

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule LSA Document #11-91

DIGEST

Adds 405 IAC 1-4.2-6 to extend the expiration date to June 30, 2013, and to codify the non-code provision found at LSA Document #10-166 (F), posted at 20100915-IR-405100166FRA, to continue the rate reductions that modify the Medicaid reimbursement formulas by five percent for providers of home health services. Amends 405 IAC 1-8-3, 405 IAC 1-10.5-3, and 405 IAC 1-10.5-4 to extend the expiration date to June 30, 2013, and to codify the non-code provision found at LSA Document #09-910(F) posted at 20100526-IR-405090910FRA, to continue the rate reductions that modify the Medicaid reimbursement formulas by five percent to hospitals for outpatient and inpatient services. Adds 405 IAC 12-1-27 to extend the expiration date to June 30, 2013, and to codify the non-code provision found at LSA Document #10-169(F), posted at 20100915-IR-405100169FRA, to continue the rate reductions that modify the Medicaid reimbursement formulas by three percent paid to enrolled privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD). Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

405 IAC 1-4.2-6; 405 IAC 1-8-3; 405 IAC 1-10.5-3; 405 IAC 1-10.5-4; 405 IAC 1-12-27;

SECTION 1. 405 IAC 1-4.2-6 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-4.2-6 Rate Reduction

Authority: IC 12-15-21-1; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 6. Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of this rule or July 1, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for services provided under this rule.

SECTION 2. 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 hospital and ambulatory surgical center services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(b) Surgical procedures shall be:

(1) classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology; and

(2) paid a rate established for each ASC payment group.

Outpatient surgeries 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 based on the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003.

(c) Payments for emergent care that:

(1) do not include surgery; and

(2) are provided in an emergency department, treatment room, observation room, or clinic; will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(d) Payments for nonemergent care that:

(1) do not include surgery; and

(2) are provided in an emergency department, treatment room, observation room, or clinic; will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(e) Reimbursement for laboratory procedures is based on the Medicare fee schedule amounts. Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule rates for the radiology services technical component.

(f) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., shall be equal to the Indiana Medicaid statewide fee schedule amounts in effect during state fiscal year 2003.

(g) Payments will not be made for outpatient hospital and ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

(h) The established rates for hospital outpatient and ambulatory surgical center reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section.

(i). Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of this rule or July 1, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for outpatient hospital services (excluding ambulatory surgical centers) provided under this rule. (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; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 16, 2010, 3:35 p.m.: 20100915-IR-405100167FRA)

SECTION 3. 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 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) Rebasement 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.

(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.

(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.

(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.

(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.

(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.

(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%).

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(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.

(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 (v). The office may establish a separate outlier threshold or marginal cost factor for such cases.

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

(aa). Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of this rule or July 1, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for services provided under this rule. (*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; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2249; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2484; errata filed Jun 16, 2004, 9:35 a.m.: 27 IR 3580; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA*)

SECTION 4. 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 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.

(g) Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of this rule or July 1, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for services provided under this rule. (*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; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 5. 405 IAC 1-12-27 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-12-27 Rate Reduction

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 27. Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of this rule or July 1, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by three percent (3%) for services provided under this rule.