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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #03-18(F)

DIGEST

Amends 405 IAC 1-10.5-3 to remove annual inflationary adjustment to inpatient rates and adds requirements to the medical education rate calculation. Effective 30 days after filing with the secretary of state.

405 IAC 1-10.5-3

SECTION 1. 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.

(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.

(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, the medical education rate, and, if applicable, the outlier payment amount (burn cases only).

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

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

(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 by the office and adjusted no more often than 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.

(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 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 and twenty percent (120%) of the statewide base amount for DRG services.

(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 shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

(k) Level-of-care cases are categorized as DRG numbers 424–428, 429 (excluding diagnosis code 317.XX–319.XX), 430–432, 456–459, 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 designated as offering~~ **offer** a burn intensive care unit.

(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.

(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 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.~~

(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.

(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.

(r) Facility-specific, per diem medical education rates shall be based on **medical education** 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 **that has been filed and audited by the office or its contractor** to determine a **medical education** cost ~~per resident~~ per day that more accurately reflects the cost of efficiently providing hospital services. **For hospitals with approved graduate medical education programs,** 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. ~~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.~~ **Indirect medical education costs shall not be reimbursed.**

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

(t) For hospitals with new medical education programs, the **corresponding** medical education per diem will **not** 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.

(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.

(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.

(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.

(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; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 57; errata filed Jan 25, 2002, 2:27 p.m.: 25 IR 1906; filed Oct 20, 2003, 10:00 a.m.: 27 IR 863)*

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