INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Hospital Assessment Fee

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled review	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: March 21, 2017	Corrected historical HAF adjustment factors for outpatient rates in the *Reimbursement Increases and Other Payment Changes* section	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: October 24, 2017	Scheduled review: • Reorganized and edited text as needed for clarity • Replaced Hewlett Packard Enterprise references with DXC Technology • Updated the HAF extension date to June 30, 2019 • Updated *Table 1 – Adjustment Factors for Inpatient Rates* and *Table 2 – Adjustment Factors for Outpatient Rates* • Updated the *Managed Care Payment Increases* section	FSSA and DXC

Table of Contents

> *Note: All Indiana Health Coverage Programs (IHCP) acute care hospitals, municipal county hospitals, community mental health centers (CMHCs), state psychiatric hospitals, and private psychiatric hospitals should refer to IHCP State Plan: Attachment 4.19A for information about participation in the following payment programs:*
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> - *Hospital Care for the Indigent (HCI) Payment*
> - *Municipal County Hospital Indiana Medicaid Shortfall Payment*
> - *Indiana Medicaid Disproportionate Share Hospital (DSH) Payment*
> - *Safety-Net Hospital Payment*
> - *Supplemental Private Hospital Adjustment*

The Family and Social Services Administration (FSSA) implemented a Hospital Assessment Fee (HAF) program in accordance with *Public Law 229-2011, Section 281,* as enacted by the 2011 Session of the Indiana General Assembly. The initial HAF was effective for the period July 1, 2011, through June 30, 2013. *House Enrolled Act (HEA) 1001 (2013)* added *Indiana Code IC 16-21-10*, which extended the hospital assessment through June 30, 2017. Effective July 1, 2017, the HAF was extended through June 30, 2019.

The HAF is used, in part, to increase reimbursement to eligible hospitals for services provided in IHCP fee-for-service and managed care programs, and as the State's share of disproportionate share hospital (DSH) payments. The HAF reimbursement increases and collection of the assessment fees will continue through June 30, 2019.

Before the implementation of the HAF, providers (other than nominal-charge hospitals identified in *IC 12-15-15-11*) were reimbursed the lower of their submitted charges or the Medicaid allowed amount for all hospital services. For HAF-participating hospitals, the limitation on payment to the lesser of the Medicaid allowed amount or the provider's billed charges is suspended. Upon calculation of the HAF payment, the provider may receive an amount in excess of the billed charges.

Eligible and Ineligible Hospitals

HAF-eligible hospitals are in-state acute care hospitals licensed under *IC 16-21-2* and freestanding psychiatric hospitals licensed under *IC 12-25*. The following hospitals are **not** eligible 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 a HAF-participating hospital becomes ineligible for HAF, or if an IHCP-enrolled hospital that was previously ineligible for HAF becomes eligible (including newly enrolling hospitals), the hospital must notify the FSSA of the change within 30 days. Hospitals should submit this notification in writing to the following address:

Myers and Stauffer LC
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.

Reimbursement Increases and Other Payment Changes

The following reimbursement information applies to HAF-participating hospitals only. 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. The HAF reimbursement increases do not apply to claims for members of the 590 Program.

For hospitals participating in the HAF, the 3% inpatient and outpatient hospital reimbursement reductions do not apply while the HAF is in effect, except for the reduction on outpatient laboratory services.

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

Table 1 – Adjustment Factors for Inpatient Rates

Effective Dates	Inpatient DRG Base Adjustment Factor	Inpatient Rehabilitation LOC Adjustment Factor	Inpatient Psychiatric LOC Adjustment Factor	Inpatient Burn LOC Adjustment Factor
July 1, 2017 – June 30, 2019	2.7	2.6	2.2	1.0
April 1, 2017 – June 30, 2017	2.5	2.6	2.2	1.0
August 1, 2014 – March 31, 2017	2.1	2.6	2.2	1.0
July 1, 2013 – July 31, 2014	3.0	3.0	2.2	1.0
July 1, 2011 – June 30, 2013	3.0	3.0	2.2	1.0

Table 2 – Adjustment Factors for Outpatient Rates

Effective Dates	Outpatient Rates (Excluding Laboratory Services) Adjustment Factor
July 1, 2017 – June 30, 2019	2.7
April 1, 2017 – June 30, 2017	2.0
August 1, 2014 – March 31, 2017	2.7
July 1, 2013 – July 31, 2014	3.2
May 1, 2013 – June 30, 2013	1.0
July 1, 2012 – April 30, 2013	3.5
May 1, 2012 – June 30, 2012	1.0
July 1, 2011 – June 30, 2013	3.5

The adjustment factors listed in Tables 1 and 2 may be revised in the future to remain within the hospital upper payment limit. Providers are notified of any changes to the adjustment factors through an IHCP bulletin.

For HAF-participating hospitals, the limitation on payments to the lesser of the Medicaid allowed amount or the provider's billed charges is suspended while the HAF is in effect. Because the submitted charges limitation does not apply to HAF-participating hospitals on a per-claim basis, the FSSA performs an annual comparison of aggregate inpatient payments to inpatient charges by hospital to ensure compliance with federal regulations. Federal regulations at *Code of Federal Regulations 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 reviews paid claims data to ensure that 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 must repay the difference.

HAF-participating hospitals remain subject to the existing outpatient claim-processing logic that limits the number of units allowed for specific revenue codes, procedure codes, or modifiers. If the provider bills multiple units when only one unit is allowed, the system will continue to cut back the number of units and use the provider's per-unit billed amount as the allowed amount unless it exceeds the IHCP Fee Schedule amount. The allowed amount for outpatient claim details subject to the unit cutback receives the HAF increase.

Inpatient, inpatient Medicare crossover, and inpatient Medicare Replacement Plan crossover claims paid using the HAF reimbursement methodology result in header-level explanation of benefits (EOB) 9032 –*Hospital Assessment Fee (HDR)*. Outpatient, outpatient Medicare crossover, and outpatient Medicare Replacement Plan crossover claims paid using the HAF reimbursement methodology result in detail-level EOB 9033 – *Hospital Assessment Fee (DTL)*. These edits alert the provider that the claims are being reimbursed with the HAF. These edits are informational only and do not cause claims to deny. The increased payment due to HAF appears with adjustment reason code (ARC) 169 – *Alternate Benefit Provided*.

DRG and Level-of-Care Payment Policies

For HAF-participating hospitals, the IHCP allowed amount for inpatient services is calculated as follows for DRG outlier payment policies:

(DRG Base Rate × Inpatient Hospital Adjustment Factor) + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

For HAF-participating hospitals, the IHCP allowed amount for inpatient services is calculated as follows for LOC outlier payment policies:

(LOC *Per Diem* Rate × Inpatient Hospital Adjustment Factor) + Capital Costs Payment + Medical Education Costs Payment (if applicable) + Outlier Payment (if applicable)

The *inpatient hospital adjustment factor* is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information regarding DRG and LOC outlier payment, medical education cost payment, and capital cost payment, see the *Inpatient Hospital Services* module.

Waiver Liability

The increased HAF reimbursement does not apply until the member has met his or her waiver liability. Following current waiver liability policy, the billed charges on the claim are credited against the member's waiver liability. If the member has not met his or her waiver liability, the member will be responsible for the billed charges on the claim. When the member's waiver liability is met, the IHCP reimburses the provider the IHCP allowed amount (increased for the HAF as appropriate) less the member's waiver liability on the claim, as follows:

- If a member is on waiver liability and the billed amount at the header is less than the remaining waiver liability balance, the HAF adjustment factor will not be applied.
- If the billed amount is greater than or equal to the remaining waiver liability balance at the header, the HAF adjustment factor will be applied to the allowed amount and the remaining waiver liability balance will be subtracted from the new HAF allowed amount.

Medicare and Medicare Replacement Plan Crossover Claims

The IHCP methodology for calculating the Medicaid payment amount on crossover claims remains unchanged for HAF-participating hospitals. Medicaid payment is still calculated as the lesser of the following:

1. Medicaid allowed amount less Medicare or Medicare Replacement Plan payment on the claim

   or

2. Coinsurance and deductible for the claim

The Medicaid allowed amount is increased using the HAF adjustment factors described previously prior to calculating the Medicaid payment amount. Total payment for a crossover claim will not exceed the Medicare or Medicare Replacement Plan allowed amount. For more information about crossover claims, see the *Claim Submission and Processing* module.

Managed Care Payment Increases

The HAF reimbursement increases apply to both fee-for-service claims and managed care claims paid by the managed care entities (MCEs).

HAF-participating hospitals are reimbursed for inpatient hospital services rendered to managed care members (including, for dates of service on or after April 1, 2017, Hoosier Healthwise and Hoosier Care Connect members) using the Medicaid All-Patient Refined Diagnosis-Related Group (APR-DRG) or LOC methodology, as appropriate, with the HAF adjustment factors applied directly to the claim. This methodology was already in effect for the Healthy Indiana Plan (HIP) effective January 1, 2016.

HAF-participating hospitals are reimbursed for outpatient hospital services rendered to managed care members (including, for dates of service on or after April 1, 2017, Hoosier Healthwise and Hoosier Care Connect members) using the Medicaid rate methodology with the HAF adjustment factors applied directly to the claim payment. This methodology was already in effect for the Healthy Indiana Plan (HIP) effective March 1, 2016.

Assessment Fee Collection

Each hospital chief executive officer (CEO) or chief financial officer (CFO) receives a letter from the State's rate-setting contractor, Myers and Stauffer, notifying them of their hospital's annual assessment fee amount. For all eligible Medicaid-enrolled hospitals, DXC Technology, acting as fiscal agent for the IHCP, collects the assessment fee through establishment of monthly accounts receivables, which are substantially offset against the increases in fee-for-service reimbursement. If the hospital's increased fee-for-service reimbursement does not cover the full amount of the assessment, DXC notifies the hospital of the outstanding accounts receivable balance, and the hospital is requested to remit a check for the difference.

In addition to the retroactive adjustments being performed, on a prospective basis, a monthly assessment fee amount is offset monthly by processing the new day claims received from the provider via an accounts receivable for the duration of the assessment fee. The monthly amount is calculated by dividing the total annual assessment fee amount into 12 equal portions. The accounts receivable appears on the hospital's Remittance Advice (RA) statement with the reason code 8494. If a hospital does not have sufficient Medicaid fee-for-service claim volume to offset the amount of the assessment fee, DXC uses current collection processes.

Disproportionate Share Hospital Payment Changes

In addition to funding the increase in hospital reimbursement, the hospital assessment fee is also used to provide the State's share of funding for DSH payments to qualifying hospitals. Hospitals must meet DSH eligibility requirements as set out in the Indiana Medicaid Plan State to be deemed a DSH-eligible hospital. A DSH-eligible hospital may decline all or part of their DSH payments by notifying the FSSA that it declines the DSH payment and the amount of the payment being declined. For the period of the hospital assessment fee, DSH payments are made in the following order:

1. Each DSH-eligible hospital receives a payment of $1,000, not to exceed its hospital-specific limit (HSL).
2. Municipal DSH 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 payment 1, 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 payment 1.
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 payment 1. 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 is reduced by the same percentage for all hospitals in the group.
5. If DSH funds are remaining 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 payment 1. 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 is 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.