Document: Proposed Rule, **Register Page Number:** 27 IR 914
Source: December 1, 2003, Indiana Register, Volume 27, Number 3
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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #03-236

DIGEST

Amends 405 IAC 1-8-2 to define intestinal and multivisceral transplants and to allow intestinal and multivisceral transplant procedures to be reimbursed on a percentage of reasonable cost until such time an appropriate diagnosis-related group (DRG) as determined by the office can be assigned. Effective 30 days after filing with the secretary of state.

405 IAC 1-10.5-2
405 IAC 1-10.5-3

SECTION 1. 405 IAC 1-10.5-2, PROPOSED TO BE AMENDED AT 26 IR 3930, SECTION 3, 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) "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~~ **that** 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. The term includes, but is not limited to, the following:
(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

(g) "Children's hospital" means a freestanding general acute care hospital licensed under IC 16-21 that:
(1) is designated by the Medicare program as a children's hospital; or
(2) furnishes services to inpatients who are 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 eighteen (18) years of age.
"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

(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. 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) "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.

(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.

(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.

(m) "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.

(n) "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.

(o) "Intestinal transplant" means the grafting of either the small or large intestines from a donor into a recipient.

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

~~(p)~~ **(q)** "Level-of-care case" means a medical stay, as defined by the office, that includes psychiatric cases, rehabilitation cases, long term care hospital admissions, and certain burn cases.

~~(q)~~ **(r)** "Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure subject to subsection ~~(p).~~ **(q).**

~~(r)~~ **(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.
"Freestanding" does not mean a wing or specialized unit within a general acute care hospital.

~~(s)~~ **(t)** "Marginal cost factor" means a percentage applied to the difference between the cost per stay and the outlier threshold for purposes of the cost outlier computation.

~~(t)~~ **(u)** "Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day. The term does not include any portion of an outpatient service under 405 IAC 1-8-3 that precedes an admission as an inpatient subject to subsection (m).

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

(x) "Multivisceral transplant" means the grafting of either the small or large intestines and one (1) or more of the following organs from a donor into a recipient:

(1) Liver.
(2) Stomach.
(3) Pancreas.

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

~~(x)~~ **(z)** "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.

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

~~(z)~~ **(bb)** "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.

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

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

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

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

~~(ee)~~ **(gg)** "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.

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

~~(gg)~~ **(ii)** "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; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 55)*

SECTION 2. 405 IAC 1-10.5-3, PROPOSED TO BE AMENDED AT 26 IR 3932, SECTION 4, 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 **or, in the case of intestinal or multivisceral transplants, as described under subsection (j).** Prospective payment shall constitute full reimbursement unless otherwise indicated herein or as indicated in provider manuals and update bulletins. There shall be no year-end cost settlement payments.

(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 lower of billed charges or 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 lower of billed charges or 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) 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. The office shall include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission will not be eligible for outpatient reimbursement under 405 IAC 1-8-3. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

(h) 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.

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

(j) The reimbursement methodology for all covered intestinal and multivisceral transplants shall be equal to ninety percent (90%) of reasonable cost, until such time an appropriate DRG as determined by the office can be assigned. The office will use the most recent cost report data that has been filed and audited by the office or its contractor to determine reasonable costs.

~~(j)~~ **(k)** 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. The office shall not set separate level-of-care rates for different categories of facilities except as specifically noted in this section.

~~(k)~~ **(l)** 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)~~ **(m)** 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 offer a burn intensive care unit.

~~(m)~~ **(n)** 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)~~ **(o)** 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)~~ **(p)** Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. 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. Capital payment rates shall be adjusted to reflect a minimum occupancy level for nonnursery beds of eighty percent (80%).

~~(p)~~ **(q)** 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)~~ **(r)** 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)~~ **(s)** Facility-specific, per diem medical education rates shall be based on medical education costs per day multiplied by the number of residents reported by the facility. 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 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. Indirect medical education costs shall not be reimbursed.

~~(s)~~ **(t)** 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)~~ **(u)** For hospitals with new medical education programs, the corresponding medical education per diem will not be effective prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data and cost report data.

~~(u)~~ **(v)** 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 the marginal cost factor multiplied by 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)~~ **(w)** Readmissions for the same or related diagnoses within three (3) calendar days after discharge will be treated as the same admission for payment purposes. Readmissions that occur after three (3) calendar days will be treated as separate stays for payment purposes but will be subject to medical review.

~~(w)~~ **(x)** Special payment policies shall apply to certain 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)~~ **(y)** Hospitals will not receive separate DRG payments for Medicaid patients subsequent to their return from a transferee hospital. Additional costs incurred as a result of a patient's return from a transferee hospital are eligible for cost outlier

reimbursement subject to subsection ~~(u).~~ **(v).** The office may establish a separate outlier threshold or marginal cost factor for such cases.

~~(y)~~ **(z)** Special payment policies shall apply to less than twenty-four (24) hour stays. For less than twenty-four (24) hours stays, hospitals will be paid under the outpatient reimbursement methodology as described in 405 IAC 1-8-3. *(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)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on December 30, 2003 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 define and reimburse intestinal and multivisceral transplant procedures. Copies of proposed amendments to this rule are now available (along with copies of the public notice) and may be inspected by contacting the Director of the local County Division of Family and Children office, except in Marion County, where public inspection may be made at 402 West Washington Street, Room W382, Indianapolis, Indiana. Written comments may be directed to IFSSA, Attention: Zachary Jackson, 402 West Washington Street, Room W382, P.O. Box 7083, Indianapolis, Indiana 46207-7083. Correspondence should be identified in the following manner: "COMMENTS RE: LSA DOCUMENT #03-236 PROPOSED CHANGE TO INPATIENT HOSPITAL REIMBURSEMENT SYSTEM". Written comments received will be made available for public display at the address herein of the Office of Medicaid Policy and Planning. 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.

Cheryl Sullivan
Secretary
Office of the Secretary of Family and Social Services