Document: Proposed Rule
Source: February 1, 2001, Indiana Register, Volume 24, Number 5
Disclaimer: These documents were created from the files used to produce the official (printed) Indiana Register, however, these documents are unofficial.

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #00-249

DIGEST

Amends 405 IAC 1-8-3 to add a definition for essential hospital services and revise the reimbursement methodology for essential hospital services. Amends 405 IAC 1-10.5-1, 405 IAC 1-10.5-2, 405 IAC 1-10.5-3, and 405 IAC 1-10.5-4 to add level-of-care reimbursement for long term care hospitals; adds an annual adjustment to DRG relative weights; removes date requirement for adjusting the number of residents in computing facility-specific medical education rates; and provides requirements for out-of-state hospitals requesting a medical education rate, and, for out-of-state children's hospitals, a separate base amount. Repeals 405 IAC 1-9, 405 IAC 1-10, and 405 IAC 1-11. Effective 30 days after filing with the secretary of state.

405 IAC 1-8-3 | **405 IAC 1-10.5-2**
405 IAC 1-9 | **405 IAC 1-10.5-3**
405 IAC 1-10 | **405 IAC 1-10.5-4**
405 IAC 1-10.5-1 | **405 IAC 1-11**

SECTION 1. 405 IAC 1-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-3 Reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The reimbursement methodology for all covered outpatient services shall be ~~subject to the lower of the submitted charges for the procedure or the~~ **a prospective system wherein payment is based upon an** established fee schedule allowance for the procedure as provided in this section. All services will be billed on the uniform billing form, using ~~both~~ **a** revenue ~~codes, and~~ **code,** HCPCS ~~codes,~~ **code, and a diagnosis code.** The appropriate HCPCS code, if one exists for the billed procedure, will be required in addition to the revenue code **and diagnosis code**.

(b) For purposes of this reimbursement methodology, essential hospital services are defined as those services that cannot be routinely or safely be performed in a nonhospital delivery setting, such as a physician's office. These services typically require the more sophisticated environment found exclusively in an acute care facility.

~~(b)~~ **(c)** Surgical procedures shall be classified into a group corresponding to the Medicare Ambulatory Surgical Center (ASC) methodology and shall be paid a rate established for each ASC payment group. Outpatient surgeries ~~which~~ **that** are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups, or additional payment groups. Reimbursement ~~will be~~ **is** based on ~~a blended rate equal to fifty percent (50%) of the Medicare ASC rate and fifty percent (50%) of the fiscal year 1992 Indiana Medicaid statewide median allowed amount for that service.~~ **one hundred percent (100%) of the aggregate cost coverage for essential hospital surgical procedures.** Hospitals will bill for surgeries using a HCPCS code.

~~(c)~~ **(d)** Emergency care (as identified by the outpatient hospital department **and determined by the office based upon emergency diagnosis codes)** payment will be based on a statewide fee schedule ~~per HCPCS code. The fee schedule amount will be equal to the Indiana Medicaid statewide median amount paid per service during fiscal year 1992.~~ **as established by the office. Reimbursement is based on one hundred percent (100%) of the aggregate cost coverage for essential hospital emergency services.** Claims for services designated as emergency by a hospital will be subject to audit on a postpayment basis to validate that a bona fide emergency existed.

~~(d)~~ **(e)** Nonemergency care, determined by the office and as identified by nonemergency diagnosis codes, that is provided in an emergency room, shall be paid based upon a nonemergency setting (for example, a clinic) fee schedule established by the office. This fee schedule amount ~~will be equal to~~ **is based on** the Indiana Medicaid statewide median amount paid per service during fiscal year 1992. ~~Hospitals will bill using HCPCS codes.~~

~~(e)~~ **(f)** Reimbursement for laboratory procedures ~~and the technical component of radiology procedures~~ shall be based on ~~ninety-five percent (95%) of~~ the Medicare allowance ~~that was in effect prior to federal adoption of the Resource Based Relative Value Scale (RBRVS) for Medicare~~ **for laboratory** services. These services will be billed by HCPCS.

(g) Reimbursement for technical component radiology procedures is based on one hundred percent (100%) of the aggregate cost coverage for essential hospital radiology procedures. These services will be billed by HCPCS code.

~~(f)~~ **(h)** Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section (for example, therapies **and** testing) ~~etc.)~~ shall be ~~equal to~~ **based on** the Indiana Medicaid statewide median amount paid per service during fiscal year 1992, **or one hundred percent (100%) of the aggregate cost coverage for essential hospital services.** All other services will be billed using a combination of HCPCS and revenue codes.

~~(g) The established~~ **(i)** Rates for **essential** hospital outpatient ~~reimbursement shall~~ **services will** be reviewed annually by the office and adjusted ~~as necessary, in accordance with this section~~ **no more often than every second year by using the most reliable claims data and audited cost report data on file with the office of its contractor. In the absence of rebasing, rates for essential and nonessential hospital services will be inflated annually using the Medicare Prospective Payment System Market Basket Index for Hospitals published in the second quarter of the current year.** *(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736)*

SECTION 2. 405 IAC 1-10.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-1 Policy; scope
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 1. ~~(a)~~ Reimbursement for inpatient hospital services, as defined by 42 CFR 440.10, is available to providers enrolled by the office of Medicaid policy and planning (office) as Medicaid providers and who are in good standing. Continued participation in the Medicaid program and payment of inpatient hospital services are contingent upon maintenance of state licensure and conformance with the office's provider agreement. ~~405 IAC 1-6-9 and 405 IAC 1-7-15~~ **405 IAC 5-17 and 405 IAC 5-28** establish criteria for providing inpatient hospital services to Medicaid recipients and set forth the types of services for which Medicaid reimbursement may be available.

~~(b) In accordance with federal law, reimbursement for inpatient hospital services provided to eligible recipients will be made through the use of rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.~~

~~(c) For general acute and rehabilitation inpatient hospital claims with dates of service prior to November 4, 1994, the interim reimbursement policy established by 405 IAC 1-10 applies. For state mental health institutions covered by this rule, reimbursement for claims with dates of service prior to implementation of this rule shall be made under 405 IAC 1-9. For non-state mental health facilities covered by this rule, reimbursement for claims with dates of service prior to June 2, 1995, shall be made under 405 IAC 1-9.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-1; filed Oct 5, 1994, 11:10 a.m.: 18 IR 243; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082)*

SECTION 3. 405 IAC 1-10.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-2 Definitions
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1; IC 12-24-1-3; IC 12-25; IC 16-21

Sec. 2. (a) The definitions in this section apply throughout this rule.

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

~~(b)~~ **(c)** "Allowable costs" means Medicare allowable costs as defined by 42 U.S.C. 1395(f).

~~(c) "All patient DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.~~

(d) "Base amount" means the rate per Medicaid stay which is multiplied by the relative weight to determine the DRG rate.

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

(f) "Capital costs" are costs associated with the capital costs of the facility. Capital costs include, but are not limited to, the following:
(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

(g) "Children's hospital" means ~~an inpatient~~ **a free-standing general acute care** hospital ~~facility, as defined in subsection (p)(1) whose primary specialty is providing short term acute care medical services for children and newborns.~~ **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 predominantly 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 the age of eighteen (18) years of age.

(h) "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. The initial fixed dollar amount for the threshold is twenty-five thousand dollars ($25,000). This amount may be changed at the time the relative weights are adjusted.

(i) "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 utilizing similar hospital resources. Classification is made through the use of the all patient (AP) DRG grouper.

~~(j) "Direct medical education costs" means the costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.~~

~~(k)~~ **(j)** "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.

~~(l)~~ **(k)** "DRG daily rate" means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the average length of stay for all stays classified into the DRG.

~~(m)~~ **(l)** "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.

~~(n)~~ **(m)** "Hospital Market Basket Index" means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw-Hill in "Health Care Costs".

~~(o)~~ **(n)** "Inpatient" means a 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.

~~(p)~~ **(o)** "Inpatient hospital facility" means:
(1) a general acute hospital licensed under IC 16-21;
(2) a mental health institution licensed under IC 12-25;
(3) a state mental health institution under IC 12-24-1-3; or
(4) a rehabilitation inpatient facility.

~~(q)~~ **(p)** "Less than one-day stay" means a medical stay of less than twenty-four (24) hours that is paid according to a DRG rate.

~~(r)~~ **(q)** "Level-of-care case" means a medical stay, as defined by the office, that is not part of the DRG reimbursement system. Level-of-care cases include psychiatric cases, rehabilitation cases, and certain burn cases.

~~(s)~~ **(r)** "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure that is not paid through the DRG payment system.

(s) "Long term care hospital" means a freestanding 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.

(t) "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.

(u) "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.

(v) "Medical education costs" means the direct costs associated with the salaries and benefits of medical interns and residents and paramedical education programs.

~~(v)~~ **(w)** "Office" means the office of Medicaid policy and planning of the family and social services administration.

~~(w)~~ **(x)** "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.

~~(x)~~ **(y)** "Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

~~(y)~~ **(z)** "Principal diagnosis" means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

~~(z)~~ **(aa)** "Readmission" means that a patient is admitted into the hospital within fifteen (15) days following a previous hospital admission and discharge for a related condition as defined by the office.

~~(aa)~~ **(bb)** "Rebasing" means the process of adjusting the base amount ~~based upon~~ **using** more recent claims data, cost report data, and other information relevant to hospital reimbursement.

~~(bb)~~ **(cc)** "Relative weight" means a numeric value which 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.

~~(cc)~~ **(dd)** "Routine and ancillary costs" means costs that are incurred in providing services exclusive of medical education and capital costs.

~~(dd)~~ **(ee)** "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 from one (1) unit to another 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.

~~(ee)~~ **(ff)** "Transferee hospital" means that hospital that accepts a transfer from another hospital.

~~(ff)~~ **(gg)** "Transferring hospital" means the hospital that initially admits and then discharges the patient to another hospital. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-2; filed Oct 5, 1994, 11:10 a.m.: 18 IR 244; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1082; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1514)*

SECTION 4. 405 IAC 1-10.5-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-3 Prospective reimbursement methodology
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 3. (a) The purpose of this section is to establish a prospective, cost-based 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. There shall be no year-end cost settlement payments.

(b) Rebasing of the DRG and level-of-care methodologies will apply information from the most recent available cost report that has been filed and audited by the office or its contractor.

~~(b)~~ **(c)** Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate, the medical education rate, and, if applicable, the outlier payment amount.

~~(c)~~ **(d)** Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate, ~~and~~ the medical education rate, **and, if applicable, the outlier payment amount (burn cases only).**

~~(d)~~ **(e)** Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient DRG grouper.

~~(e)~~ **(f)** The DRG rate is equal to the product of the relative weight and the base amount.

~~(f)~~ **(g)** Initial relative weights were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports. Relative weights will be reviewed ~~annually~~ by the office and adjusted no more often than ~~every second year~~ **annually** 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 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 whether an adjustment to the relative weights will be made.** DRG average length of stay values and outlier thresholds will be revised when relative weights are adjusted.

~~(g)~~ **(h)** Initial base amounts were calculated using cost report data from facilities' fiscal year 1990 as-settled cost reports. Cost report data were inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index available at the end of the 1993 calendar year. Base amounts will be reviewed annually 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. In the absence of rebasing, base amounts will be inflated annually according to the Hospital Market Basket Index published in the second quarter of the current year.

(i) The office may establish **a** separate base ~~amounts~~ **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 adjusted cost per discharge greater than one (1) 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 twenty percent (120%) of the statewide base amount for DRG services.**

~~(h)~~ **(j)** Initial level-of-care payment rates were calculated using Indiana Medicaid claims data for inpatient stays with dates of admission within state fiscal years 1990, 1991, and 1992 and cost report data from facilities' fiscal year 1990 cost reports. Cost report data was inflated to the midpoint of the state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index. Level-of-

care rates will be reviewed annually 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. In the absence of rebasing, level-of-care rates will be inflated annually according to the Hospital Market Basket Index published in the second quarter of the current year. The office ~~may establish~~ **shall not set** separate level-of-care rates for ~~children's hospitals to the extent necessary to reflect significant differences in cost.~~ **different categories of facilities, except as specifically noted in this section.**

(k) Level-of-care cases are categorized as DRG numbers 424 through 428, 429 (excluding diagnosis code 317.XX – 319.XX), 430 through 432, 456 through 459, 462, and 472, as defined and grouped using the all patient DRG grouper, version 14.1. These DRG numbers represent burn, psychiatric, and rehabilitative care.

(l) 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 be certified by the Indiana state department of health as a specialized burn facility.

(m) 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 (1) 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.

(n) 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 long term hospital set forth in this rule to be eligible for the separate level-of-care rate.

~~(i)~~ **(o)** Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. The initial flat, statewide per diem capital rate was calculated using cost report data from facilities' fiscal year 1990 cost reports, inflated to the midpoint of state fiscal year 1995 using the DRI/McGraw-Hill Hospital Market Basket Index and adjusted to reflect a minimum occupancy level for non-nursery beds of eighty percent (80%). Capital per diem rates will be reviewed annually 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. In the ~~absent~~ **absence** of rebasing, the per diem capital rate will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

~~(j)~~ **(p)** The capital payment amount for Medicaid stays reimbursed under the DRG methodology shall be equal to the product of the per diem capital rate and the average length of stay for all cases within the particular DRG. Medicaid stays reimbursed under the level-of-care methodology will be paid 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 rule.**

~~(k)~~ **(q)** Medical education rates shall be prospective, hospital-specific per diem amounts. The medical education payment amount for stays reimbursed under the DRG methodology shall be equal to the product of the medical education per diem rate and the average length of stay for the DRG. Payment amounts for medical education for stays reimbursed under the level-of-care methodology shall be equal to the medical education per diem rate for each covered day of care.

~~(l)~~ **(r)** Facility-specific, per diem medical education rates shall be based on costs per resident per day multiplied by the number of residents reported by the facility. Initial costs per resident per day were determined according to each facility's fiscal year 1990 cost report. In subsequent years, but no more often than every second year, the office will use the most recent cost report data to determine a cost per resident per day that more accurately reflects the cost of efficiently providing hospital services. The number of residents will be determined according to the most recent available cost report **that has been** filed ~~on or before April 1 of the current fiscal year.~~ **and audited by the office or its contractor.** In the absence of rebasing, the medical education per diem will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

~~(m)~~ **(s)** Medical education payments will only be available to hospitals that continue to operate medical education programs. Hospitals ~~that discontinue medical education programs~~ must ~~promptly~~ notify the office **within thirty (30) days following discontinuance of their medical education program.**

~~(n)~~ **(t)** For hospitals with new medical education programs, the medical education per diem will be effective no earlier than two (2) months 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 and cost report data.

~~(o)~~ **(u)** Cost outlier cases are determined according to a threshold established by the office. For purposes of establishing outlier payment amounts, prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio by submitted and approved charges. Outlier payment amounts shall be equal to a percentage of the difference between the prospective cost per stay and the outlier threshold amount. **Cost outlier payments are not available for cases reimbursed using the level-of-care methodology, except for burn cases that exceed the established threshold.**

~~(p)~~ **(v)** Readmissions will be treated as separate stays for payment purposes, but will be subject to medical review. If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment.

~~(q)~~ **(w)** Special payment policies shall apply to transfer cases. The transferee, or receiving, hospital is paid according to the DRG methodology or level-of-care methodology. The transferring hospital is 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. Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate.

~~(r)~~ **(x)** Special payment policies shall apply to less than one-day stays that are paid according to a DRG rate. For less than one-day stays, hospitals will be paid a DRG daily rate, the capital per diem rate for one (1) day of stay, and the medical education per diem rate for one (1) day of stay, if applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-3; filed Oct 5, 1994, 11:10 a.m.: 18 IR 245; filed Nov 16, 1995, 3:00 p.m.: 19 IR 664; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1083; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1515; errata filed Mar 21, 1997, 9:45 a.m.: 20 IR 2116)*

SECTION 5. 405 IAC 1-10.5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-4 Reimbursement for new providers and out-of-state providers
Authority: IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-15-1

Sec. 4. (a) The purpose of this section is to establish payment rates for inpatient hospital facilities that commenced participation in the state Medicaid program after fiscal year 1990 and for out-of-state hospital providers participating in the Indiana Medicaid program.

(b) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate calculated using the statewide median capital rate, the medical education rate, and, if applicable, the outlier payment calculated using the statewide median cost-to-charge ratio.

(c) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate calculated using the statewide median capital rate, and the medical education rate.

(d) Outlier payments for inpatient stays reimbursed under subsection (b) shall be determined according to the methodology described in section ~~3(o)~~ **3** of this rule; however, for purposes of estimating costs, the statewide cost-to-charge ratio shall be used.

(e) 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) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement.

(f) 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) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount. *(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-4; filed Oct 5, 1994, 11:10 a.m.: 18 IR 246; filed Dec 19,*

1995, 3:00 p.m.: 19 IR 1084; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1517)

SECTION 6. THE FOLLOWING ARE REPEALED: 405 IAC 1-9; 405 IAC 1-10; 405 IAC 1-11.

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on February 23, 2001 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room 2, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to hospital outpatient and inpatient Medicaid reimbursement rules.

In accordance with the public notice requirements of 447.205 of Title 42, Code of Federal Regulations, and Section 1902(a)(13)(A) of the Social Security Act, the Indiana Family and Social Services Administration publishes this notice of proposed amendments to the Medicaid reimbursement methodology for inpatient and outpatient hospital services.

The proposed amendments will revise 405 IAC 1-8 and 405 IAC 10.5 by defining outpatient "essential hospital services" and revising the reimbursement methodology for long term care acute hospitals. Reimbursement for long term care acute hospitals would move from the DRG methodology to a level-of-care per diem. In addition, the amendments include: (1) a change from biennial adjustments to the DRG relative weight to annual adjustments; (2) the removal of date requirements for adjusting the number of residents for medical education rates; and (3) requirements for out-of-state hospitals that request medical education rates or separate base rate amounts for children's facilities.

The changes are not expected to result in a fiscal impact and only the revisions to the inpatient hospital reimbursement methodology for long term care hospitals will result in the establishment of new rates. Aggregate Medicaid payments under the proposed amendments will be similar to payments under the current methods of reimbursement. The OMPP anticipates an improvement in cash flow to long term acute care hospitals under the level-of-care payment system as residents will not need to be discharged before Medicaid payments are made.

Written comments concerning these proposed amendments should be directed to: Jared B. Duzan, Myers and Stauffer LC, 8555 North River Road, Suite 360, Indianapolis, Indiana 46240. Correspondence should be identified in the following manner: COMMENTS RE: AMENDMENTS TO INPATIENT AND OUTPATIENT REIMBURSEMENT RULES.

Copies are available on the Internet at www.mslcindy.com/hospitals/. Long term acute care hospital per diem rates will be available for public inspection and comment when completed, in accordance with the public notice requirements of 447.205 of Title 42, Code of Federal Regulation and Section 1902(a)(13)(A) of the Social Security Act. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Katherine Humphreys
Secretary
Office of the Secretary of Family and Social Services