

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201412 MARCH 27, 2014



Hospital Assessment Fee to resume

The Hospital Assessment Fee (HAF) reimbursement increases and collection of the assessment fees will resume retroactive to July 1, 2013, and continue through June 30, 2015.

The HAF resumption will continue the collection of assessment fees from eligible hospitals, as explained in *Indiana Health Coverage Programs (IHCP) Bulletin* [BT201217](#). The fee is used, in part, to increase reimbursement to eligible hospitals for services provided in fee-for-service and managed care programs, and as the State's share of disproportionate share hospital (DSH) payments. The Centers for Medicare & Medicaid Services (CMS) has approved the *Indiana Medicaid State Plan* amendment necessary to reactivate the HAF program with an effective date of July 1, 2013.

Eligible and ineligible hospitals (IC 16-21-10-4)

Eligible hospitals remain the in-state acute care hospitals licensed under *Indiana Code IC 16-21-2* and the freestanding psychiatric hospitals licensed under *IC 12-25*. The following hospitals remain ineligible for participation in the HAF program:

- Long-term acute care (LTAC) hospitals
- State-owned hospitals
- Hospitals operated by the federal government
- Freestanding rehabilitation hospitals
- Out-of-state hospitals

If an eligible hospital becomes ineligible, or if a previously ineligible hospital becomes eligible (including new hospitals), the hospital must notify the Family and Social Services Administration (FSSA) of the change within 30 days. Hospitals

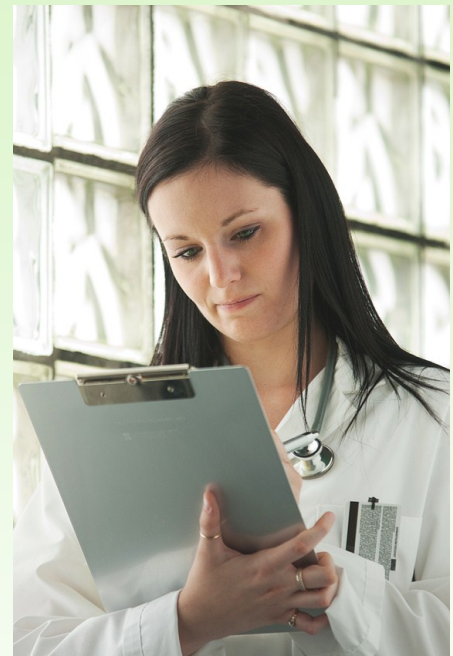
should submit this notification in writing to Myers and Stauffer, LC, at 9265 Counselors Row, Suite 200, Indianapolis, IN 46240. The calculation of the assessment fee is based on hospital cost report information; therefore, it is critical that hospitals ensure cost reports are filed timely with Myers and Stauffer, LC.

Reimbursement increases and other payment changes

The following reimbursement changes apply to eligible hospitals only. The increases in inpatient and outpatient reimbursement will result in aggregate payments that reasonably approximate the Medicare upper-payment limits without exceeding those limits. The increases in reimbursement will be based on the following adjustment factors that will be applied to the inpatient diagnosis-related group (DRG) base rate, inpatient level-of-care (LOC) *per-diem* rates, and outpatient rates:

- The initial adjustment factor for the inpatient DRG base rate is 3.0.
- The initial adjustment factor for the inpatient rehabilitation LOC rate is 3.0.
- The initial adjustment factor for the inpatient psychiatric LOC rate is 2.2.
- The initial adjustment factor for the inpatient burn LOC rate is 1.0.
- The initial adjustment factor for the outpatient rates, excluding laboratory services, is 3.2.

For inpatient claims, the adjustment factors will apply to claims with “from” dates of service on or after July 1, 2013. Inpatient admissions that occurred before July 1, 2013, will receive the HAF increase based on adjustment factors and parameters published in *IHCP Bulletin BT201217*, even if the discharge date was after July 1. For outpatient claims, the adjustment factors will apply to claim detail lines with dates of service on or after July 1, 2013. Reimbursement for outpatient laboratory services, defined as the procedure codes listed on the Medicare Clinical Laboratory Fee Schedule are not subject to the HAF increase.



For hospitals participating in the HAF, the 5% inpatient and outpatient hospital reimbursement reductions effective for dates of service January 1, 2010, through December 31, 2013, and the 3% reimbursement reduction effective for dates of service January 1, 2014, through June 30, 2015, (see *IHCP Bulletin [BT201331](#)*) will not apply while the HAF is in effect, except for the reduction in outpatient laboratory services. The HAF reimbursement increases do not apply to claims for members of the 590 Program. The adjustment factors previously listed may be revised in the future to remain within the hospital upper-payment limit. Providers will be notified of any changes to the adjustment factors through an *IHCP Bulletin*.

The limitation on payments to the lesser of the Medicaid allowed amount or the provider's billed charges will be suspended while the HAF is in effect. Because this payment limitation will no longer apply on a per-claim basis, the FSSA will perform an annual comparison of aggregate inpatient payments to inpatient charges by hospital to ensure compliance with federal regulations. Federal regulations at *42 CFR 447.271* limit the amount of inpatient payments made by the Medicaid agency to no more than the hospital's customary charges. Therefore, following the close of each state fiscal year, the FSSA will review paid claims data to ensure no hospital has received Medicaid payments exceeding the

hospital's charges for inpatient services. If a hospital receives aggregate Medicaid payments in excess of its inpatient charges, the hospital will have to repay the difference. Nominal charge hospitals identified at *IC 12-15-15-11* are excluded from the inpatient charge limitation previously described.

Because the HAF program was approved with an effective date of July 1, 2013, previously paid claims will be mass adjusted to apply the increased reimbursement amounts. This mass adjustment will apply to claims with dates of service from July 1, 2013, through April 1, 2014. Mass-adjusted claims will appear on Remittance Advices (RAs) beginning on or after April 15, 2014, and will be identified with internal control numbers (ICNs) that begin with region code 56. The first mass adjustments will be inpatient claims, followed by inpatient crossover, outpatient, and outpatient crossover claims. Due to the volume of claims, the mass adjustment will take several weeks to complete.

Spend-down and crossover claims clarification

No changes will be made to claims processing for IHCP members with spend-down. The increased HAF reimbursement will not apply until the member has met his or her spend-down liability. Following current spend-down policy, the billed charges on the claim will be credited against the member's spend-down. If a member has not met his or her spend-down, the member will be responsible for the billed charges on the claim. When the member's spend-down liability is met, the IHCP will reimburse the provider the IHCP allowed amount (increased for the HAF, as appropriate) less the member's spend-down liability on the claim.

The IHCP methodology for calculating the Medicaid payment amount on crossover claims will not change. Medicaid payment will be calculated as the lesser of the following:

- The Medicaid allowed amount less Medicare payment on the claim; or
- The [Medicare] coinsurance and deductible for the claim

The Medicaid allowed amount will be increased using the HAF adjustment factors previously described before calculating the Medicaid payment amount. Total payment for a crossover claim will not exceed the Medicare allowed amount.



Managed care payment increases

As previously noted, the HAF reimbursement increases will also apply to risk-based managed care (RBMC) claims paid by the managed care entities (MCEs). Each MCE will generate payments to eligible hospitals and will distribute the increased reimbursement across eligible hospitals based on historical utilization from calendar year 2012. Payments to eligible hospitals for this portion of the reimbursement increase will come directly from the MCEs on a monthly basis.

Disproportionate share hospital payment changes

In addition to funding the increase in hospital reimbursement, the HAF will continue to be used to provide the State's share of funding for DSH payments to qualifying hospitals. To be deemed DSH-eligible, hospitals must meet DSH eligibility requirements as set out in the *Indiana Medicaid State Plan*. A DSH-eligible hospital may decline all or part of its

DSH payments by notifying the FSSA that it declines the DSH payment and indicating the amount of the payment being declined. For the period during which HAF is in effect, DSH payments will be made in the following order:

1. Each DSH-eligible hospital receives a payment of \$1,000, not to exceed the hospital's hospital-specific limit (HSL).
2. Municipal DSH-eligible hospitals established and operated under *IC 16-22-2* or *16-23* receive payment amounts equal to the lower of the hospital's HSL for the payment year less any payments received in #1 above, or the hospital's net 2009 supplemental payment amount.
3. DSH-eligible acute care hospitals licensed under *IC 16-21* located in Lake County, Indiana, receive payment amounts equal to the hospital's HSL for the payment year, less any payment received in #1 above.
4. DSH-eligible private acute care hospitals licensed under *IC 16-21* and DSH-eligible hospitals established and operated under *IC 16-22-8* receive payment amounts equal to the hospital's HSL for the payment year, less any payment received by the hospital in #1 above. If not enough DSH funds are available to pay all eligible hospitals in this group up to their respective HSLs, the amount paid to each hospital will be reduced by the same percentage for all hospitals in the group.
5. If DSH funds remain after the previous payments, DSH-eligible freestanding psychiatric institutions licensed under *IC 12-25* receive payment amounts equal to the institution's HSL for the payment year, less any payment received in #1 above. If not enough DSH funds are available to pay all eligible institutions in this group up to their respective HSLs, the amount paid to each institution will be reduced by the same percentage for all institutions in the group. Institutions owned by the state of Indiana are not eligible for payments from this pool.

Assessment fee collection

Each hospital's chief executive officer (CEO) or chief financial officer (CFO) will receive a letter from the State's rate-setting contractor, Myers and Stauffer LC, notifying them of their hospital's annual assessment fee amount. For all eligible IHCP-enrolled hospitals, HP will collect the assessment fee by establishing monthly accounts receivables, which will be substantially offset against the increases in fee-for-service reimbursement. To the extent possible, retroactive accounts receivable from July 1, 2013, to April 1, 2014, will be processed concurrently with mass adjustments of fee-for-service claims for the same period. In most cases, this process will allow the FSSA to collect the retroactive amount of the assessment fee from the increased reimbursement resulting from the mass-adjusted fee-for-service claims. If the hospital's increased fee-for-service reimbursement does not cover the full amount of the assessment, HP will notify the hospital of the outstanding accounts receivable balance, and the hospital will be requested to remit a check for the difference.

In addition to the retroactive adjustments, on a prospective basis, a monthly assessment fee



amount will be offset, via an accounts receivable, for the duration of the assessment fee. The monthly amount will be calculated by dividing the total annual assessment fee amount into 12 equal portions. The accounts receivable will appear on the hospital's Remittance Advice (RA) with the reason code *8494 – Hospital Assessment Fee*. If a hospital does not have sufficient Medicaid fee-for-service claim volume to offset the amount of the assessment fee, HP will use current collection processes.

If it is determined that the assessment fee amount collected, either during retroactive adjustments or subsequent monthly collections, is not correct, necessary adjustments will be made in future months to increase or reduce subsequent assessment fee amounts to correct the error.

For hospitals that are not IHCP-enrolled providers, the assessment fee will be collected from the provider through the manual invoicing process. Non-IHCP-enrolled facilities will receive instructions on payment of the assessment fee amount from Myers and Stauffer LC.

QUESTIONS?

If you have questions about this information, contact the HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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