TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #15-372(F)

DIGEST

Adds 405 IAC 1-8-5 and 405 IAC 1-10.5-7 to implement an assessment fee on certain hospitals and reimbursement methodology changes authorized by P.L.205-2013, SEC. 214 (codified at IC 16-21-10). The hospital assessment fees will be used to cover the nonfederal share of disproportionate share hospital payments as well as to increase Medicaid inpatient and outpatient payment rates to the aggregate level of reimbursement that would be paid under Medicare payment principles. These statutory changes are effective July 1, 2013, and continue through June 30, 2017. Effective 30 days after filing with the Publisher.

405 IAC 1-8-5; 405 IAC 1-10.5-7

SECTION 1. 405 IAC 1-8-5 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-8-5 Outpatient hospital assessment fee

Authority: IC 12-15-21-2; IC 12-15-21-3; IC 16-21-10-16
Affected: IC 4-21.5-3; IC 12-15-15-1; IC 12-15-21-3; IC 12-25; IC 16-18-2-179; IC 16-21-2; IC 16-21-10

Sec. 5. (a) Effective through June 30, 2017, the office shall collect an outpatient hospital assessment fee (HAF) from each outpatient hospital that:
(1) meets the definition set forth in IC 16-18-2-179(b); and
(2) is licensed under either:
(A) IC 16-21-2 as an acute care hospital; or
(B) IC 12-25 as a private psychiatric hospital.

(b) The outpatient hospital assessment fee applies to equivalent outpatient days. Equivalent outpatient days are derived by dividing each hospital's outpatient revenue by its inpatient revenue per day. Each hospital's equivalent outpatient days will be reduced to account for services provided to patients residing outside of Indiana. Cost report data shall be obtained from each eligible hospital's most recent cost report on file with the office, as of the last day of February preceding the HAF period, defined in subsection (c). Cost report data will be adjusted to account for fiscal years other than twelve (12) months and to exclude hospitals that have closed. Hospitals that are newly licensed in the HAF period that do not have a cost report on file with the office as of the last day of February preceding the HAF period defined in subsection (c) will be excluded from the assessment fee. For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) and that do not have a cost report on file, information for computing the assessment fee will be obtained from the hospital by the office or its designee.

(c) The HAF period is defined as separate two (2) year periods during the fee period, defined at IC 16-21-10-3.

(d) The following hospitals are excluded from the assessment fee:
(1) Long term care hospitals.
(2) State-owned hospitals.
(3) Hospitals operated by the federal government.
(4) Freestanding rehabilitation hospitals.
(5) Freestanding psychiatric hospitals with:
(A) greater than forty percent (40%) of admissions having a primary diagnosis of chemical dependency; or
(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging. A freestanding psychiatric hospital that was certified as part of a community mental health center at any time during the HAF period is subject to the assessment fee.

(6) Out-of-state hospitals.

(e) The assessment fee rate for the following hospitals shall be reduced by the following percentages:
(1) Seventy-five percent (75%) of the full rate for:
(A) hospitals qualifying for disproportionate share hospital (DSH) payments during each HAF period through meeting Medicaid inpatient utilization rate (MIUR) criteria; or
(B) acute care hospitals that:
(i) qualify for DSH payments during each HAF period through meeting low income utilization rate (LIUR) criteria; and
(ii) did not have LIUR status in 2010.
(2) Fifty percent (50%) of the full rate for acute hospitals that:
(A) qualify for DSH payments during each HAF period through meeting LIUR criteria; and
(B) met LIUR status in 2010.
(3) Fifty percent (50%) of the full rate for psychiatric hospitals qualifying for DSH payments during each HAF period through meeting LIUR criteria.
(4) Fifty percent (50%) of the full rate for all hospitals qualifying for DSH payments during each HAF period when more than twenty-five percent (25%) of the hospital's Medicaid days are provided to patients residing outside Indiana.

(f) The office or its contractor shall notify each hospital of the amount of the hospital's assessment after the amount of the assessment has been computed. If the hospital disagrees with either the computation or the amount of the assessment, the hospital may request an administrative reconsideration by the Medicaid rate-setting contractor. A reconsideration request shall meet the following requirements:
(1) Be in writing.
(2) Contain the following:
(A) Specific issues to be reconsidered.
(B) The rationale for the hospital's position.
(3) Be signed by the authorized representative of the hospital.
(4) Be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.
Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the hospital of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. If the rate-setting contractor does not make a timely response to the hospital's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

(g) The office shall collect the assessment fee for a hospital as follows:
(1) Offset the amount owed against either of the following:
(A) A Medicaid payment to the hospital.
(B) A Medicaid payment to another provider that is related to the hospital through common ownership or control.
(2) In another manner determined by the office.

(h) A hospital may file a request to pay the assessment fee on an installment plan. The request shall be:
(1) made in writing setting forth the hospital's rationale for the request; and
(2) submitted to the office or its designee.
If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. The installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and shall include provisions for the collection of interest. The interest shall not exceed the percentage determined in IC 12-15-21-3(6)(A).

(i) If a hospital fails to pay the assessment fee due under this section within ten (10) days after the date

the payment is due, the hospital shall pay interest on the assessment fee at the same rate as determined under IC 12-15-21-3(6)(A).

(j) For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital shall remit the assessment fee to the state of Indiana within ten (10) days after the due date. If a hospital fails to pay the hospital assessment under this subsection within ten (10) days after the due date, the hospital shall pay interest on the assessment fee at the rate as determined under IC 12-15-21-3(6)(A).

(k) If a hospital fails to pay the assessment fee within one hundred twenty (120) days after the payment is due, the office shall report the hospital to the Indiana state department of health to initiate license revocation proceedings.

(l) For hospitals certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital assessment fee shall be an allowable cost for cost reporting and auditing purposes.

(m) The office may adjust the assessment fee to incorporate DSH eligibility information for each HAF period and to make changes as necessary to the assessment fee because of administrative reconsideration requests and appeals. Adjustments of the assessment fee as a result of administrative reconsideration requests or appeals are available only for reconsideration requests and appeals filed timely in accordance with subsection (f). If the assessment fee is adjusted as described in this subsection, the determination of the assessment fee as adjusted for each HAF period will be final and shall not be subject to additional reconsideration requests or appeals.

(n) For the fee period, as defined at IC 16-21-10-3, outpatient hospital rates are subject to an outpatient hospital adjustment factor that may be changed but not more frequently than every six (6) months. The outpatient hospital adjustment factors shall result in aggregate payments that reasonably approximate the federal Medicare upper payment limit under 42 CFR 447.321, but shall not result in payments in excess of the federal Medicare upper payment limit. The outpatient hospital adjustment factors are as follows:

(1) The initial outpatient hospital adjustment factor is three and twenty-hundredths (3.20) for the following:

(A) Acute care hospitals licensed under IC 16-21, except for those specified in subdivision (2).

(B) Psychiatric institutions licensed under IC 12-25.

(2) For the period through June 30, 2015, the outpatient hospital adjustment factor is ninety-seven hundredths (0.97), and thereafter is one (1.0), for the following:

(A) Long term care hospitals.

(B) Freestanding rehabilitation hospitals.

(C) Out-of-state hospitals.

(D) Clinical laboratory services.

(o) For the period through June 30, 2017, the limitation on payments for an individual claim to the lesser of the amount computed or billed charges shall not apply.

(Office of the Secretary of Family and Social Services; 405 IAC 1-8-5; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)

SECTION 2. 405 IAC 1-10.5-7 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-10.5-7 Inpatient hospital assessment fee

Authority: IC 12-15-21-2; IC 12-15-21-3; IC 16-21-10-16
Affected: IC 4-21.5-3; IC 12-15-15-1; IC 12-15-15-11; IC 12-15-21-3; IC 12-25; IC 16-18-2-179; IC 16-21-2; IC 16-21-10

Sec. 7. (a) Effective through June 30, 2017, the office shall collect an inpatient hospital assessment fee (HAF) from each inpatient hospital that:

(1) meets the definition set forth in IC 16-18-2-179(b); and
(2) is licensed under either:
(A) IC 16-21-2 as an acute care hospital; or
(B) IC 12-25 as a private psychiatric hospital.

(b) The inpatient hospital assessment fee applies to inpatient days from each eligible hospital's most recent cost report on file with the office as of the last day of February preceding the HAF period, defined in subsection (c). Cost report data will be adjusted as follows:
(1) To account for fiscal years other than twelve (12) months.
(2) To exclude hospitals that have closed.
Hospitals that are newly licensed in each HAF period that do not have a cost report on file with the office as of the last day of February preceding the HAF period, defined in subsection (c), shall be excluded from the assessment fee. For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) and that do not have a cost report on file, information for computing the assessment fee will be obtained from the hospital by the office or its designee. For purposes of computing the assessment fee, the total number of inpatient hospital days shall include days for sub-providers, employee discount days, and labor and delivery days. Days on which services are provided to patients residing outside of Indiana shall be excluded from the assessment fee.

(c) The HAF period is defined as separate two (2) year periods during the fee period, defined at IC 16-21-10-3.

(d) If a hospital's cost report that is used for purposes of calculating the hospital's assessment fee for the HAF period includes inpatient days attributable to a distinct part rehabilitation or psychiatric unit of the hospital that was terminated by the hospital prior to or during that HAF period, the date of the unit's termination as stated in the letter referenced in subdivision (1) shall be deemed to be the date of termination, and the assessment fee for the hospital for that HAF period shall be adjusted consistent with the process for adjusting fees for the closing of hospitals, provided that the hospital:
(1) provides written notice to the Indiana state department of health of the termination of the distinct part unit, along with an effective date of the termination;
(2) no longer provides rehabilitation or psychiatric services in the physical space where the distinct part unit was located, beginning no later than the effective date of termination;
(3) does not relocate any of the services previously provided in the distinct part unit to another part of the hospital;
(4) does not replicate in another part of the hospital any of the services previously provided in the distinct part unit; and
(5) provides the office with a copy of the letter referenced in subdivision (1) and written confirmation of the hospital's compliance with the requirements of subdivisions (2) through (4) within fifteen (15) days following the effective date of termination stated in the letter referenced in subdivision (1).

(e) The following hospitals shall be excluded from the assessment fee:
(1) Long term care hospitals.
(2) State-owned hospitals.
(3) Hospitals operated by the federal government.
(4) Freestanding rehabilitation hospitals.
(5) Freestanding psychiatric hospitals with:
(A) greater than forty percent (40%) of admissions having a primary diagnosis of chemical dependency; or
(B) greater than ninety percent (90%) of admissions comprised of individuals at least fifty-five (55) years of age having a primary diagnosis of Alzheimer's disease, early onset Alzheimer's disease, dementia, mood disorders, anxiety, psychotic disorders, other behavioral health illnesses or disorders, or neurologic disorders related to trauma or aging. A freestanding psychiatric hospital that was certified as part of a community mental health center at any time during the HAF period is subject to the assessment fee.
(6) Out-of-state hospitals.

(f) The assessment fee rate for the following hospitals shall be reduced by the following percentages:
(1) Seventy-five percent (75%) of the full rate for:

(A) hospitals that qualify for disproportionate share hospital (DSH) payments during each HAF period through meeting Medicaid inpatient utilization rate (MIUR) criteria; or
(B) acute care hospitals that:
(i) qualify for DSH payments during each HAF period through meeting low income utilization rate (LIUR) criteria; and
(ii) did not have LIUR status in 2010.
(2) Fifty percent (50%) of the full rate for acute hospitals that qualify for DSH payments during the fee period through meeting LIUR criteria and that met LIUR status in 2010.
(3) Fifty percent (50%) of the full rate for psychiatric hospitals that qualify for DSH payments during each HAF period through meeting LIUR criteria.
(4) Fifty percent (50%) of the full rate for all hospitals that qualify for DSH payments during each HAF period when more than twenty-five percent (25%) of the hospital's Medicaid days are provided to patients residing outside Indiana.

(g) The office or its contractor shall notify each hospital of the amount of the hospital's assessment after the amount of the assessment has been computed. If the hospital disagrees with the computation or the amount of the assessment, the hospital may request an administrative reconsideration by the Medicaid rate-setting contractor. The reconsideration request shall meet the following requirements:
(1) Be in writing.
(2) Contain the following:
(A) Specific issues to be reconsidered.
(B) The rationale for the hospital's position.
(3) Be signed by the authorized representative of the hospital.
(4) Be received by the contractor within forty-five (45) days after the notice of the assessment is mailed.
Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the assessment or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the hospital of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. If a timely response is not made by the rate-setting contractor to the hospital's reconsideration request, the request shall be deemed denied and the provider may initiate an appeal under IC 4-21.5-3.

(h) The office shall collect the assessment fee for a hospital as follows:
(1) Offset the amount owed against either of the following:
(A) A Medicaid payment to the hospital.
(B) A Medicaid payment to another provider that is related to the hospital through common ownership or control.
(2) In another manner determined by the office.

(i) A hospital may file a request to pay the assessment fee on an installment plan. The request shall be:
(1) made in writing setting forth the hospital's rationale for the request; and
(2) submitted to the office or its designee.
If the office or its designee approves the hospital's request, the office or its designee and the requesting hospital shall enter into a written agreement for an installment plan. An installment plan established under this section shall not exceed a period of six (6) months from the date of execution of the agreement. The agreement shall set forth the amount of the assessment that shall be paid in installments and include provisions for the collection of interest. The interest shall not exceed the percentage determined under IC 12-15-21-3(6)(A).

(j) If a hospital fails to pay the assessment fee due under this section within ten (10) days after the date the payment is due, the hospital shall pay interest on the assessment fee at the rate determined under IC 12-15-21-3(6)(A).

(k) For hospitals that are not certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital shall remit the assessment fee to the state of Indiana within ten (10) days after the due date. If a hospital fails to pay the assessment fee due under this subsection within ten (10) days after the payment is due, the hospital shall pay interest on the

assessment fee at the rate determined under IC 12-15-21-3(6)(A).

(l) If a hospital fails to pay the assessment fee within one hundred twenty (120) days after the payment is due, the office shall report the hospital to the Indiana state department of health to initiate license revocation proceedings.

(m) For hospitals certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the hospital assessment fee shall be an allowable cost for cost reporting and auditing purposes.

(n) The office may adjust the assessment fee to incorporate DSH eligibility information for each HAF period and to make changes as necessary to the assessment fee as a result of administrative reconsideration requests and appeals. Adjustments of the assessment fee as a result of administrative reconsideration requests and appeals are available only for reconsideration requests and appeals filed timely in accordance with subsection (g). If the assessment fee is adjusted as described in this subsection, the determination of the assessment fee for each HAF period shall be final and shall not be subject to additional reconsideration requests or appeals.

(o) For the fee period, as defined at IC 16-21-10-3, inpatient hospital rates are subject to an inpatient hospital adjustment factor that may be changed but not more frequently than every six (6) months. The inpatient hospital adjustment factors shall result in aggregate payments that reasonably approximate the federal Medicare upper payment limit under 42 CFR 447.272, but shall not result in payments in excess of the federal Medicare upper payment limit. The initial inpatient hospital adjustment factors are as follows:
(1) The initial hospital adjustment factor for the DRG base rate is three (3.00).
(2) The initial hospital adjustment factor for psychiatric level of care rates is two and twenty-hundredths (2.20).
(3) The initial hospital adjustment factor for acute care hospital rehabilitation level of care rates is three (3.00).
(4) The initial hospital adjustment factor for burn level of care rates is one (1.00).

(p) The inpatient hospital adjustment factors in subsection (o) apply to the following:
(1) Acute care hospitals licensed under IC 16-21, except for those specified in subsection (q).
(2) Psychiatric institutions licensed under IC 12-25.

(q) For the period through June 30, 2015, the inpatient hospital adjustment factor is ninety-seven hundredths (.97), and thereafter is one (1.0), for the following:
(1) Long term care hospitals.
(2) Freestanding rehabilitation hospitals.
(3) Out-of-state hospitals.

(r) Effective through June 30, 2017, the limitation on payments for an individual claim to the lesser of the amount computed or billed charges shall not apply to those hospitals eligible for the HAF adjustments.

(s) Following the close of each state fiscal year, the office or its contractor shall perform a test to ensure that annual aggregate inpatient payments to a hospital do not exceed the hospital's total inpatient billed charges for the fiscal year. Annual aggregate inpatient payments to a hospital in excess of the hospital's billed charges for the fiscal year shall be recovered by the office or its designee. As permitted by 42 CFR 447.271(b), payments to nominal charge hospitals identified in IC 12-15-15-11 are not subject to this inpatient billed charge limitation.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-7; filed Sep 16, 2016, 4:41 p.m.: 20161012-IR-405150372FRA)

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