



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Hospital Assessment Fee

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the [IHCP Bulletins](#) page at [in.gov/medicaid/providers](#):

- [BT2024106](#) – IHCP announces HAF adjustment factors for outpatient and inpatient rates
- [BT202389](#) – IHCP revises Hospital Assessment Fee adjustment factor for outpatient and inpatient rates

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7.1	Policies and procedures as of Jan. 1, 2023 Published: March 3, 2025	Interim update: <ul style="list-style-type: none">• Added note on title page pointing to <i>IHCP Bulletins BT2024106 and BT202389</i>	FSSA and Gainwell

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		<ul style="list-style-type: none">Added footnote to <u>Table 1 – Adjustment Factors for Inpatient Rates</u>	

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Hospital Assessment Fee

Note: All Indiana Health Coverage Programs (IHCP) acute care hospitals, municipal county hospitals, community mental health centers (CMHCs), state psychiatric hospitals and private psychiatric hospitals should refer to IHCP State Plan: Attachment 4.19A for information about participation in the following payment programs:

- *Hospital Care for the Indigent (HCI) Payment*
- *Municipal County Hospital Indiana Medicaid Shortfall Payment*
- *Indiana Medicaid Disproportionate Share Hospital (DSH) Payment*
- *Safety-Net Hospital Payment*
- *Supplemental Private Hospital Adjustment*

For updates to information in this module, see [IHCP Banner Pages](#) and [IHCP Bulletins](#) at in.gov/medicaid/providers.

Introduction

The Indiana Family and Social Services Administration (FSSA) implemented a Hospital Assessment Fee (HAF) program in accordance with *Public Law 229-2011, Section 281*, as enacted by the 2011 Session of the Indiana General Assembly. The initial HAF program was effective for the period of July 1, 2011, through June 30, 2013. *House Enrolled Act (HEA) 1001 (2013)* added *Indiana Code IC 16-21-10*, and subsequent legislation further extended the HAF program. The fee is currently in place through June 30, 2023.

The HAF is used, in part, to increase reimbursement to eligible hospitals for services provided to IHCP fee-for-service and managed care members, and as the state's share of disproportionate share hospital (DSH) payments. The reimbursement increases, as well as collection of the assessment fees, will continue through the duration of the HAF program.

Before the implementation of the HAF program, providers (other than nominal-charge hospitals identified in *IC 12-15-15-11*) were reimbursed the lower of their submitted charges or the Medicaid allowed amount for all hospital services. For HAF-participating hospitals, the limitation on payment to the lesser of the Medicaid allowed amount or the provider's billed charges is suspended. Upon calculation of the HAF payment, the provider may receive an amount in excess of the billed charges.

Eligible and Ineligible Hospitals

HAF-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 program:

- Long-term acute care (LTAC) hospitals
- State-owned hospitals
- Hospitals operated by the federal government
- Freestanding rehabilitation hospitals
- Out-of-state hospitals (including out-of-state hospitals that have been designated as in-state for prior authorization purposes)

If a HAF-participating hospital becomes ineligible for the HAF program, or if an IHCP-enrolled hospital that was previously ineligible for the HAF program becomes eligible (including newly enrolling hospitals), the hospital must notify the FSSA of the change within 30 days.

Hospitals should submit this notification in writing to the following address:

Myers and Stauffer LC
800 E. 96th St., 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.

Reimbursement Increases and Other Payment Changes

The following reimbursement information applies to HAF-participating hospitals only.

The HAF reimbursement increases apply to both fee-for-service claims and claims paid by managed care entities (MCEs) – including claims for Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise members. The HAF reimbursement increases do **not** apply to claims for members of the 590 Program.

The HAF reimbursement increase does not apply to the following services billed on an outpatient claim:

- Laboratory procedure codes listed on the Medicare Clinical Laboratory Fee Schedule, available from the [Clinical Laboratory Fee Schedule](#) page at cms.gov
- Drug procedure codes linked to revenue code 636 – *Pharmacy (Extension of 025X) – Drugs Requiring Detailed Coding*
- Durable medical equipment (DME) procedure codes linked to revenue code 274 – *Medical/Surgical Supplies and Devices – Prosthetic/Orthotic Devices*

The HAF increases in inpatient and outpatient reimbursement result in aggregate payments that reasonably approximate the Medicare upper-payment limits without exceeding those limits. The increases in reimbursement are based on the following adjustment factors, which are applied to the inpatient diagnosis-related group (DRG) base rate, inpatient level-of-care (LOC) per diem rates and outpatient rates.

Table 1 – Adjustment Factors for Inpatient Rates

Effective Dates	Inpatient DRG Base Adjustment Factor	Inpatient Rehabilitation LOC Adjustment Factor ¹	Inpatient Psychiatric LOC Adjustment Factor	Inpatient Burn LOC Adjustment Factor
Aug. 1, 2022 – TBD	3.5	2.6	3.2	1.0
Aug. 1, 2021 – July 31, 2022	3.1	2.6	3.0	1.0
Aug. 1, 2020 – July 31, 2021	3.2	2.6	2.2	1.0
Aug. 1, 2019 – July 31, 2020	2.7	2.6	2.2	1.0
Aug. 1, 2018 – July 31, 2019	3.1	2.6	2.2	1.0
July 1, 2017 – July 31, 2018	2.7	2.6	2.2	1.0
April 1, 2017 – June 30, 2017	2.5	2.6	2.2	1.0
Aug. 1, 2014 – March 31, 2017	2.1	2.6	2.2	1.0
July 1, 2013 – July 31, 2014	3.0	3.0	2.2	1.0
July 1, 2011 – June 30, 2013	3.0	3.0	2.2	1.0

¹ The inpatient rehabilitation LOC adjustment factor changed to 3.2 effective Aug. 1, 2023. All other adjustment factors remain the same.

Table 2 – Adjustment Factors for Outpatient Rates

Effective Dates	Outpatient Rate Adjustment Factor*
Aug. 1, 2022 – TBD	3.9
Aug. 1, 2021 – July 31, 2022	3.6
Aug. 1, 2020 – July 31, 2021	3.5
Aug. 1, 2019 – July 31, 2020	2.9
Aug. 1, 2018 – July 31, 2019	3.0
July 1, 2017 – July 31, 2018	2.7
April 1, 2017 – June 30, 2017	2.0
Aug. 1, 2014 – March 31, 2017	2.7
July 1, 2013 – July 31, 2014	3.2
May 1, 2013 – June 30, 2013	1.0
July 1, 2012 – April 30, 2013	3.5
May 1, 2012 – June 30, 2012	1.0
July 1, 2011 – June 30, 2013	3.5

** The adjustment factor does not apply to outpatient laboratory services, drugs or DME as previously noted.*

The adjustment factors listed in Tables 1 and 2 may be revised in the future to remain within the hospital upper payment limit. Providers are notified of any changes to the adjustment factors through an IHCP bulletin.

The increased payment due to HAF appears with adjustment reason code (ARC) 169 – *Alternate Benefit Provided*. In addition, designated explanations of benefits (EOB) alert the provider that the claims were reimbursed using the HAF methodology. These EOBs are informational only and do not cause claims to deny.

The EOB returned depends on the type of claim:

- Inpatient and inpatient crossover claims receive the header-level EOB 9032 – *Hospital Assessment Fee (HDR)*.
- Outpatient and outpatient crossover claims receive the detail-level EOB 9033 – *Hospital Assessment Fee (DTL)*.

In addition, the limitation on payments to the lesser of the IHCP allowed amount or the provider's billed charges is suspended for participating hospitals while the HAF is in effect. Because the submitted charges limitation does not apply to HAF-participating hospitals on a per-claim basis, the FSSA performs an annual comparison of aggregate inpatient payments to inpatient charges by hospital to ensure compliance with federal regulations. *Code of Federal Regulations 42 CFR 447.271* limits 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, the FSSA reviews paid claims data to ensure that no hospital has received Medicaid payments exceeding the hospital's charges for inpatient services. If a hospital receives aggregate Medicaid payments in excess of its inpatient charges, the hospital must repay the difference.

Outpatient HAF Reimbursement Methodology

For FFS outpatient claims submitted by HAF-participating hospitals, revenue codes reimbursed at a flat rate will have the HAF adjustment applied to the IHCP allowed amount (Outpatient Fee Schedule rate).

HAF-participating hospitals remain subject to the existing outpatient claim-processing logic that limits the number of units allowed for specific revenue codes, procedure codes or modifiers. If the provider bills more units than are allowed, the system will continue to cut back to the allowed number of units. The HAF increase is applied to the allowed amount for outpatient claim details after they have been subject to the unit cutback.

*Example: Revenue code XXX has an **allowed amount of \$10** and only **one unit** is allowed per day.*

*For outpatient services provided on Sept. 1, 2022, a HAF-participating hospital submits a claim for revenue code XXX with **five units** and a **billed amount of \$25**.*

*The system disregards the billed amount and reimburses **one unit** of revenue code XXX at the **allowed amount of \$10**, multiplied by the HAF outpatient **adjustment factor of 3.9**, for a total reimbursement of **\$39**.*

Inpatient DRG and Level-of-Care HAF Payment Policies

For HAF-participating hospitals, the IHCP allowed amount for inpatient services is calculated as follows for DRG outlier payment policies:

$$(\text{DRG Base Rate} \times \text{Inpatient Hospital Adjustment Factor}) + \text{Capital Costs Payment} + \\ \text{Medical Education Costs Payment (if applicable)} + \text{Outlier Payment (if applicable)}$$

For HAF-participating hospitals, the IHCP allowed amount for inpatient services is calculated as follows for LOC outlier payment policies:

$$(\text{LOC Per Diem Rate} \times \text{Inpatient Hospital Adjustment Factor}) + \text{Capital Costs Per Diem} + \\ \text{Medical Education Costs Per Diem (if applicable)} + \text{Outlier Payment (if applicable)}$$

The *inpatient hospital adjustment factor* is a multiplier used to increase the reimbursement rate for HAF-participating hospitals. For more information regarding DRG and LOC outlier payment, medical education cost payment, and capital cost payment, see the [Inpatient Hospital Services](#) module.

Waiver Liability and HAF Reimbursement

For members with a waiver liability, the increased HAF reimbursement does not apply until the members have met their monthly liability amount. Following current waiver liability policy, the billed charges on the claim are credited against the member's waiver liability. If the member has not met their waiver liability, the member will be responsible for the billed charges on the claim. When the member's waiver liability is met, the IHCP reimburses the provider the IHCP allowed amount (increased for the HAF as appropriate) minus the member's waiver liability on the claim, as follows:

- If a member is on waiver liability and the billed amount at the header is less than the remaining waiver liability balance, the HAF adjustment factor will not be applied.
- If the billed amount is greater than or equal to the remaining waiver liability balance at the header, the HAF adjustment factor will be applied to the allowed amount and the remaining waiver liability balance will be subtracted from the new HAF allowed amount.

Copayment Obligations and HAF Reimbursement

Some members are subject to copayments for certain services, as described in the [Member Eligibility and Benefit Services](#) module. The increased HAF reimbursement applies only to the allowed amount, after the copayment amount has been deducted.

Medicare and Medicare Advantage Plan Crossover Claims

The IHCP methodology for calculating the Medicaid payment amount on crossover claims remains unchanged for HAF-participating hospitals. Medicaid payment is still calculated as the lesser of the following:

- Medicaid allowed amount minus Medicare or Medicare Advantage Plan payment on the claim
Or
- Coinsurance and deductible for the claim

The Medicaid allowed amount is increased using the HAF adjustment factors described previously prior to calculating the Medicaid payment amount. Total payment for a crossover claim will not exceed the Medicare or Medicare Advantage Plan allowed amount. For more information about crossover claims, see the [Claim Submission and Processing](#) module.

Assessment Fee Collection

Myers and Stauffer, the rate-setting contractor for the state of Indiana, sends each hospital chief executive officer (CEO) or chief financial officer (CFO) a letter notifying them of their hospital's annual assessment fee amount for the non-HIP fees. FSSA Finance issues each hospital a notification regarding the HIP portion of the fees.

For all eligible Medicaid-enrolled hospitals, the fiscal agent for the IHCP collects a portion of the assessment fee through establishment of monthly accounts receivable, which are offset against the increases in fee-for-service reimbursement. Hospitals remit the remainder of the assessment fee by check. If the hospital's increased fee-for-service reimbursement in combination with the hospital's check payments does not cover the full amount of the assessment, the fiscal agent notifies the hospital of the outstanding accounts receivable balance, and the hospital is requested to remit a check for the difference.

In addition to the retroactive adjustments being performed, on a prospective basis, a monthly assessment fee amount is offset monthly by processing the new day claims received from the provider via an accounts receivable for the duration of the assessment fee. The monthly amount is calculated by dividing the total annual assessment fee amount into 12 equal portions. The accounts receivable appears on the hospital's Remittance Advice (RA) statement with the reason code 8494. If a hospital does not have sufficient Medicaid fee-for-service claim volume to offset the amount of the assessment fee, the fiscal agent uses current collection processes.

Disproportionate Share Hospital Payment Changes

In addition to funding the increase in hospital reimbursement, the HAF is also used to provide the state's share of funding for DSH payments to qualifying hospitals. Hospitals must meet DSH eligibility requirements as set out in the Indiana State Plan to be deemed a DSH-eligible hospital.

Note: Members who qualify for IHCP benefits are typically included in a hospital's DSH eligibility calculation. However, certain members qualifying for Children's Health Insurance Program (CHIP) coverage are excluded from the DSH eligibility calculation:

- All members qualifying under State-CHIP (SCHIP) are excluded from DSH eligibility calculations. These members are identified with the benefit plan: **Package C – Children's Health Plan (SCHIP)**.
- Certain members qualifying under Medicaid-CHIP (MCHIP) are excluded from DSH eligibility calculations. These members are identified with the benefit plan: **Package A – Standard Plan – CHIP**.

A DSH-eligible hospital may decline all or part of their DSH payments by notifying the FSSA that it declines the DSH payment and the amount of the payment being declined. For the period of the HAF, DSH payments are made in the following order:

1. Each DSH-eligible hospital receives a payment of \$1,000, not to exceed its 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 hospital's HSL for the payment year minus any payments received in the first payment, 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, minus any payment received in the first payment.
4. DSH-eligible private acute care hospitals licensed under *IC 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, minus any payment received by the hospital in the first payment. 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 is reduced by the same percentage for all hospitals in the group.
5. If DSH funds are remaining after the previous payments, DSH-eligible freestanding psychiatric institutions licensed under *IC 12-25* receive payment amounts equal to the institution's HSL for the payment year, minus any payment received in the first payment. 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 is 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.