Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

"Inlier" means a case where the length of stay or cost of treatment falls within the actual calculated length-of-stay criteria, or the cost of treating the patient is within the cost boundaries of a DRG payment.

"Long-stay outlier" means a case that has a length of stay that is greater than the calculated length-of-stay parameters, as defined with the length-of-stay calculations for that DRG.

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments. A separate low-income utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital, where services are provided predominantly to children under 18 years of age.

"Medicaid-certified unit" means a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa Department of Inspections and Appeals on or after October 1, 1987. Medicaid certification of substance abuse, psychiatric, and rehabilitation units is based on the Medicare reimbursement criteria for these units. A Medicare-certified physical rehabilitation unit or hospital in another state is considered Medicaid-certified.

"Medicaid claim set" means the hospital applicable Medicaid claims for the period of January 1, 2006 through December 31, 2007 and paid through March 31, 2008.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients. A separate Medicaid inpatient utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" means a neonatal unit designated level II or level III unit using standards set forth in Section 19, Payment for Medicaid-Certified Special Units.

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"Net allowable hospital-specific base costs" means the hospital-specific base costs or charges, as reported, from which has been subtracted the costs associated with capital and direct medical education, as well as calculated payment amounts associated with indirect medical education, transfers, outliers, and physical rehabilitation services.

"Net discharges" means total discharges minus transfers and short-stay outliers.

"Net number of hospital-specific Medicaid discharges" means the total number of Medicaid discharges reported by a hospital, less the actual number of transfer cases and short-stay outliers.

"Outlier" means a case that has an extremely short or long length of stay (day outliers) or an extraordinarily high cost (cost outlier) when compared to other discharges classified in the same DRG.

"Quality improvement organization (QIO)" means the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy, and quality of care; appropriateness of admission, discharge, and transfer; and appropriateness of a representative sample of prospective-payment outlier cases.

"Rate-table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate, by hospital, before being multiplied by the appropriate DRG weight.

"Rebasing" means the redetermination of the blended base amount or the capital cost components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short-stay day outlier" means a case that has a length of stay that is less than the calculated length-of-stay parameters, as defined within the length-of-stay calculations.

"Transfer" means the movement of a patient from a bed in a non-Medicaid-certified unit of a hospital to a bed in a Medicaid certified unit of the same hospital or to another hospital.

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If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

j. Qualifying for disproportionate share as a children's hospital. Licensed hospitals qualify for disproportionate share payments as a children's hospital if they provide services predominantly to children under 18 years of age or include a distinct area or areas providing services predominantly to children under 18 years of age, are a voting member of the National Association of Children's Hospitals and Related Institutions, and have Medicaid utilization and low-income utilization rates for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age of one percent or greater.

Hospitals wishing to qualify for disproportionate share payments as a children's hospital, must provide the following information to the IME Provider Cost Audits and Ratesetting Unit within 20 business days of a request:

1. Base-year cost reports.

2. Medicaid claims data for children under age 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

30. Relationship to Managed Care

All monetary allocations made to fund the Graduate Medical Education and Disproportionate Share Fund for direct medical education, indirect medical education, and routine disproportionate share payment are reimbursed directly to hospitals. These payments have been deducted from all managed care capitation payments as part of the rate-setting methodology. No additional payments for these components will be made to any managed care organization.

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31. Final Settlement Process for Non-State Government-Owned or Government-Operated Hospitals (Inpatient)

At the end of the cost reporting period, the aggregate payments made to such hospitals under the DRG payment methodology will be determined and compared to each hospital's actual medical assistance program costs as determined from the facility's audited or desk reviewed cost report. For purposes of this rule, aggregate payments include amounts received from the Medicaid program, including Graduate Medical Education (GME) payments, outlier payments, as well as patient and third party payments up to the Medicaid allowed amount.

If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs will be requested and collected from the hospital.

Cost settlements, as described above, will be performed annually following completion of the cost report desk review and/or audit.

32. Iowa State-Owned Teaching Hospital Disproportionate-Share Fund

In addition to payments from the Graduate Medical Education and Disproportionate Share Fund, payment will be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this provision. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate-share fund is $26,633,430.

Hospitals qualify for Iowa state-owned teaching hospital disproportionate-share payments if they meet the disproportionate share qualifications defined in Section 29.g and being an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

The total amount of disproportionate-share payments from the Graduate Medical Education and Disproportionate Share Fund and the Iowa state-owned teaching hospital disproportionate-share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate-share payments shall not exceed the hospital-specific disproportionate-share limits under Public Law 103-666.

The Department's total year end DSH obligations to a qualifying hospital will be calculated following completion of the CMS 2552-96, Hospital and Healthcare Complex Cost Report desk review or audit.

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33. Iowa Non-State Government-Owned Acute Care Teaching Hospital Disproportionate-Share Payments

In addition to payments from the Graduate Medical Education and Disproportionate Share Fund, payment will be made to Iowa hospitals qualifying for the non-state government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this provision.

Hospitals qualify for non-state government-owned acute care teaching hospital disproportionate-share payments if they meet the disproportionate share qualifications defined in Section 29.g and being a non-state government-owned acute care teaching hospital located in a county with a population over three hundred fifty thousand.

The total amount of disproportionate-share payments from the Graduate Medical Education and Disproportionate Share Fund and the non-state government-owned acute care teaching hospital disproportionate-share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate-share payments shall not exceed the hospital-specific disproportionate-share limits under Public Law 103-666.

The Department's total year end DSH obligations to a qualifying hospital will be calculated following completion of the CMS 2552-96, Hospital and Healthcare Complex Cost Report desk review or audit. The Department's total year end DSH obligation shall equal the difference between $51,000,000 less actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid Enterprise.

34. Inpatient Hospital Services Reimbursement to Indian Health Services and Tribal 638 Health Facilities

Medicaid reimbursement for inpatient hospital care provided by Indian Health Service and Tribal 638 providers is based on payment according to diagnosis-related groups (DRG). These rates are rebased and the DRG weights are recalibrated once every three years.

Reimbursement for the provision of care to Iowa Medicaid patients will be equal to either:
A. The Iowa statewide average cost per discharge plus the Iowa statewide average capital cost add-on in effect at time of the patient's discharge multiplied by the DRG weight; or
B. Blended base and capital rates calculated by using 80% of the hospital's submitted capital costs.

Hospitals choosing Option B must submit a form CMS 2552, Hospital and Healthcare Complex Cost Report or a CMS-accepted substitute, using data for Iowa Medicaid patient only. This should be the hospital's most recent fiscal-year end cost report and should be received no later than May 31 in a rebasing year. Hospitals that elect to submit cost reports will receive a case-mix adjusted blended base rate using hospital-specific Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount. Capital costs will be reimbursed using the blended capital rate if choosing Option B.

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Acute Care Psychiatric Hospitals

7. Cost Reporting

Each participating Medicaid provider must file a CMS-2552 Medicare Cost Report, or a CMS-accepted substitute. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the fiscal agent for Iowa within 150 days after the close of the hospital's fiscal year.

8. Audits

Each participating hospital is subject to a periodic audit of its fiscal and statistical records. The Department has agreements for the exchange of Medicare and Medicaid information with the following Medicare intermediaries in Iowa and surrounding areas:

Cahaba Government Benefits Administrator (Des Moines and Sioux City)
Mutual of Omaha (Omaha, Nebraska)
United Government Services (Milwaukee, Wisconsin)
Blue Cross and Blue Shield of Wisconsin (Madison, Wisconsin)
Riverbend Government Benefits Administrator (Chattanooga, Tennessee)

9. Recovery of Overpayments

When it has been determined that an inpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider fails to submit a refund or an acceptable response to the notice within 30 days, the amount of the overpayment will be withheld from bi-monthly payments to the provider.

10. Fixed Rate for Out-of-State Acute Care Psychiatric Hospitals

Out-of-state hospitals are paid at the Medicare target rate.

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Acute Care Psychiatric Hospitals

Reserved for future use

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Reserved for future use

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Reserved for future use

OS Notification

State/Title/Plan Number: Iowa 10-007

Type of Action: SPA Approval

Required Date for State Notification: 2/13/2010

Fiscal Impact: FFY 10 $1,190,813 FFY 11 $4,697,250

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: Yes or **Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective July 1, 2010, this amendment modifies Attachment 4.19-A of the Iowa Medicaid State plan to remove language that became obsolete with the renewal of the IowaCare 1115 waiver. This SPA also establishes a new DSH payment in the amount of $7,500,000 to the University of Iowa Hospital and clinics. Additionally, a DSH payment previously made under the IowaCare waiver to the Broadlawns Medical Center is converted to a DSH payment under the State plan. Funding for the DSH payment to the UIHC comes from an up-front IGT of State appropriations to the UIHC. Funding for the DSH payment to Broadlawns comes from State appropriations to the Medicaid agency. Public process / public notice requirements were met. Tribal consultations were held by the State.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS Contact:
Tim Weidler (816) 426-6429, National Institutional Reimbursement Team