
Statewide Hospital Quality Care Assessment Frequently Asked Questions

Original 12.17.10; Revised 1.28.11; 2.8.13; 9.23.13; 8.1.15; 2.5.16

Statewide Hospital Quality Care Assessment

1. Q: Why are hospitals being assessed?

A: Federal regulations, CFR 42 Part 433 - Fiscal Administration, allows states to assess 19 classes of providers under a healthcare related tax and use the revenue as the State share to make Medicaid payments. Forty-nine states and the District of Columbia currently impose provider assessments on a variety of healthcare providers. In keeping with these Federal regulations, Act 49 of 2010 was passed by the Pennsylvania (PA) legislature on July 9, 2010, allowing for the creation of a Hospital Quality Care Assessment to be paid by approximately 180 covered facilities in Pennsylvania. Act 49 was later amended by Act 84 of 2010 and Act 22 of 2011. Act 55 of 2013 reauthorized this assessment for an additional three years, commencing July 1, 2013. Act 92 of 2015 further reauthorized this assessment through June 30, 2018. Revenues from the assessment are used to update Medical Assistance claims pricing under the fee-for-service system for inpatient hospital services, to establish new or revise existing supplemental or disproportionate share payments and increase reimbursement through HealthChoices Managed Care Plans for inpatient hospital services. Pursuant to Acts 49, 84, 22, 55, and 92 the state share of these changes is funded solely by revenues from the assessment.

2. Q: What types of hospitals are assessed?

A: All inpatient acute care general and freestanding rehabilitation hospitals located within the Commonwealth of Pennsylvania are assessed. The following hospitals are exempt from assessment: private and state-owned psychiatric hospitals; long term acute care hospitals; federal veterans' affairs hospitals; hospitals that do not charge for their services; hospitals defined as critical access hospitals under the Medicare program; and cancer hospitals.

3. Q: What approvals were necessary to implement the assessment?

A: The Center for Medicare & Medicaid Services (CMS) approved a waiver authorizing the Pennsylvania Department of Human Services (Department) to implement the quality care assessment as specified in Act 49 and a state plan amendment authorizing the changes to its payment methods and standards. CMS also approves the HealthChoices agreements annually which require the Managed Care Organization (MCO) to demonstrate that the additional funding is being spent on inpatient acute care services.

4. Q: What is the assessment rate that is imposed?

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A: Act 49 of 2010 and a final public notice published January 22, 2011 authorized the Department of Human Services (Department) to assess each covered hospital 2.95% of the net inpatient revenue of the covered hospital. Act 84 of 2010 and Act 55 of 2013 authorized the Department to assess each covered hospital 3.22% of the net inpatient revenue of the covered hospital. Act 92 of 2015 authorized the Department to assess each covered hospital 3.71% of the net inpatient revenue of the covered hospital. The Department issues an Annual Assessment Notice to each hospital annually detailing the hospital's assessment amount for the fiscal year. As legislation is developed for future assessment years, the percentage of assessment may be revised.

5. Q: How is my quarterly assessment being determined?

A: Each hospital's assessment for a fiscal year is determined by multiplying the assessment percentage for the year by the hospital's net inpatient revenue amount. For SFY 2015-2016, the SFY 2010-2011 Medical Assistance Cost Report is the revenue source utilized for the net inpatient revenue amount. As described in question 4 a hospital's quarterly assessment is a pre-determined percentage of their net inpatient revenue amount identified in the Annual Assessment Notice. As legislation is developed for future assessment years, consideration may be given to updating the Cost Report year as the basis of the hospitals' assessment amount.

For purposes of assessing new hospitals, the data used to determine the assessment is based on forms specified by the Department as identified in the hospital's records for the most recent state fiscal year, or part thereof. If the Medical Assistance Cost Report information is not available, the Pennsylvania Health Care Cost Containment (PHC4) data is used for the net inpatient revenue amount. For newer hospitals if both the 2010-2011 Medical Assistance Cost Report and the PHC4 data is not available, the 2011-2012 Medical Assistance Cost Report data will be the source used to determine a new hospital's net inpatient revenue amount.

Once the assessment amount is determined for the fiscal year, the Department issues an Annual Assessment Notice to each covered hospital detailing the hospital's assessment amount for the fiscal year. Assessment payments are due in accordance with each Quarterly Notice issued by the Department to each covered hospital.

6. Q: Am I able to review the revenue amount for my hospital?

A: Yes, a process has been established for each hospital to confirm the net inpatient revenue amount that is used to establish the hospital's assessment amount. Each year hospitals are given 30 days to review and confirm their net inpatient revenue amount prior to the Annual Assessment Notice being issued. Hospitals can dispute their net inpatient revenue amount by clicking on the Dispute button on their NIR notice posted in the PROMISe web portal. Additional

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documentation to validate the dispute will be required to be sent to the Department within 30 days of the posting date on the NIR notice.

7. Q: How often will the assessment occur?

A: Assessment payments are due quarterly. The Department issues an Annual Assessment Notice to each covered hospital for which an assessment is due. This Annual Assessment Notice is not a bill, but rather notifies the hospital of the total assessment amount due for the fiscal year. At least thirty days (30) prior to the due date of each quarterly assessment, the Department will issue a Quarterly Notice to each covered hospital. The assessment due date and amount due are clearly stated within each Quarterly Notice.

8. Q: Do I receive notification from DHS as to when and how much my organization will need to pay?

A: Yes, The Department issues an Annual Assessment Notice to each covered hospital at the beginning of each fiscal year for which an assessment is due. This Annual Assessment Notice is not a bill, but rather notifies the hospital of its total assessment amount due for the fiscal year. The Department issues a Quarterly Notice to each covered hospital, at least thirty days (30) prior to the due date of each quarterly assessment. The Notice describes the amount due and due date. In the event a hospital fails to satisfy its financial responsibilities by the due date specified within any Quarterly Notice, the Department issues a delinquency notice to the hospital on the day following the due date. For applicable hospitals, a final quarterly notice is sent sixty (60) days after the delinquency notice, if a delinquency amount remains at that time. See Question 11 for additional information related to delinquency or non-payment.

In addition, the Department has developed a web-based hospital assessment secure system that contains revenue data and contact information. The system generates and sends assessment notices each quarter and has reporting capabilities to track payments and delinquencies. Questions related to the secure web-based hospital assessment system, including set-up for access, should be directed to: ra-pwhai@pa.gov

9. Q: Who at the hospital receives notice of the hospital assessment?

A: The Annual Assessment Notice and Quarterly Notices are sent to the "Primary Hospital Contact" identified by your facility. This Hospital Contact receives all systematic correspondence in regards to the quarterly hospital assessments notices. Both the Annual Assessment Notice and Quarterly Notices are sent via regular mail.

10. Q: What forms of payment are acceptable?

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A: Act 92 of 2015 requires hospitals to pay their assessment amounts electronically. The Department strongly encourages the Automated Clearing House (ACH) method of electronic payment in order to expedite the posting of payment to the hospital's balance and to make funding available for the payments financed by the hospital assessment revenues. An ACH electronic transfer of funds has distinct advantages over other methods of payment. An ACH payment is received and posted to your account much faster. Confirmation of an ACH payment is posted to the hospital's on-line account within twenty-four (24) hours of issuance.

Timely receipt of payment for the assessment helps to expedite the Department's various payments to the hospital community. Electronic Payment Instructions for the Hospital Quality Care Assessment can be found within the Hospital Assessment Initiative section of the Department's website. Questions related to setting up an ACH account for your provider should be directed to: ra-pwhai@pa.gov.

Wire transfers are highly discouraged due to the lack of detail such transactions provide. Wire transfers often take much longer to process than ACH transfers, which may cause a payment to post past the due date causing the account to become delinquent and accrue interest. See Question 11 for information related to delinquency or non-payment.

11. Q: What happens if a hospital does not pay the assessment?

A: Interest and applicable penalties are applied when the Department does not receive timely payment. In accordance with Section 809-G of Act 92 of 2015, the Department has the right to recover any balance that is sixty (60) or more days delinquent from Medical Assistance (MA) payments for those hospitals participating in MA.

If any delinquent balance continues beyond ninety (90) days, Section 809-G of Act 92 of 2015 calls for the Department to notify the Department of Health (DOH) of any hospitals failing to comply. At such time, DOH has the right to suspend future license renewals, until all assessment-related responsibilities have been satisfied by the hospital.

12. Q: Will disproportionate share (DSH) and supplemental payment programs funded by assessment revenue be distributed prior to quarterly assessment due dates?

A: Yes, the following disproportionate (DSH) and supplemental payment programs which are funded, in whole or part, by assessment revenue are anticipated to be distributed prior to quarterly assessment due dates.

- Managed Care Organization (MCO) Payments
- Inpatient DSH Restoration and Adjustment Payments as part of the regular Inpatient DSH Quarterly Payments

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- Outpatient Supplemental Restoration Payments as part of the regular Outpatient Supplemental Quarterly Payments
- Enhanced Payment to Certain DSH Hospitals Payment
- Direct Medical Education Restoration and Adjustment Payments as part of the regular Medical Education Quarterly Payments
- Medical Assistance (MA) Stability Payment
- MA Dependency Payment
- MA Small and Sole Community Hospital Payment
- MA Rehabilitation Adjustment Payment

Hospitals newly enrolled in PA MA that are assessed will receive and be asked to complete a New Hospital Survey to enable the Department to gather the necessary information to determine the newly enrolled hospital's eligibility for many of the payment programs listed above. Questions regarding DSH and supplemental payments can be directed to ra-pwdshpymt@pa.gov.

13. Q: Will the hospital receive a breakdown of the assessment that was used?

A: In accordance with Act 49 of 2010 and as later amended by Act 84 of 2010, Act 22 of 2011, Act 55, 2013, and Act 92 of 2015, the Department retains a portion of the assessment revenue, with the majority of the funds being sent to hospitals in the form of managed care, disproportionate share, supplemental and increased fee-for-service (FFS) acute care general hospital claim payments. For more information please see the Hospital Assessment Legislative Report located at:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/report/p_031834.pdf

14. Q: What happens after the current legislation expires, will rates continue or will future legislation be needed?

A: Future legislation will be needed to continue the assessment beyond June 30, 2018.

All Patient Refined Diagnosis Related Groups (APR-DRG)

15. Q: Why did the Department change to a new payment method?

A: In FY 2010-2011, The Department updated the current Medical Assistance Fee-for-Service (FFS) payment system for inpatient acute care general hospitals. The previous FFS payment system relied on a version of Diagnosis Related Grouping software which is no longer maintained by CMS necessitating the change. The APR-DRG case-based severity adjusted classification
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system financially incentivizes hospitals to provide cost-efficient care. As compared to Medicare's MS-DRG severity-adjusted system, APR-DRG adequately addresses the Medicaid population.

16. Q: Why was APR DRG chosen? Why not the same DRG system as Medicare uses?

A: APR-DRGs were chosen because they are suitable for use with the Medicaid population, especially with regard to neonatal and pediatric care. Additionally, they incorporate sophisticated clinical logic to capture the differences in co-morbidities and complications that can significantly affect hospital resource use. Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity of illness (minor, moderate, major or extreme) that are specific to the base APR-DRG.

17. Q: Were new payment rates for Medicaid also implemented when the switch to APR-DRGs occurred?

A: Yes, The Department implemented new Fee-for-Service hospital payment rates for inpatient acute care general hospitals as part of the hospital assessment initiative. A hospital's payment rate is determined based on a statewide average cost per discharge using Medical Assistance (MA) cost report information and is adjusted for each hospital based on labor, medical education, capital, and MA dependency factors.

18. Q: When was the new APR-DRG payment method implemented?

A: The payment rates and the APR-DRG classification system have been used for FFS inpatient claims submitted by acute care general hospitals beginning March 4, 2011, retroactive to inpatient claims with a date of discharge on or after July 1, 2010.

19. Q: Who developed APR-DRGs? Who uses them?

A: APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals Related Institutions (NACHRI). APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are the "America's Best Hospitals" list by *U.S. News & World Report*, state "report cards", and analysis performed by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

20. Q: What version of APR-DRGs was implemented originally? What APR-DRG version is currently used?

A: The Department implemented APR-DRG version 27 for inpatient Fee-for-Service claims with dates of discharge through June 30, 2015. The Department implemented ICD-10 ready APR-DRG version 31 on July 1, 2015 for dates of discharge on or after July 1, 2015. The first

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available ICD-10 certified version of APR-DRG is version 33. Version 33 was implemented by DHS on February 1, 2016 retrospective to discharge dates on or after October 1, 2015. The Department will reprocess claims that were processed under APR-DRG version 31 for discharge dates of service October 1, 2015 through February 1, 2016 at a later date.

21. Q: Is my hospital required to buy APR-DRG software in order to be paid?

A: No, DHS's processing system assigns the DRG and calculates payment without any need for the hospital to submit a DRG on the claim.

22. Q: Please explain how this affects rehabilitation hospitals. Will this increase current MA payment/reimbursement rates?

A: Inpatient rehabilitation hospitals are included in the hospital assessment; however, claims submitted by rehabilitation hospitals will continue to be paid the facility's per diem rate, not through the APR-DRG grouper software. A separate supplemental payment funded by assessment revenue was created for freestanding rehabilitation hospitals.