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State Name: Pennsylvania

State Plan Amendment (SPA) #10-017

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS-179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

Center for Medicaid , CHIP, and Survey & Certification

DEC 2 9 2010

Mr. Michael Nardone, Acting Secretary
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, PA 17105

RE: State Plan Amendment (SPA) 10-017

Dear Mr. Nardone:

We completed our review of the proposed amendment to section 4.19A of Pennsylvania's Title XIX Medicaid State plan submitted under transmittal number (TN) 10-017. Specifically, this amendment establishes a reimbursement system for acute care general hospitals using all patient refined-diagnosis related groups.

We conducted our review of your submittal according to the statutory requirements at Sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Pennsylvania SPA 10-017 with an effective date of July 1, 2010. We are enclosing the HCFA-179 and the amended state plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

Cindy Mann
Director
Centers for Medicaid, CHIP, and Survey & Certification

cc: Leesa Allen, Director, Bureau of Policy, Analysis and Planning
Dawn Poppenwimer PA-OMAP

bcc: Mr. Gallagher, ARA RO3
Mr. McCullough RO3
Michael Cruse, PA Rep. RO3
Rob Weaver – NIRT
Mark Cooley – NIRT
NIRT Official file

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: 10-017

2. STATE: Pennsylvania

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2010

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:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY	2010	$9,432,514
b. FFY	2011	$278,738,004

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, Pages 1, 1a, 1aa, 1aaa, 2, 2bbb, 3, 4, 5, 6, 6a, 9, and 10

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19A, Pages 1, 2, 2bbb, 3, 4, 5, 6, 6a, 9, and 10

10. SUBJECT OF AMENDMENT:
Revised Payment Methodology for Inpatient Hospital Services

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:
Review and approval authority has been delegated to the Department of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael Nardone

14. TITLE:
Acting Secretary of Public Welfare

15. DATE SUBMITTED:

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, Pennsylvania 17105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12-29-10 DEC 29 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

The Department pays for inpatient hospital services provided by acute care general hospitals using prospective payment rates based on diagnosis related groups (DRGs). This payment system is described under the heading of Payments Under the Acute Care General Hospital Prospective Payment System.

The Department pays for inpatient hospital services provided by the following types of hospitals or hospital units using a prospective payment system: rehabilitation hospitals, distinct part drug and alcohol detoxification rehabilitation units of acute care general hospitals and distinct part medical rehabilitation units of acute care general hospitals. This payment system is described under the heading of Prospective Rehabilitation Payment System.

The Department pays for inpatient hospital services provided by distinct part psychiatric units of acute care general hospitals and private psychiatric hospitals using a prospective payment system. This payment system is described under the heading of Prospective Psychiatric Payment System.

The Department pays for public psychiatric hospitals on a cost-reimbursement basis, as described under the heading of State Operated Psychiatric Hospitals and Facilities.

The Department pays out-of-state hospitals as described under the heading of Out-of-State Hospital Payments.

ACUTE CARE GENERAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM

General Policy

The Department pays for inpatient hospital services provided by acute care general hospitals in a hospital unit not excluded from the DRG prospective payment system using predetermined rates based on the DRG into which the patient is classified.

The DRG classification system the Department will use is the All Patient Refined Diagnosis Related Group (APR DRG) system for classification of inpatient hospital stays into APR DRGs. All compensable services provided to an inpatient are covered by the prospective payment rate, except for direct care services provided by practitioners who directly bill the Department for their services.

Prospective payment rates are developed from cost reports submitted by hospitals, and from each hospital's paid claims history. Costs are determined using Medicare principles unless specified otherwise.

Malpractice insurance costs. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general costs center and allocated according to established accounting procedures.

ACUTE CARE GENERAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM

Prospective Payment System

The prospective payment rate for each recipient discharged from the hospital is established by multiplying the relative value of the APR DRG into which the patient has been classified, by the hospital specific payment rate. Payment is made based on the rate effective on the date of discharge.

METHODS USED TO ESTABLISH PROSPECTIVE RATES

Computation of Relative Values

The Department will use the relative values established for New York Medicaid adjusted for the Pennsylvania Medical Assistance Program for claims payment during Fiscal Years (FY) 2010-2011, FY 2011-2012 and FY 2012-2013. An adjustment factor is applied to each of the New York Medicaid relative values so that the Pennsylvania statewide case mix index is 1.0 based upon Pennsylvania's Medical Assistance Program FY 2007-2008 paid inpatient fee-for-service claims for operating in-state hospitals.

The Department will monitor the statewide average APR-DRG Case Mix Index (CMI) for the first three years to determine if they meet the following Target CMI ranges:

Year 1 (dates of services July 1, 2010 to June 30, 2011) – CMI target range 1.02 to 1.04.
Year 2 (dates of service July 1, 2011 to June 30, 2012) – CMI target range 1.03 to 1.05.
Year 3 (dates of service July 1, 2012 to June 30, 2013) – CMI target range 1.04 to 1.06.

The Department will review paid claims data for each prior twelve month period to determine if the statewide average CMI is outside of the target range and will make a corresponding prospective adjustment (plus or minus) to the relative weights to bring the statewide average within the specified ranges. For Year 1, an initial analysis will be made using a valid sample of the first six months of claims data at the end of Year 1. Once complete fiscal year data is available for the first fiscal year, the complete data will be used to revise the initial adjustment, if necessary. For each subsequent fiscal year, any adjustment to the relative weights will not be made until the analysis for that fiscal year has been completed.

Calculation of Hospital-Specific Payment Rates

During the period July 1, 2010 through June 30, 2013, payments for inpatient hospital services under the fee-for-service prospective payment system shall be determined as follows:

(a) The Department will establish a statewide average base rate for all general acute care hospitals, except for services in a hospital unit not covered under the acute care prospective payment system. That rate will then be adjusted for a hospital's regional labor costs, teaching status, MA dependency, and average capital costs to determine the hospital's base rate.

(1) The labor cost adjustment will be the area wage index effective October 1, 2009 and used by the Centers for Medicare & Medicaid Services (CMS) under Section 1886(d) of the Social Security Act to reflect the differences in local market prices for labor. If an area wage index is below 1, it will be adjusted to 1.

(2) The teaching adjustment will be provided for hospitals that have accredited medical education programs for physicians to account more fully for factors such as severity of illness of patients requiring the specialized services provided by teaching programs and the additional costs associated with the teaching of medical residents.

(3) The Medical Assistance dependency adjustment will be provided for hospitals that serve a high percentage or number of Medical Assistance inpatient days or discharges.

Calculation of Hospital-Specific Payment Rates

(b) The calculation of rates is as follows:

(1) Each hospital shall have a rate that is based on a statewide average of the state's fiscal year 2008 Medical Assistance inpatient fee-for-service cost per discharge standardized for case mix and multiplied by 90 percent. This cost per discharge excludes capital and medical education costs.

(2) For each hospital the statewide average rate calculated in (1) is divided into a labor and non-labor share using the same labor/non-labor proportions as used by the Medicare Program. The labor portion will be multiplied by the area wage index and then will be added to the non-labor portion to establish the labor-adjusted rate. If a hospital's wage index is lower than 1, the labor portion shall be multiplied by 1.

(3) If the hospital has a medical residency teaching program, the labor-adjusted rate shall be multiplied by 1.10 if the resident-to-bed ratio, according to the CMS 2010 Impact File, is greater than 0.2363 (the average for Pennsylvania teaching hospitals) or if the hospital is a children's hospital; if the resident-to-bed ratio is equal to or less than 0.2363, the labor-adjusted rate will be multiplied by 1.05.

(4) The labor-adjusted rate, adjusted for medical residency teaching programs, derived for each hospital will then be multiplied by 1.0592 for a capital costs adjustment.

(5) The Medical Assistance dependency adjustment will be determined as follows:

(i) For any hospital that ranks in the ninetieth percentile of:

(A) the number of MA acute care inpatient days; or

(B) the percentage of MA acute care inpatient days to total acute inpatient days; or

(C) the number of MA acute care inpatient discharges; or

(D) the percentage of MA acute care inpatient discharges to total acute care inpatient discharges;

the hospital shall be ranked using its highest qualifying percentile and assigned a high MA dependency value of between 1.15 and 1.20 proportionately. This value will then be applied to the rate calculated in (4).

(ii) For any hospital that does not rank in the ninetieth percentile in the above categories but has a number or percentage of MA acute care inpatient days that exceeds the statewide average (of 7,993 days or 13.3%), then the rate calculation in (4) is modified by a factor of 1.10 to adjust for MA dependency.

RESERVED

Payments for Direct Medical Education Costs

*Hospitals participating in the Quality Incentive Pilot that have an insufficient number of cases to calculate a 7-day readmission rate will be assigned one point for each of the four chronic conditions where a readmission rate is unavailable.

The Department will use a scoring methodology for acute care general non-children's hospitals based on points in order to determine the adjustment factor increase to medical Education payments for payments occurring after January 1, 2006 as follows:

(1) 12-15 points – 150% of scheduled adjustment factor increase
(2) 8-11 points – 125% of scheduled adjustment factor increase
(3) 5-7 points – 100% of scheduled adjustment factor increase
(4) 1-4 points – 75% of scheduled adjustment factor increase
(5) 0 points – no adjustment factor increase

The Departments will use a scoring methodology for acute care general children's hospital based on point to determine the adjustment factor increase to Medical Education payments for payments occurring after January 1, 2006 as follows:

(1) 5-6 points – 150% of scheduled adjustment factor increase
(2) 3-4 points – 125% of scheduled adjustment factor increase
(3) 2 points – 100% of scheduled adjustment factor increase
(4) 1 points – 75% of scheduled adjustment factor increase
(5) 0 points – no adjustment factor increase

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Upon discharge of the patient, the hospital receiving the transferred patient will be paid the DRG payment for the case. In addition, the hospital may receive an outlier payment to the extent it qualifies for an outlier payment as described below.

The transfer pricing described above does not apply to cases categorized into either the 'burns' or 'newborns and other neonates (perinatal period)' major diagnostic categories.

Readmissions

Effective September 2, 2008, when an eligible recipient is readmitted to a hospital within 14 days of the date of discharge, payment will be made as follows:

(1) If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the Department will make no payment in addition to the original DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment will be made.

(2) If the readmission is due to complications from the original diagnosis that result in a different DRG with a higher payment, the Department will pay the higher DRG payment rather than the original DRG payment.

(3) If the readmission is due to conditions unrelated to the previous admission, the Department will consider the readmission as a new admission for payment purposes.

Outliers

The Department makes cost outlier payments in addition to the APR DRG payment as described below:

(1) 100 percent of allowable costs beyond the fixed threshold for burn, transplant and neonate cases.

(2) 80 percent of allowable costs beyond the fixed threshold for all other cases.

Services in Non-distinct Part Psychiatric Units

If a hospital does not have a psychiatric unit that is excluded from the acute care general hospital prospective payment system and provides inpatient services to a recipient with a psychiatric principle diagnosis, the Department pays a two day per diem amount for the hospital stay. The two day per diem amount is determined by dividing the APR DRG payment rate by the statewide average length of stay for the APR DRG and multiplying the result by two.

Non-distinct Part Drug and Alcohol Rehabilitation Units

If a hospital does not have a distinct part drug and alcohol rehabilitation unit approved by the Department of Health, Office of Drug and Alcohol Programs, and provides services to a recipient with a drug or alcohol principle diagnosis, the Department pays a maximum two day per diem amount for the hospital stay. The two day per diem amount is determined by dividing the APR DRG payment rate by the statewide average length of stay for the APR DRG and multiplying the result by two.