

Indiana Hospital Assessment Fee -- DRAFT

September 27, 2011

Inpatient Fee

The initial Indiana Inpatient Hospital Fee applies to inpatient days from each hospital's most recent FYE as taken from the cost reports on file as of February 28, 2012 with Myers & Stauffer, LC – the State's rate setting contractor.

The file will be adjusted to account for FYs other than 12 months and to exclude hospitals that have closed. Hospitals that are new in the fee year that did not have a cost report on file with the State's contractor will be excluded. Days are total hospital days including days for sub providers, employee discount days, and labor and delivery. Using Form CMS-2552-96, days will be taken from Worksheet S-3, Part I, Column 6, Lines 12, 14, any additional 14.XX lines, 28, 29 less lines 3 and 4 if applicable. For reports filed on Form CMS-2552-10, appropriate references will be identified to get equivalent data.

From each hospital's total days from the cost reporting periods described above, any days provided to patients residing outside Indiana will be excluded from the fee. The days for patients residing outside Indiana will be obtained from information provided to the Indiana Hospital Association.

The following hospitals are excluded from the fee:

- Long term care hospitals
- State-owned hospitals
- Hospitals operated by the federal government
- Freestanding Rehabilitation hospitals
- Freestanding psychiatric hospitals with greater than 50% of admissions having a primary diagnosis of chemical dependency.

The fee rate for the following hospitals is reduced:

- 75% of the full rate for hospitals qualifying for DSH during the fee period through meeting MIUR criteria or an acute hospital qualifying for DSH during the fee period through meeting LIUR criteria that did not have LIUR status in 2010.
- 50% of the full rate for acute hospitals qualifying for DSH during the fee period through meeting LIUR criteria and that met LIUR status in 2010.
- 50% of the full rate for psychiatric hospitals qualifying for DSH during the fee period through meeting LIUR criteria.
- 50% of the full rate for all hospitals qualifying for DSH during the fee period where more than 25% of the hospital's Medicaid days are provided to patients residing outside Indiana.

Outpatient Fee

The initial Indiana Outpatient Hospital Fee applies to equivalent outpatient days. Equivalent outpatient days are derived by dividing each hospital's outpatient revenue by each hospital's inpatient revenue per day. Each hospital's equivalent outpatient days will be reduced to account for services provided to patients residing outside of Indiana defined in the Inpatient Fee section.

The sources of the data are as follows:

- Total Outpatient and Inpatient Revenue: Cost Report Worksheet C, Columns 6 and 7
- Medicaid Outpatient Revenue: Medicaid claims from MMIS
- Total and Medicaid Inpatient Days: Worksheet S-3 (see Inpatient Fee section)
- Out of state days: Patient Discharge Data reported to Indiana Hospital Association
- Medicaid out of state days: Medicaid DSH Eligibility Survey

The hospitals excluded from the fee and the hospitals with reduced fee rates are the same as the criteria for the Inpatient Hospital Fee.

Waiver Eligibility

Data from FY 2009 cost reports has been used to verify that the fee described above meets accepted standards for a waiver of the broad based and uniformity provisions of the Provider Donation and Tax regulations.

Federal Regulations at 42 C.F.R. § 433.68 prescribe a methodology for testing whether or not the fee is broad based. A statistical test is used to determine that the proposed fee methodology meets the requirement that its plan is generally redistributive.

If the ratio of the slope of each of two linear regressions (referred to as B1 and B2) is greater than 1.00, CMS will automatically approve the waiver request.

The data from FY 2010 cost reports and Medicaid utilization are expected to be very similar to the data and utilization from FY 2009. Since the B1/B2 ratio using the FY 2009 data exceeds 1.05 for inpatient and 1.13 for outpatient it is anticipated that the test using FY 2010 data will result in ratios well above the minimum of 1.00 to gain automatic approval of the waiver.

Hold Harmless

The revenue from the fee is being used to support Medicaid payments. The hold harmless provisions of the Social Security Act are not violated.

- (A) The State does not provide (directly or indirectly) for a payment (other than Medicaid) to hospitals and the amount of Medicaid payment is not positively correlated either to the amount of the fee or to the difference between the amount of the fee and the amount of payment under the State plan.

(B) No portion of the Medicaid payment to hospitals varies based only upon the amount of the total fee paid.

(C) The State does not provide (directly or indirectly) for any payment, offset, or waiver that guarantees to hold hospitals harmless for any portion of the costs of the fee.

Total Amount of the Fee

The inpatient portion of the fee is \$590M which is less than 6% of the projected FY 2012 net inpatient revenue for Indiana hospitals.

The outpatient portion of the fee is \$19M and is less than 1% of the projected FY 2012 net outpatient revenue for Indiana hospitals.

The rates paid to providers in accordance with methods described in the preceding pages of Attachment 4.19-A for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 5% reduction for services on and after January 1, 2010. The 5% rate reduction will remain in effect through June 30, 2011 and will be replaced by a hospital adjustment factor.

For the period of July 1, 2011 through June 30, 2013, Indiana Hospital rates are subject to a hospital adjustment factor that may be changed but no more frequently than every 6 months. The hospital adjustment factors will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits.

A test will be made following the close of each state fiscal year to assure that annual inpatient payments do not exceed total inpatient billed charges for the fiscal year. Payments in excess of billed charges will be recovered. As permitted by 42 CFR 447.271(b), nominal charge hospitals identified in IC 12-15-15-11 are not subject to the inpatient charge limitation above.

The initial hospital adjustment factor for the DRG Base rate is 3.00.
The initial hospital adjustment factor for Psych Level of Care rates is 2.20.
The initial hospital adjustment factor for acute care hospital Rehab Level of Care rates is 3.00.
The initial hospital adjustment factor for Burn Level of Care rates is 1.00.

The adjustment factors above apply to acute care hospitals licensed under IC 16-21, except for those specified below, and psychiatric institutions licensed under IC 12-25.

The hospital adjustment factor is 0.95 for:

- Long term care hospitals
- Out-of-state hospitals
- Freestanding Rehabilitation hospitals.

The following sections of the State Plan do not apply for the period of July 1, 2011 through June 30, 2013:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Inpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals.
- High Volume Outlier Payment Adjustment

The agency's rates are published in provider bulletins which are accessible through the agency's website, www.indianamedicaid.com.

TN: 11-022

Supersedes

TN: 11-005

Approval Date: _____

Effective Date: July 1, 2011

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

Disproportionate Share Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment calculated in the following manner for SFY 2012 and SFY 2013:

In no instance will any Disproportionate Share Hospital payments exceed the hospital specific limit as defined in subsection B 1. The provisions in subsection B 1 are applicable for SFY 2012 and SFY 2013 and also apply to DSH eligible freestanding psychiatric institutions licensed under IC 12-25. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered by the office. Any DSH allotment recovered by the office may be redistributed to other DSH eligible hospitals in accordance with the payment order below, not to exceed any hospital's hospital specific limit.

Any Disproportionate Share Hospital may decline all or part of the annual DSH payments by submitting documentation to the State indicating that it declines the DSH payments and the amount of DSH payments being declined.

- Step One: Each Disproportionate Share Hospital receives a payment of \$1,000, not to exceed the hospital's hospital specific limit.
- Step Two: Municipal Disproportionate Share Providers established and operated under Indiana Code 16-22-2 or 16-23 receive payment amounts equal to the lower of the hospital's hospital specific limit for the payment year less any Step One amount received by that hospital; or the hospital's net 2009 supplemental payment amount.
- Step Three: DSH eligible acute care hospitals licensed under IC 16-21 located in Lake County, Indiana receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any Step One amount received by that hospital.
- Step Four: DSH eligible private acute care hospitals licensed under IC 16-21 and DSH eligible hospitals established and operated under Indiana Code 16-22-8 receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital under step one. If not enough DSH funds are available to pay all eligible hospitals in this group up to their respective hospital specific limits, the amount paid to each hospital will be reduced by the same percentage for all hospitals in the group.
- Step Five: If there is DSH remaining after the above steps, DSH eligible freestanding psychiatric institutions licensed under IC 12-25 receive payment amounts equal to the institution's hospital specific limit for the payment year, less any payment received by the institution under step one. If not enough DSH funds are available to pay all eligible institutions in this group up to their respective hospital specific limits, 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.

Disproportionate share hospital payments described in this section may be made on an interim basis throughout the year as determined by the office.

The disproportionate share payment adjustment calculations described below and in subsections B 2 and C through G do not apply for SFY 2012 and SFY 2013.

- (1) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars (\$2,000,000) shall be distributed to all qualified private psychiatric DSH's licensed by the director of the state department of health to provide private institutional psychiatric care, whose Medicaid inpatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana and/or whose low income utilization rate exceeds twenty-five percent (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each qualifying hospital's Medicaid inpatient utilization rate bears to the total of the Medicaid inpatient utilization rates of all hospitals in the pool as determined based on data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital. In no instance will any hospital in this pool be entitled to disproportionate share amounts that when added to the hospital's payments associated with Medicaid and uninsured care yield a combined total reimbursement that exceeds 100% of the hospital's allowable cost of delivering Medicaid and uninsured care. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered by the office.
- (2) For each state fiscal year ending on or after June 30, 1995, a pool not exceeding one hundred ninety-one million dollars (\$191,000,000) shall be distributed to all state mental health DSH's whose inpatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana or whose low income utilization rate exceeds twenty-five percent (25%). The fund in this pool must be distributed to the qualifying hospitals in the proportion that each hospital's low income utilization rate, multiplied by total Medicaid days, bears to the product of the same factors of all hospital in the pool using data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital.

TN No. 11-022

Supersedes

TN No. New

Approval Date _____

Effective Date July 1, 2011

Outpatient Hospital Services

The rates paid to outpatient hospital providers for services provided on and after January 1, 2010, and in accordance with methods described in Attachment 4.19-B in the Outpatient Hospital Services section are subject to a 5% reduction. The 5% rate reduction will remain in effect through June 30, 2011 and will be replaced by an outpatient hospital adjustment factor.

For the period of July 1, 2011 through June 30, 2013, Indiana outpatient hospital rates are subject to an outpatient hospital adjustment factor that may be changed but no more frequently than every 6 months. The outpatient hospital adjustment factors will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits.

The initial outpatient hospital adjustment factor is 3.50 for:

- Acute care hospitals licensed under IC 16-21, except for those specified below
- Psychiatric institutions licensed under IC 12-25

The outpatient hospital adjustment factor is 0.95 for:

- Long term care hospitals
- Freestanding rehabilitation hospitals
- Out-of-state hospitals
- Clinical laboratory services

The following sections of the State Plan do not apply for the period of July 1, 2011 through June 30, 2013:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Outpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's rates are published in provider bulletins which are accessible through the agency's website.

The State's website, www.indianamedicaid.com, allows providers access to the provider manual as well as all provider bulletins. The revenue codes and current rates can be found via the website as noted below.

Revenue Codes: <http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter08.pdf>

Current rates and codes: Provider Bulletin BT200129

TN: 11-023

Supersedes

TN: 11-006

Approval Date: _____

Effective Date: July 1, 2011

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS
OUTPATIENT HOSPITAL SERVICES

Outpatient cost, payment, and utilization data is included per federal regulations and Indiana Medicaid policy within the Inpatient Disproportionate Share Hospital Payments of Attachment 4.19A.

DRAFT

TN: 11-023
Supersedes
TN: 92-09

Approval Date: _____

Effective Date: July 1, 2011