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State/Territory Name: IN

State Plan Amendment (SPA) #: 15-018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JAN 19 2016

Mr. Joseph Moser, Director of Medicaid
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 West Washington Street, Room W461
Indianapolis, IN 46204-2739

ATTN: Amber Swartzell, State Plan Coordinator

Dear Mr. Moser:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-018. Effective October 1, 2015, This SPA makes change to the State Plan to modify the reimbursement methodology for inpatient hospital services by adopting the All Patient Refined (APR) Diagnosis Related Group (DRG) grouper, version 30, & implementing updated inpatient hospital DRG relative weights & payments rates. OMPP is making these changes in accordance with the CMS requirements that all HIPAA covered entities transition to the ICD-10 diagnosis & procedures codes on 10/1/15. In order to comply with the requirements it is necessary to implement a DRG grouper that will accommodate ICD-10 diagnoses & procedure coding.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-018 is approved effective October 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Fredrick Sebree at (217) 492-4122 or via email at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-018

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

45 CFR Part 158; 45 CFR Part 162

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $514 (thousands)
b. FFY 2017 $514 (thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19 A Page 1A
Attachment 4.19A Page 1D
Attachment 4.19A Page 1E

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19 A Page 1A
Attachment 4.19A Page 1D
Attachment 4.19A Page 1E

10. SUBJECT OF AMENDMENT:
This SPA makes changes to the State Plan to modify the reimbursement methodology for inpatient hospital services by adopting the All-Patient Refined (APR) Diagnosis-Related Group (DRG) grouper, version 30, and implementing updated inpatient hospital DRG relative weights and payment rates. OMPP is making these changes in accordance with the CMS requirement that all HIPAA-covered entities transition to the ICD-10 diagnosis and procedure codes on October 1, 2015. In order to comply with these requirements, it is necessary to implement a DRG grouper that will accommodate ICD-10 diagnosis and procedure coding.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph Moser

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 11/19/2015

16. RETURN TO:
Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Kelly Flynn, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 19 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

REIMBURSEMENT FOR INPATIENT HOSPITALS SERVICES

DEFINITIONS

"Allowable costs" means Medicare allowable costs as defined by 42 USC 1395 (f).

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

"Base amount," means the rate per Medicaid stay that is multiplied by the relative weight to determine the DRG rate.

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

"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.

"Children's hospital" means a free-standing 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 predominately 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.

"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 DRG relative weights are adjusted.

"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 using similar resources. Classification is made using the all patient refined (APR) DRG grouper.

"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.

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 unless otherwise indicated herein or as indicated in provider manuals and update bulletins. There shall be no year-end cost settlement payments.

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient refined DRG grouper. The DRG rate is equal to the relative weight multiplied by the base amount.

Payment of 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 if applicable, and the outlier payment amount, if applicable.

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 if applicable, and the outlier payment amount, if applicable.

Relative weights will be reviewed periodically by the office and adjusted no more often than annually 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 wither an adjustment to the relative weights will be made. DRG average length of stay values 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 Attachment 4.19B. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

A base amount is the rate per Medicaid stay. DRG base amounts will be reviewed periodically by the office and adjusted no more often than every second year 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 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 adjustment cost per discharge greater than one 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.

Level-of-care rates are per diem rates. Level-of-care rates will be reviewed periodically 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.

Level-of-Care cases are categorized as DRG numbers 740, 750–756, 757 (excluding diagnosis codes for Intellectual Disabilities-Mild, Moderate, Severe and Profound or not otherwise specified classifiable to F70-F79), 758–760, 841–844, 850, and 860–863, as defined and grouped using the all patient refined DRG grouper, version 30. These DRG numbers represent burn, psychiatric, and rehabilitative care. The office may assign a LOC DRG number for long term care hospital admissions.

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 operate a burn intensive care unit.

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 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.

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 a long-term care hospital to be eligible for the separate level-of-care rate.

Add-On Payments

Capital payment rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

- Depreciation
- Interest
- Property Taxes
- Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital payment rates will be calculated using a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data.