSH survey document section II or the certified audited opinion needs to be filed.

A municipal county hospital or CMHC will need to submit a certified audited opinion from an independent certified public accounting firm, if the provider exceeds the following threshold amounts for the provider's fiscal period within the SFY:

- Medicaid shortfall (net of SFY Medicaid HCI payment) is greater than \$100,000; or,
- Charity/uninsured care is greater than \$200,000.

If the municipal county hospital or CMHC meets neither one of these thresholds, then the municipal county hospital or CMHC will only need to submit the DSH survey document section II, before receiving a Basic and/or Enhanced DSH payment. However, the provider may

still choose to submit a certified audited opinion rather than the DSH survey document section II.

If a provider is eligible to receive a regular Enhanced DSH payment, then the provider must submit a certified audited opinion before receiving a regular Enhanced DSH payment.

Private psychiatric hospitals need only to submit DSH survey document section II.

Federal law limits the amount of DSH payments the Indiana Medicaid program can reimburse a specific provider and all providers in the aggregate. The limit on the amount of a DSH payment to a specific provider is contained in *42 U.S.C. Section 1396r-4(g)(1)(A)*, which states the following:

“A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) of this section with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.”

As a guide to providers as to what costs can be included within the provider’s hospital specific limit and ultimately, DSH survey document section II or certified audited opinion, the above-definition can be simplified using the following formula:

$$\text{DSH Limit} = M + U$$

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

U = Cost of service to uninsured patients, less any payments made by the uninsured patient.

Using the formula as a guide to calculate a provider’s hospital specific limit, the first component is commonly known as Medicaid shortfall. The Indiana Medicaid program shortfall should be net of the Indiana Medicaid HCI payment. For those providers whose fiscal year ends during the mid-point of a SFY, the provider can proportion the SFY

Indiana Medicaid HCI payment in accordance with the provider's fiscal year end.

Also, all providers may include out-of-state and Risk-Based Managed Care (RBMC) Medicaid shortfalls in the Medicaid shortfall component. Municipal county hospitals should separate out their Indiana Medicaid shortfall and their out-of-state Medicaid shortfall in their Medicaid shortfall component. Gross (state and federal share) MRO payments should be included within this component, too.

The Indiana Medicaid program interprets the second component of the formula to mean inpatient and outpatient costs of performing services on hospital uninsured patients, less any payments made by the uninsured patients. If a hospital incurs costs to pay physicians to care for its uninsured patients, then those costs may be included in the provider's hospital specific limit. Uninsured patients is defined as care provided to patients who have no health insurance or other source of third party coverage to pay for services provided during the cost reporting period. Patients who have no health insurance are defined as patients who have:

- No health insurance coverage for any health care service.
- Health insurance that does not cover a particular service rendered.
- Health insurance that does not cover the particular procedure for which the individual sought treatment.

Bad debt related to self-pay can be included within the second component of the formula so long as the cost of providing the service was associated with uninsured patients, less any payments made by the uninsured patient in the cost reporting period. Contractual allowances and discounts (other than for uninsured patients) should not be included.

According to the last sentence contained in *42 U.S.C. Section 1396r-(g)(1)(A)*, "payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment." Therefore, for CMHC's only, HAP as well as other state or county payments and the costs of servicing patients receiving these payments should be considered in the following manner:

1. HAP, as well as other state or county payments, do not need to be netted when calculating the provider's hospital specific limit.
2. The costs of servicing patients receiving these payments should be included within the calculation for the provider's hospital specific limit.

Please send the DSH survey document section II or the certified audited opinion by certified mail to Myers and Stauffer, Attention Kay Spear, or to the OMPP, Attention Bill Washienko. The addresses of each may be found on page 23 of this bulletin.

## **Indiana State-Wide DSH Cap and Institutions for Mental Diseases (IMD) DSH Cap**

Payments under the Indiana Medicaid DSH program are made in the following order

1. Basic DSH payments
2. Regular Enhanced DSH payments
3. Municipal County Hospital Enhanced DSH payments
4. CMHC Enhanced DSH payments

If after making payments under a DSH pool, the Indiana Medicaid program does not exceed either the Indiana state-wide cap under *42 U.S.C. Section 1396r-(f)(2)* or the IMD state-wide cap under *42 U.S.C. Section 1396r-4(h)*, then the Indiana Medicaid program makes payment to the next DSH pool in sequential order.

If, however, the Indiana Medicaid program will exceed either the Indiana state-wide cap under *42 U.S.C. Section 1396r-(f)(2)* or the IMD state-wide cap under *42 U.S.C. Section 1396r-4(h)*, then the Indiana Medicaid program may pro-rate the payments to the DSH pool that is next in the sequence to avoid exceeding the Indiana state-wide cap and/or the IMD state-wide cap. If the Indiana Medicaid program will exceed the Indiana state-wide cap and/or the IMD state-wide cap after the pro-ration of payments, then the Indiana Medicaid program will not make payment to the DSH pool next in the sequence.

## **Disallowance of Federal Financial Participation**

- A payment made under any of these programs may be recovered by the OMPP, or
- The OMPP may determine to discontinue any or all portions of these programs if federal financial participation is not available

## Deadline Dates for Submission of Documentation to Receive SFY 1998 and SFY 1999 DSH Payments

### SFY 1998 DSH Payments

November 15, 1999	For all providers, either the DSH survey document section II or the certified audited opinion must be submitted by this date to receive a SFY 1998 DSH payment.
November 15, 1999	For CMHC's only, signed affidavits from all county treasurers must be submitted by this date to receive a SFY 1998 DSH payment.
December 17, 1999	Municipal County Hospitals participating in the Municipal County Hospital Indiana Medicaid Shortfall Payment program only, must submit an intergovernmental transfer by this date to receive a SFY 1998 Indiana Medicaid Shortfall payment.
December 17, 1999	Municipal County Hospitals participating in the Indiana Medicaid Municipal County Hospital Enhanced DSH Payment program must submit an intergovernmental transfer by this date to receive a SFY 1999 Indiana Medicaid Enhanced DSH payment.
December 17, 1999	For Regular Enhanced DSH providers only, this is a proposed date for submitting an intergovernmental transfer and for receiving a regular Enhanced DSH payment.

### SFY 1999 DSH Payments

November 15, 1999	DSH survey document sections I for SFY 1999 and 2000 DSH eligibility determination purposes.
February 11, 2000	DSH survey document section II or certified audited opinion.
February 11, 2000	For CMHC's only, signed affidavits from all county treasurers must be submitted by this date to receive a SFY 1999 DSH payment.

## Questions

For questions regarding the payment of intergovernmental transfers, please contact:

Tilena Henry  
Family and Social Services Administration  
Office of Financial Management, E-442  
MS34, P.O. Box 7128  
Indianapolis, IN 46207-7128  
Telephone number: (317) 233-6327  
Fax number: (317) 233-6572

For all other questions regarding these payment programs, please contact either:

Jared Duzan, Manager, or Sandra K. Spear, Senior Accountant  
Myers and Stauffer, LC  
Certified Public Accountants  
8555 North River Road, Suite 360  
Indianapolis, IN 46240-4305  
Telephone number: (317) 846-9521, (800) 877-6927  
Fax number: (317) 571-8481

Bill Washienko  
Office of Medicaid Policy and Planning  
402 West Washington Street, W-382  
MS07  
Indianapolis, IN 46204  
Telephone number: (317) 233-1553  
Fax number: (317) 232-7382