Indiana Medicaid Update

HIP 2.0 Financing, Hospital Assessment Fee (HAF), and Other Updates

November 27, 2017

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Basics of the HAF

- Legal authority for fees
- Who is assessed or exempt
- Basis of fee
- Fee rates
- History of HAF Payment Factors
- Applying Payment Factors
- History of Total Fees
- HIP 2.0 Funding
- HAF vs HIP Fees

Legal Authority

- HAF exists in the Indiana Code as enacted by the General Assembly
- The Medicaid State Plan governs the HAF factors along with DSH eligibility and payment order
  - Changes must be submitted by the end of the first quarter of the SFY to be effective for a SFY
- There is a waiver from CMS that allows Indiana to make exceptions to fees so that they do not have to be “broad-based” and/or uniform
  - Changes in exemptions or fee rates require changes to the waiver and must meet statistical tests that prove the fee is not redistributive
- Changes to any of the above can create long delays

Who is Assessed or Exempt

- Facilities within the class that are assessed
  - Acute care hospitals
  - Freestanding psychiatric hospitals
- Facilities exempt from the fee
  - Long-term care hospitals
  - Freestanding rehabilitation hospitals
  - Hospitals owned by the state or federal government
  - Freestanding psychiatric hospitals with greater than 40% of admissions having a primary diagnosis of chemical dependency
  - Freestanding psychiatric hospitals with greater with > 90% of admissions comprised of individuals 55 or older having a primary diagnosis of Alzheimer's disease or certain neurologic disorders related to trauma or aging

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Basis of the Fee

- Fees are based on the total patient days and outpatient charges from cost reports on file at end of Feb. for each upcoming fee year
  - SFYs 2018-19 were based on reports on file Feb. 2017
- This data is the basis of a hospital's fees for a two-year period, but the amount assessed will change based on total program expenditures

Basis of the Fee

- Fees assessed on total days (not Medicaid days) capped at 6% of net statewide inpatient revenue
  - Days are net of out-of-state days
  - “Day is a day”; cannot be manipulated like other statistics
- Outpatient fee assessed for amount over 6% of net statewide inpatient revenue
  - Outpatient fee based on OP-equivalent patient days
  - Excludes MRO and non-UB billings if properly identified on the cost report
  - OP portion has increased with HIP

"Rate" of the Fee

- Three "tiers"
  - 100% of days (net of OOS days)
  - 75% of days for most acute care DSH hospitals,
  - 50% of days for psychiatric hospitals meeting the LIUR (low income utilization rate)

*The LIUR is determined during the Medicaid DSH Eligibility Surveys – next one early 2018

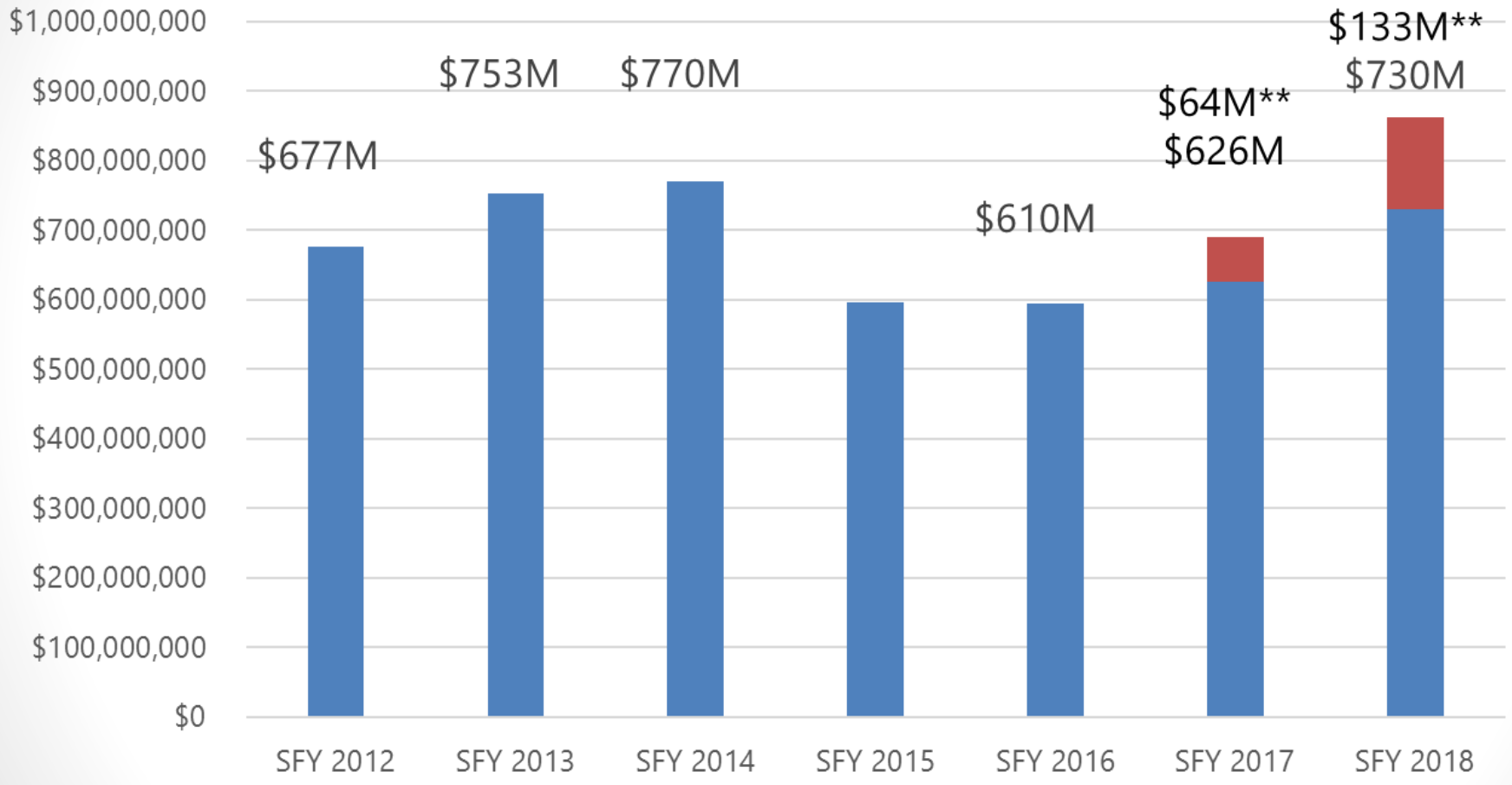
History of HAF Payment Factors

SERVICE	SFYs 2012-13	SFY 2014	SFY 2015 - 3/31/17	4/1/17-6/30/17	SFY 2018
Inpatient					
Base	3.0	3.0	2.1	2.5	2.7
Psych	2.2	2.2	2.2	2.2	2.2
Rehab	3.0	3.0	2.6	2.6	2.6
Burn	1.0	1.0	1.0	1.0	1.0
Outpatient	3.5	3.2	2.7	2.0	2.7

Applying Payment Factors

- Fee-for-service (FFS), Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and HIP claims should be reimbursed in similar manner
- Payment from Anthem, MDWise, MHS, and Caresource, should be consistent between MCEs
- HAF Factors applied at the claim level
  - Monthly lump sum checks from MCEs ended for 12/31/16 services
  - All add-on factors applied at claims level
- Laboratory services are still exempt from HAF outpatient factor – paid at fee schedule less 3%

History of Total Fees



** HIP 2.0 Fees

HIP 2.0 Funding

- Per Term Sheet, no HAF funding used until SFY 2017 for HIP 2.0 program (started July 1, 2016).
- Hospitals' obligation to fund these expenses ceases immediately if the waiver is terminated for any reason.

ACA Enhanced Medicaid Match

CY	FMAP
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

Enhanced Medicaid Match applied on State Fiscal Year

SFY	FMAP
2014	100%
2015	100%
2016	100%
2017	97.5%
2018	94.5%
2019	93.5%
2020	91.5%

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HAF VS HIP FEES

HAF Fees Fund…

- Difference between Medicaid fee schedule and "Medicare" for Traditional & Managed Care population (FFS, HHW, HCC)
- IP, OP, Psych and Distinct Part Rehab
- Medicaid DSH

HIP Fees Fund…

- Expansion population
- Medical expenses
- Limited administrative costs
- Increases to physician payments to 75% of Medicare

Legislative Issues

- HAF expires in state law June 30, 2019
- External threats, like legal challenges from net contributors
- Possible federal limitations, such as reducing 6% limit on provider fee programs
- Federal DSH reductions under ACA
  - Delayed until FY 2018 under H.R. 2

Non-HAF Funding Sources

- The portion of the tobacco tax that was established for funding HIP 1.0 will represent the "first dollar" commitment to the program, reducing the amount needed from the HAF (this revenue is currently about $112 M per year)

- In addition, the balance of the HIP Trust Fund will remain dedicated to the program, either for regular expenses or in case of a phase-out (current balance is around $338 M)

- IHA will work to explore other funding sources (other provider fees, excise taxes, etc.) in the future that could supplement HAF contributions

Hospital Assistance Program (HAP)

- Some hospitals are “net contributors” under the HAF program
- Voluntary 501(c)(3) “foundation” model
- Participation open to all, even non-members
- Net contributors within “winner” systems not eligible
- SFY 2012-16 completed
  - Five to seven eligible hospitals each year to-date
  - For 2012 through 2016, collected just under $2 M each year which was about 90% of the requested amounts

Thank you and Questions?

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