IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202264 AUGUST 16, 2022

HIP reimbursement policy updated for members requiring admission to LTC facilities

Following its review of the reimbursement methodology for members enrolled in the Healthy Indiana Plan (HIP) and admitted to nursing facilities, the Indiana Health Coverage Programs (IHCP) is implementing new requirements, effective for dates of service on or after Nov. 1, 2022.

Per HIP contractual requirements, managed care entities (MCEs) are required to establish reimbursement rates that are comparable to one of the following:

- The federal Medicare reimbursement rate for the service provided
- 130% of the Medicaid reimbursement rate for services that do not have a Medicare reimbursement rate

The IHCP review found that some MCEs are reimbursing at the federal Medicare reimbursement rate, reimbursing at 130% of the Medicaid reimbursement rate or are using both payment methods. Based on this review, it was clear that guidance was necessary to ensure consistency in the HIP Medicaid reimbursement methodology.

Additionally, the potential for conflicting payment guidance was noted in relation to *IHCP Bulletin* BT2021110, which requires separate MCE reimbursement for covered outpatient drugs and covered over-the-counter drugs to all IHCP-enrolled pharmacy providers servicing members admitted to long-term care (LTC) facilities. This could lead to IHCP reimbursing MCEs for duplicative pharmacy services provided to members during their nursing facility stay. However, Medicare Part A reimbursement for nursing facility services is generally an all-inclusive reimbursement rate that covers the cost of both skilled nursing facility services and ancillary care services, such as pharmacy, therapy and laboratory needs.

New requirements

The IHCP is implementing the following requirements effective for dates of service on or after Nov. 1, 2022.

Reimbursement methodology

HIP MCEs must use the Medicare reimbursement methodology and associated reimbursement rates for payment of member nursing facility stay claims. These Medicare equivalent rates should be inclusive of geographic adjustments, value-based purchasing adjustments and variable payment reduction factors required under the Medicare payment methodology.

Payment methodology

In conjunction with the requirement for use of the Medicare payment methodology, the IHCP is also requiring a modification to the Medicare payment methodology to mitigate any duplicative pharmacy service reimbursement considerations following the issuance of *BT2021110*. The IHCP will require HIP MCEs to remove the 3.00 Non-Therapy Ancillary (NTA) Medicare variable per diem adjustment factor (multiplier) from the first three days of the

member's nursing facility stay. To operationalize the removal of the 3.00 NTA multiplier, HIP MCE's Medicare pricing/ payment tools must incorporate a minimum three-day prior stay in the appropriate field (see Figure 1). This in turn will eliminate the 3.00 NTA multiplier from being paid on the member claim, which will eliminate the potential for duplicative pharmacy payments.

The NTA component of the Medicare payment methodology includes payment for pharmacy, laboratory, radiology, IV therapy and supplies, and respiratory/inhalation therapy services. The 3.00 multiplier was implemented by Medicare to account for the high upfront costs of a member entering a nursing home, which is predominantly driven by the member's pharmacy needs.

Figure 1 – Prior days field must contain at least a "3" for prior day stay

MCEs Enter at Least a "3" Here

Adjusted Medicare equivalent rate

Effective for claims submitted on or after Nov. 1, 2022, MCEs must use an adjusted Medicare equivalent rate for the reimbursement of HIP members in nursing facilities using the 3.00 NTA multiplier.

On the institutional claim (*UB-04* claim form or electronic equivalent), providers should enter revenue code 0022 and the appropriate Patient Driven Payment Model Health Insurance Prospective Payment System (PDPM HIPPS) code, which will be used by the MCEs to calculate the Medicare-like payment. Providers should work with the MCE to ensure prior authorization is in place as required.

For more information

Please direct questions regarding this bulletin to the MCE with which the HIP member is enrolled.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *Bulletins* page of the IHCP provider website at in.gov/medicaid/providers.

TO PRINT

A printer-friendly version of this publication, in black and white and without photos, is available for your convenience.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.