Anthem Blue Cross and Blue Shield

Hospital Assessment Fee
Agenda

- HAF policy overview
- Eligible and ineligible hospitals
- Hospital eligibility
- Reimbursement
- Reimbursement calculation
- Anthem’s HAF role
The Indiana Family and Social Services Administration (FSSA) implemented a hospital assessment fee (HAF) in accordance with Public Law 229-2011, SECTION 281 as enacted by the 2011 Session of the Indiana General Assembly.

www.in.gov/legislative/bills/2012/HE/HE1001.1.html

- Permits increases in hospital inpatient and outpatient reimbursement.
- Aggregate payments that reasonably approximate the Medicare upper payment limits without exceeding those limits.
- Effective July 1, 2011, for two years.
  - Extended to June 30, 2015
- Applies to all Anthem Medicaid programs: Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect
Eligible and ineligible hospitals

Eligible hospitals

• In-state acute care hospitals licensed under IC 16-21-2
• Freestanding psychiatric hospitals licensed under IC 12-25

Ineligible hospitals

• 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 FSSA of the change within 30 days.

Hospitals should submit this notification in writing to:

Myers and Stauffer, LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240
Reimbursement

The increases in inpatient and outpatient reimbursement will result in aggregate payments that reasonably approximate the Medicare upper payment limits, without exceeding those limits.

Effective September 27, 2014, for dates of service beginning August 1, 2014, increases in reimbursement will be based on the following adjustment factors:

- Inpatient diagnosis related group (DRG) base rate: 2.1
- Inpatient rehabilitation level of care (LOC) rate: 2.6
- Inpatient psychiatric LOC rate: 2.2
- Inpatient burn LOC rate: 1.0
- Outpatient rates (excluding laboratory): 2.7
Reimbursement

For **inpatient admissions** that occurred before **August 1, 2014**, hospitals will receive the HAF increase based on adjustment factors and parameters posted in IHCP bulletin BT201412, even if the discharge date was after **August 1, 2014**.

For **outpatient claims**, the adjustment factors will apply to claim detail lines with dates of service on or after **August 1, 2014**. 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.

Outpatient laboratory services will continue to be subject to the applicable reimbursement reduction.

**Note:** For hospitals participating in HAF, the 5% inpatient and outpatient reductions effective for dates of service **January 1, 2010** through **December 31, 2013**, and the 3% reimbursement reduction effective dates of service **January 1, 2014** through **June 30, 2015**, (see IHCP CT201331) will not apply while HAF is in effect, except for the reduction in outpatient laboratory services.
Reimbursement methodology is applied to the:

- Inpatient DRG base rate
- Inpatient LOC *per-diem* rates
- Outpatient rates

HAF calculation does not include:

- Outliers
- Capital costs
- Medical education reimbursement
- Previous 5% reimbursement reduction
The calculation of the assessment fee is:

- Based on hospital cost report
- Hospital cost reports must be filed timely with Myers and Stauffer, LC

If FSSA determines that the assessment fee amount collected, either during retroactive adjustments or subsequent monthly collections, is not correct:

- Adjustments will be made in the future months to increase or reduce subsequent assessment fee amounts to correct the error.
Reimbursement for Healthy Indiana Plan

Hospital claims (inpatient and outpatient) for members in the low-income parent/caretaker plans are paid at Medicaid rates.

Hospitals will also receive hospital assessment fee wraparound payment.
Anthem Blue and Cross Blue Shield (Anthem) receives a monthly report from FSSA with the amount to be paid.

- Payments based on historical utilization

Anthem will generate payments and distribute to eligible hospitals the month following receipt of FSSA report.

- FSSA reports received at end of each month

Average time to pay will be 10 days.

- From receipt of FSSA monthly report to the first of the following month when checks are mailed
Helpful resources

Anthem Hoosier Healthwise Provider Helpline: 1-866-408-6132
Anthem Healthy Indiana Plan Provider Helpline: 1-800-345-4344
Anthem Website


IHCP website

www.indianamedicaid.com

IHCP Bulletins

BT 201443 – September 25, 2014

BT201412 – March 27, 2014
www.indianamedicaid.com/ihcp/Bulletins/BT201412.pdf

BT201217 – Mary 22, 2012
http://provider.indianamedicaid.com/ihcp/Bulletins/BT201217.pdf