

	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE		
	NUMBER: 11-88-02, 12-88-05, 13-88-05, 1151-88-02, 1163-88-02	ISSUE DATE: June 29, 1988	EFFECTIVE DATE: July 1, 1988
SUBJECT: Revisions to Chapters 1151 and 1163 Regulations		BY:  Eileen M. Schoen Deputy Secretary for Medical Assistance Programs	

PURPOSE:

The purpose of this bulletin is to transmit July 1, 1988, changes to the Department of Public Welfare's (Department) regulations governing payments for inpatient hospital services set forth in Chapters 1151 and 1163. The regulations incorporating the changes specified in this bulletin are to be published in the Pennsylvania Bulletin within 180 days.

SCOPE:

This bulletin is applicable to all general hospitals, drug and alcohol units, psychiatric units, medical rehabilitation units of general hospitals, drug & alcohol hospitals, freestanding psychiatric hospitals, and freestanding medical rehabilitation hospitals enrolled in the Medical Assistance (MA) Program.

POLICY/DISCUSSION:

The following Changes are being made effective July 1, 1988:

1. **Regrouping** - Effective July 1, 1988, the Department will regroup hospitals paid under the prospective payment system. The Department will use the most current data available and the current grouping system in determining the new peer groups. As in past years, there will be seven in-state hospital peer groups, a single group for each of the three children's hospitals, and a single group for out-of-state hospitals.
2. **Group Rates** - For in-state hospitals paid under the DRG system, the Department will determine a new group rate for each peer group using Fiscal Year (FY) 1986-87 cost and claims data. The rate for the out-of-state hospitals will be the overall statewide average cost per case.

The group rates will include a capital component amount in accordance with the appropriate phase-in percentage specified in current regulations at §1163.53a. For FY 1988-89, the in-state capital component phase-in percentage is set at 40 percent. Group rates will therefore be increased by 40 percent of the statewide average capital cost-to-operating-cost ratio, which is fixed at 7.1 percent under the capital phase-in provisions. In-state hospitals will also receive a capital pass-through payment equal to 60 percent of their 1985-86 hospital-specific capital costs in accordance with current regulations at § 1163.54. Out-of-state hospitals will have a capital component added to their group rate equal to 7.1 percent, multiplied by the statewide average cost per case.

As in previous years, the final group rates will be subject to a budget neutrality adjustment.

3. **Organ Transplants** - Effective with discharges after July 1, 1988, the Department will pay heart transplants under the DRG payment system. Properly coded heart transplant claims will group into DRG 103, and the appropriate payment will be made through the automated claims processing system. DRG 103 will also be eligible for day outliers. In the past, payment for heart transplants was only made through a program exceptions process. Liver, bone marrow, and any other transplant procedure not currently paid under the DRG system will continue to be reviewed and processed as program exceptions.
4. **Rebasing Relative Values** - The Department will rebase the DRG relative values for discharges on or after July 1, 1988. As in previous years, rebasing will result in changes to relative values, day outlier trim points, and average lengths of stay. Concurrent with rebasing, the Department will convert to GROUPER 5.0, which is the most current version of the DRG classification system. The revised relative values, trim points, and average lengths of stay will be provided in a separate MA Bulletin.
5. **Readmissions** - Effective with discharges on or after July 1, 1988, the Department will adopt a new readmission policy for hospitals paid under the DRG system. The current policy published at § 1163.57, addresses readmissions

within seven days of discharge and readmissions due to complications of the original diagnosis. The Department is modifying this policy as follows:

- a. If a recipient is readmitted to a hospital within 31 days of discharge as the result of premature discharge, the Department will deny any payment related to the readmission.
 - i. For purposes of this policy, "premature discharge" is defined as the discharge of a patient who should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in the judgment of the Department, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal studies on the day of discharge indicate that a patient may have been prematurely discharged from a hospital.
 - b. Except in cases of premature discharge as specified in "a" above, if a recipient is readmitted to a hospital within 31 days of discharge for the provision of services that could have or should have been provided during the previous hospital stay, the Department will combine both stays in order to determine the appropriate DRG payment.
6. Disproportionate Share Payment Adjustment - Effective on July 1, 1988, the Department will implement a disproportionate share payment adjustment for inpatient hospitals, which serve a disproportionate share of MA patients. Inpatient hospitals, which have a percentage of MA days to total days exceeding one standard deviation of the statewide average percentage of assistance days to total days will be eligible for a disproportionate share payment adjustment. For purposes of this calculation, MA days will include, to the extent possible, HIO days and MA HMO days and will exclude general assistance days. General assistance is a 100 percent state-funded program not currently subject to federal disproportionate share adjustment. Data for this calculation will be taken from the most recently completed fiscal year.

Hospitals deemed eligible for this payment adjustment will have their DRG payment rates increased by a percentage amount. The percentage add-on amount will be determined by a formula, which takes into account the proportion by which the eligible hospital exceeds the one standard deviation minimum. Eligible hospitals will be advised of their individual payment adjustment percentage in their 1988-89-rate notice.

7. Direct Medical Education Payments - Effective July 1, 1988, the Department will limit final direct medical education payments to 2.5 percent over the allowable amount determined at audit for Fiscal Year 1987-88. Interim payments for direct medical education will be the lesser of a hospital's FY 1987-88 interim payment amount increased by 2.5 percent, or the hospital's reported FY 1986-87 direct medical education costs increased by 4.2 percent and then 2.5 percent.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.