visited on 8/31/2015

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201217 MAY 22, 2012

Hospital Assessment Fee

As the Indiana Hospital Association (IHA) and the Office of Medicaid Policy and Planning (OMPP) have previously communicated, they have been working together to develop and implement a hospital assessment fee program in accordance with *Public Law 229-2011, SECTION 281* as enacted by the 2011 Session of the Indiana General Assembly. These changes are effective retroactive to July 1, 2011 and will continue through June 30, 2013. Under this program, OMPP will collect an assessment fee from eligible hospitals. The fee will be used in part to increase reimbursement to eligible hospitals for services provided in both fee-for-service and managed care programs, and as the state share of disproportionate share hospital (DSH) payments. The Centers for Medicare and Medicaid Services (CMS) has approved the state plan amendment necessary to implement these changes with an effective date of July 1, 2011. This bulletin provides additional details about which hospitals are eligible, the reimbursement increases including mass adjustments of fee-for-service claims, and the assessment fee collection process.

Eligible and Ineligible Hospitals

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:

- Long term acute care (LTAC) hospitals
- State-owned hospitals

Continue

visited on 8/31/2015

- 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 OMPP 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 rehab LOC rate is 3.0.
- The initial adjustment factor for the inpatient psych 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 3.5.

For inpatient claims, the adjustment factors will apply to claims with “From” dates of service on or after July 1, 2011. Inpatient admissions that occurred prior to July 1, 2011 will not receive the HAF increase, even if the discharge date was after July 1st. For outpatient claims, the adjustment factors will apply to claim detail lines with dates of service on or after July 1, 2011. 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 percent inpatient and outpatient hospital reimbursement reductions will not apply while the HAF is in effect, except for the reduction on outpatient laboratory services. (See BT201122 for an explanation of these reductions.) The HAF reimbursement increases do not apply to claims for members of the 590 Program. The adjustment factors listed above may be revised in the future, in order to remain within the hospital upper payment limit. Providers will be notified of any changes to the adjustment factors through an IHCP bulletin.

For the period May 1, 2012 – June 30, 2012, the OMPP will recoup a portion of the increased reimbursement for outpatient hospital claims. This recoupment will result in hospitals receiving outpatient reimbursement at the IHCP fee schedule amounts for dates of service within those two months and is necessary to remain within the federal upper payment limit for outpatient hospital services.

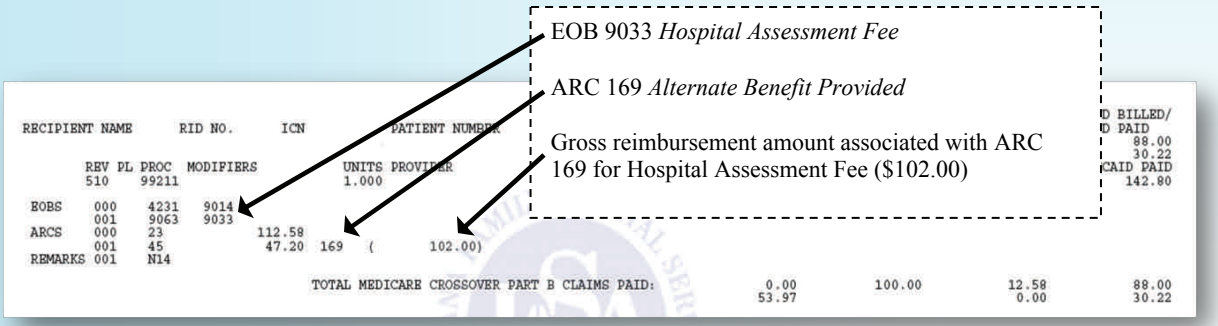
Continue

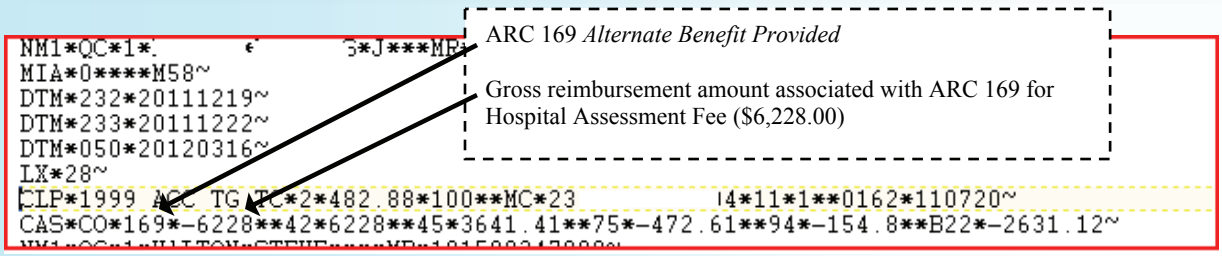
visited on 8/31/2015

Additionally, 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 OMPP will perform an annual comparison of aggregate inpatient payments to inpatient charges by hospital in order 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, OMPP 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 their 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 described above.

No changes will be made to the outpatient claims processing system logic currently in place to limit 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 will receive the HAF increase.

Inpatient and inpatient crossover claims paid using the HAF reimbursement methodology will set a new header edit 9032 – *Hospital Assessment Fee*. Outpatient and outpatient crossover claims paid using the HAF reimbursement methodology will set a new detail edit 9033 – *Hospital Assessment Fee*. These new edits will alert the provider that the claims are being reimbursed with the Hospital Assessment Fee. These edits are informational only and will not cause claims to deny. The increased payment due to HAF will appear with ARC 169 – *Alternate Benefit Provided*. Below are examples of how this will appear on the electronic remittance advice statement and in the 835 transaction.





Continue

visited on 8/31/2015

Because the hospital assessment fee program was approved with an effective date of July 1, 2011, retroactive adjustments will be processed to adjust previously paid claims to the increased reimbursement amounts. Claims that are subject to retroactive adjustment with dates of service from July 1, 2011 through April 30, 2012 will be mass adjusted. Mass-adjusted clams will appear on Remittance Advices (RAs) beginning on or after May 23, 2012. The mass adjustment will pay the claims at the new rates. Mass adjusted claims are identified on the RA with region number 56 as the first two digits of the internal control number (ICN). Inpatient claims will be mass adjusted first, followed by inpatient crossover, outpatient, and outpatient crossover claims. Due to the volume of claims, the mass adjustment process will take several weeks to complete.

Spend-Down and Crossover Claims Clarification

No changes will be made to the processing of claims for IHCP members with spend-down. The increased HAF reimbursement will not apply until the member has met their spend-down liability. Following current spend-down policy, the billed charges on the claim will be credited against the member's spend-down. If the member has not met their 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 still be calculated as the lesser of 1) the Medicaid allowed amount less Medicare payment on the claim or 2) the coinsurance and deductible for the claim. The Medicaid allowed amount will be increased using the HAF adjustment factors described above prior to calculating the Medicaid payment amount. Total payment for a crossover claim will not exceed the Medicare allowed amount.

Managed Care Payment Increases

As noted above, the hospital assessment fee 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, based on a methodology developed by the Indiana Hospital Association. This methodology will distribute the increased reimbursement across eligible hospitals based on historical utilization from calendar year 2010. Payments to eligible hospitals for this portion of the reimbursement increase will come directly from the MCEs on a monthly basis.

Disproportionate Share Hospital (DSH) Payment Changes

In addition to funding the increase in hospital reimbursement, the hospital assessment fee will also be used to provide the state share of funding for Disproportionate Share Hospital (DSH) payments to qualifying hospitals. Hospitals must meet DSH

Continue

visited on 8/31/2015

eligibility requirements as set out in the Indiana Medicaid state plan in order to be deemed a DSH-eligible hospital. A DSH-eligible hospital may decline all or part of their DSH payments by notifying OMPP that it declines the DSH payment and the amount of the payment being declined. For the period of the hospital assessment fee, 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 hospitals established and operated under *IC 16-22-2* or *16-23* receive payment amounts equal to the lower of the hospitals 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 I*C 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 there is DSH remaining after the above 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 CEO or 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 Medicaid-enrolled hospitals, the assessment fee will be collected by HP through establishment of 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, 2011 to April 30, 2012 will be processed concurrently with mass adjustments of fee-for-service claims for the same period. In most cases, this will allow the OMPP 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 monthly, 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 twelve equal portions. The accounts receivable will appear on the hospital's remittance advice (RA) statement with the reason code 8494, as shown on the next page. If a hospital does not have sufficient Medicaid fee-for-service claim volume to offset the amount of the assessment fee, HP will utilize current collection processes.

Continue

visited on 8/31/2015

----------ACCOUNTS RECEIVABLE----------

A/R NUMBER	SETUP DATE	ORIGINAL AMOUNT	BALANCE	REASON CODE	FIN ARC	ORIGINAL --ICN--	RID NO.
6	3 041612	12,001.10	7,832.10	8494	WO	0000000000000	
6	4 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	5 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	6 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	7 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	8 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	9 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	0 041612	12,001.10	12,001.10	8494	WO	0000000000000	
6	0 042012	12,001.10	12,001.10	8494	WO	0000000000000	
	TOTAL BALANCE		$103,840.90				

Reason code 8494 Hospital Assessment Fee

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 Medicaid enrolled providers, the assessment fee will be collected from the provider through a manual invoicing process. Non-Medicaid enrolled facilities will receive instructions on payment of the assessment fee amount from Myers and Stauffer LC.

QUESTIONS?

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

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com. To receive email notices of future IHCP publications, subscribe to IHCP E-mail Notifications.