Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

1. Introduction

Medicaid reimbursement for inpatient hospital care is based on payment according to diagnosis-related groups (DRG). These rates are rebased and the DRG weights are recalibrated once every three years. Hospitals receiving reimbursement as critical access hospitals are not subject to rebasing.

This state plan reflects the rebasing and recalibration implemented October 1, 2018. The current DRG payment is established through a base-year rate (2016) to which an annual legislative index may be applied on July 1 of each year.

The reimbursement amount is a blend of hospital-specific and statewide average costs reported by each hospital, for the routine and ancillary base and capital cost components, per Medicaid discharge.

Direct medical education, indirect medical education, and disproportionate share payments are made directly from the Graduate Medical Education and Disproportionate Share Fund. They are not added to the reimbursement for claims.

2. Definitions

Certain mathematical or technical terms may have a specific meaning used in this context. The following definitions are provided to ensure understanding amount all parties.

"Adolescent" means a Medicaid patient 17 years of age or younger.

"Adult" means a Medicaid patient 18 years of age or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base-year cost report" means the hospital's cost report with a fiscal year ending on or after January 1, 2016 and before January 1, 2018. Cost reports shall be reviewed using Medicare cost reporting and cost reimbursement principles for those cost-reporting periods.

For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15).

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Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. Costs are considered to be reasonable when they do not exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Inclusion in the cost report of costs that are not directly related to patient care or are not in accord with Medicare principles of reimbursement is not appropriate. Examples of administrative and general costs that must be related to patient care to be a reportable cost are:

- Advertising
- Promotional items
- Feasibility studies
- Dues, subscriptions or membership costs
- Contributions made to other organizations
- Home office costs
- Public relations items
- Any patient convenience items
- Management fees for administrative services
- Luxury employee benefits (i.e., country club dues)
- Motor vehicles for patient care
- Reorganization costs

"Blended base amount" means the case-mix-adjusted, hospital-specific operating costs per discharge associated with treating Medicaid patients, plus the statewide average, case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report are not used to determine the statewide average, case-mix-adjusted operating cost per Medicaid discharge. For purposes of calculating the disproportionate share rate only, a separate blended base amount is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the case – mix adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

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"Blended capital costs" means case-mix-adjusted hospital-specific capital costs, plus state-wide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report are not used in determining the statewide average capital costs. For purposes of calculating the disproportionate share rate only, separate blended capital costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" means an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for building, fixtures, and movable equipment are defined in the hospital's base-year cost report, are case-mix adjusted, are adjusted to reflect 80% of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate. For purposes of calculating the disproportionate share rate only, separate capital costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" means an arithmetical index used to measure the relative average costliness of cases treated in a hospital as compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

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"Disproportionate share percentage" means either (1) the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2 ½ percent. A separate disproportionate share percentage is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate 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.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. The Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case coded as a transfer to another hospital shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed, or nominally reimbursed patients.

"Graduate Medical Education and Disproportionate Share Fund (GME/DSH Fund) Apportionment Claim Set" means the hospital applicable Medicaid claims paid from July1, 2017 through June 30, 2018. The claim set is updated in July of every third year and is modeled using the most recently effective recalibrated weights.

"High cost adjustment" shall mean an add-on to the blended base amount (considered part of the blended base amount), which shall compensate for the high cost incurred for providing services to medical assistance patients. The high cost adjustment add on is effective for the time period of July 1, 2004 through June 30, 2005.

"Implementation Year" means October 1, 2018.

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- Either provides services predominately under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
- Is a member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" means a case that has an extraordinarily high cost, so as to be eligible for additional payments above and beyond the initial DRG payment.

"Diagnosis-related group (DRG)" means a group of similar diagnoses based on patient age, organ systems, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital's base-year cost reports, and is inflated and case-mix-adjusted in determining the direct medical education rate. For purposes of calculating the disproportionate share rate only, separate direct medical education costs are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

Payment for direct medical education costs is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS-2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is further divided by the hospital's case-mix index, then is divided by net discharges. For purposes of calculating the disproportionate share rate only, a separate direct medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate-share payment" means a payment that shall compensate for costs associated with the treatment of a disproportionate share of poor patients. The disproportionate-share payment is made directly from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

"Disproportionate share percentage" means either (1) the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2 ½ percent. A separate disproportionate share percentage is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate 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.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. The Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case coded as a transfer to another hospital shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed, or nominally reimbursed patients.

"Graduate Medical Education and Disproportionate Share Fund (GME/DSH Fund) Apportionment Claim Set" means the hospital applicable Medicaid claims paid from July1, 2015 through June 30, 2016.

"High cost adjustment" shall mean an add-on to the blended base amount (considered part of the blended base amount), which shall compensate for the high cost incurred for providing services to medical assistance patients. The high cost adjustment add-on is effective for the time period of July 1, 2004 through June 30, 2005.

"Implementation Year" means October 1, 2015.

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"Indirect medical education costs" means costs that are not directly associated with running a medical education program, but are incurred by the facility because of that program (for example, costs of maintaining a more extensive library to serve those educational needs).

The indirect medical education payment is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

"Indirect medical education rate" means a rate calculated as follows:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.

- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

  For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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"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, 2016 through December 31, 2017 and paid through March 31, 2018.

"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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Reserved for future use

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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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3. Definition of Allowable Costs

Allowable costs are those defined as allowable in 42 CFR, Part 413, except as specifically excluded or restricted in the state plan.

Costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only those costs are considered in calculating the Medicaid Inpatient reimbursable cost per discharge for the purpose of this plan.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per discharge and the statewide-average cost per discharge can be determined by using the individual hospital's base year Medicare Cost Report (CMS-2552), Worksheets D-1 and D-4, as submitted to the state.

The total number of Medicaid discharges can be determined from documents labeled PPS-1 and PPS-2. Worksheet S-3 in the report or the MMIS claims documentation system.

a. Calculation of Hospital-Specific and Statewide Net Medicaid Discharges

The total number of Medicaid discharges is determined from the number reported in the cost report or the MMIS claims documentation system. Subtracted from this total number of discharges for each hospital are discharges that have been paid as transfers or short-stay outliers.

This number is known as the net hospital-specific number of discharges. To arrive at the statewide net number of discharges, all net hospital-specific numbers of discharges are summed. For purposes of calculating the disproportionate share rate only, separate discharges are determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

b. Calculation of the Hospital-Specific Case-Mix-Adjusted Average Cost Per Discharge

As determined from the base-year cost report, the hospital-specific case-mix adjusted average cost per discharge is calculated by starting from:

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The **lower** of total Medicaid costs **or** covered reasonable charges for each Iowa hospital (LOCOC) less 20% of capital expenses

– The remaining 80% of actual costs reported for capital expenditures

– The actual costs reported for direct medical education

– Calculated payments for non-full DRG transfers

– Calculated payments made for outliers

– Payment made for physical rehabilitation (if included)

– Payment made for inpatient psychiatric services (if included)

= **Net allowable base costs or charges**

The net allowable base costs or charges amount is then inflated, case-mix adjusted and divided by the net number of hospital-specific Medicaid discharges to obtain the hospital-specific case-mix-adjusted average cost per discharge, as shown:

Net allowable base costs or charges

X Hospital inflation update factor
= Inflated net allowable base cost

÷ Hospital-specific case-mix index

= Inflated, case-mix-adjusted net allowable base costs or charges

÷ Net hospital-specific Medicaid discharges (less non-full DRG transfers and short stay outliers)

= **Hospital-specific case-mix-adjusted average cost per discharge**

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix adjusted average cost per discharge is calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charge, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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c. **Calculation of the Statewide Average Case-Mix-Adjusted Cost per Discharge**

The statewide average case-mix-adjusted cost per discharge is calculated from:

The LOCOC figures for each Iowa hospital, except those receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report, less 20% of actual capital costs as reported

- The remaining 80% of hospital-specific capital costs
- Hospital-specific direct medical education costs
- All hospital-specific payments for transfers
- All hospital-specific payment for outliers
- All hospital-specific payments for physical rehabilitation (if included in above)
- All hospital-specific payments for inpatient psychiatric services (if included in above)
- All hospital-specific payments for indirect medical education

= **Hospital-specific net base cost for statewide average**

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The hospital-specific net base cost for the statewide average is then case-mix adjusted.

Net hospital-specific base cost for statewide average
÷ (Total number of Iowa Medicaid discharges minus the number of non-full DRG transfers and short-stay outliers)
= **Case-mix-adjusted hospital-specific base costs for statewide average**

Next, to arrive at the statewide average cost per discharge, sum all the case-mix-adjusted hospital-specific base costs for the statewide average from above, and divide by the total number of net Medicaid discharges for all Iowa hospitals.

+ Hospital 1 case-mix-adjusted base costs
+ Hospital 2 case-mix-adjusted base costs
+ Hospital 3 case-mix-adjusted base costs
+ Hospital N case-mix-adjusted base costs
= Sum of case-mix-adjusted statewide allowable base costs
÷ Sum of the statewide net Medicaid discharges (less non-full DRG transfers and short-stay outliers)
= **Statewide average case-mix-adjusted cost per discharge**

d. Calculation of the Final Blended Base Rate

To calculate the final blended base rate, the hospital-specific case-mix-adjusted cost per discharge is added to the statewide average case-mix-adjusted cost per discharge and divided by 2.

5. Calculation of the Capital Component to the Final Blended Base Rate

Added to the final blended base rate is a component that reflects the individual hospital's cost for capital-related expenditures. The capital cost component is a 50/50 blend of hospital-specific capital costs and statewide average capital costs.

The capital-related costs are found in the last column of CMS-2552, Worksheet B, Part II and Part III. These costs are then apportioned to Medicaid using Medicaid patient days and ancillary charges. Routine costs are reflected in Worksheet D, Part I. Ancillary costs are reflected in Worksheet D, Part II. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used.

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The capital component is calculated by taking the sum of the routine and ancillary capital-related costs from the submitted Medicaid cost report, multiplying by 80%, dividing by the hospital-specific case-mix index and then dividing by the net number of Medicaid discharges for that hospital.

Hospitals whose blended capital add-on exceeds one standard deviation from the mean Medicaid capital rate will be subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation.

The sum of the hospital-specific routine and ancillary capital costs multiplied by 0.8
÷ Hospital-specific case-mix index
= Case-mix-adjusted capital cost component
÷ Net number of hospital-specific Medicaid discharges
= **Case-mix-adjusted hospital-specific capital cost per discharge**

For purposes of calculating the disproportionate share rate only, a separate case-mix-adjusted hospital-specific capital cost per discharge is calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the discharges and routine and ancillary capital costs multiplied by 0.8, attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

The statewide average capital cost per discharge is determined by adding together all hospital-specific case-mix-adjusted capital costs for all Iowa hospitals. This total is divided by the total statewide number of net Medicaid discharges. The total number of net discharges is calculated by adding together all the hospital-specific net discharge figures for all Iowa Medicaid discharges. Net discharges are defined within Section 4, paragraph (a).

+ Hospital 1 case-mix-adjusted capital costs
+ Hospital 2 case-mix-adjusted capital costs
+ Hospital 3 case-mix-adjusted capital costs
+ Hospital N case-mix-adjusted capital costs
= Statewide total case-mix-adjusted capital costs
÷ Statewide total number of net Medicaid discharge
= **Statewide average case-mix-adjusted capital cost per discharge**

The blended capital cost component is determined by adding together the hospital-specific case-mix-adjusted capital cost per discharge and the statewide average case-mix-adjusted capital cost per discharge and dividing by 2. This blended capital rate component is added to the final blended base rate.

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6. Calculation of the Direct Medical Education Rate

Direct medical education costs are reflected in the cost report when a facility operates a program that qualifies for medical education reimbursement under Medicare. The routine costs are found in the cost report in Worksheet D, Part III. Ancillary costs are found on Worksheet D, Part IV. These costs are apportioned to Medicaid on the basis of Medicaid days and ancillary charges.

The total hospital-specific routine and ancillary direct medical education costs are added together and multiplied by inflation factors. This result is further divided by the hospital's case-mix index, then is divided by the net number of Medicaid discharges for that hospital. This formula is limited by funding availability that is legislatively appropriated.

Routine medical education costs (Worksheet D, Part III)
+ Ancillary medical education costs (Worksheet D, Part IV)
= Hospital-specific total direct medical education costs
x Inflation factors
= Hospital-specific total inflated direct medical education cost
÷ Hospital-specific case-mix index
= Case-mix-adjusted hospital-specific direct medical education costs
÷ Net hospital-specific number of net Medicaid discharges
= Hospital-specific case-mix-adjusted inflated direct medical education cost per discharge

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix, index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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For purposes of calculating the disproportionate share rate only, a separate direct medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix, index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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7. Calculation of the Disproportionate-Share Rate

The disproportionate share rate is determined using the following formula: Sum the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate. Multiply this sum by the disproportionate share percentage.

8. Calculation of the Indirect Medical Education Rate

The indirect medical education rate is determined using the following formula:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.
- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.
- For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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9. Trending Reimbursement Rates Forward

The final payment rate for the current rebasing uses the hospital's base-year cost report. The only adjustments made to this rate are for fraud, abuse, and material changes brought about by cost report re-openings done by Medicare or Medicaid.

The rates have been trended forward using inflation indices of:

A. State Fiscal Year 2000 – 2.0%
B. State Fiscal Year 2001 – 3.0%
C. State Fiscal Year 2002 – (3.0%)
D. State Fiscal Year 2003 – 0.0%
E. State Fiscal Year 2004 – 0.0%
F. State Fiscal Year 2005 – 0.0%
G. State Fiscal Year 2006 – 3.0%
H. State Fiscal Year 2007 – 3.0%
I. State Fiscal Year 2008 – 0.0%
J. State Fiscal Year 2009 – 11.0%
K. December 1, 2009 – (5.0%)
L. October 1, 2010 – 20.46%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
M. August 1, 2011 – 76.94%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
N. October 1, 2011 – (41.18%), except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
O. November 1, 2011 – 5.72%
P. July 1, 2012 – 9.89%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.
Q. July 1, 2013 – 1.00%
R. October 1, 2015 – 0.0%
S. October 1, 2018 – 0.0%

Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

For purposes of calculating the hospital inflation update factor, the original payments from the base-year Medicaid claim set are aggregated for all hospitals that submitted cost report data (excluding critical access hospitals). The total payment amount is then adjusted for any applicable legislative appropriations affecting budget neutrality. The resulting total becomes the target payment amount for budget neutrality.

The initial blended base rates are calculated with a hospital inflation factor update of 1.0. Once initial blended base rates are calculated, Medicaid claim set payments are modeled using blended base rates. Total calculated payments for participating hospitals are then compared to the target payment amount for budget neutrality.

The difference between modeled claim payments and the target payment for budget neutrality is used to calculate a hospital inflation update trending factor. The new hospital inflation update trending factor is then applied in the blended base rate calculation. Updated base rates are used to model Medicaid claim set payments. The new calculated payments are then compared to the target payment amount for budget neutrality.

This process is repeated until new calculated payments result in the target payment amount for budget neutrality.

10. Ceilings and Upper Limit Requirements

Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost. This principle is not altered by the DRG reimbursement methodology.

At the end of the cost reporting period, the aggregate covered charges for the period are determined and compared to the aggregate payments made to the hospital under the DRG payment methodology (before any subtraction of third-party payments). If the aggregate covered charges are less than the aggregate payments made using the DRG rates, the amount by which payments exceed the covered charges is requested and collected from the hospital.

This adjustment is performed each year at the end of the hospital's fiscal year, and does not have any impact upon the DRG rates that have been calculated for the next year. There is no carryover of unreimbursed costs into future periods under this DRG reimbursement methodology.

The total payments for Medicaid are determined as if this aggregate customary charge per day had been used. Final payment for the cost reporting period in question is made to each hospital at a per-day amount not to exceed its aggregate customary charge per day. This test is applied on a hospital-by-hospital basis.

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In accordance with 42 CFR 447.271, as part of the final settlement process, the IME Provider Cost Audit and Rate Setting Unit determines each hospital's total inpatient customary charges for all patients and total days for all patients during the cost reporting period. This is converted to an aggregate customary charge per day.

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In establishing payment rates for inpatient hospital services, the State is governed by 42 CFR 447.272. In its present form, the provisions of 42 CFR 447.272 are summarized below.

In accordance with 42 CFR 447.272, as part of the final settlement process, the Medicaid upper payment limit is determined.

In accordance with 42 CFR 447.272(a), the application of upper payment limits applies to rates set to pay for inpatient services furnished by hospitals within one of the following categories:

- State government-owned or government-operated facilities
- Non-state government-owned or government-operated facilities
- Privately owned and operated facilities.

In accordance with 42 CFR 447.272(b), payments to hospitals, aggregated by the categories described in 42 CFR 447.272(a), may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

In accordance with 42 CFR 447.272(c), exceptions are made for:

- Payments to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (PL 93-638), and
- Payments made in accordance with an approved state plan to hospitals found to serve a disproportionate number of low-income patients with special needs.

To the extent applicable federal regulations are changed in the future, the State Plan will be further amended to reflect such changes.

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11. Explanation of Iowa-Specific Relative Weights

Diagnosis-related groups are categories established by CMS and distributed by 3M. The number of DRGs is determined by CMS, and is updated when needed. A DRG weight is a relative value associated with the charge for treating a particular diagnosis when compared to the cost of treating an average discharge. The recalculation of the Iowa-specific weights is called recalibrating.

Iowa-specific weights have been calculated using the Medicaid claim set. The recalibrating includes all normal inlier claims, the estimated inlier portion of long-stay outliers, transfer cases where the payment is greater than or equal to the full DRG payment, and the estimated inlier portion of cost-outlier cases. Short-stay outliers and transfer cases where the final payment is less than the full DRG payment are discarded from that group. This group is known as "trimmed claims."

a. Iowa-specific weights are calculated with Medicaid cost data, less indirect medical education, from the Medicaid claim set using trimmed claims. Indirect medical education cost is calculated by multiplying the cost of each claim by the Medicare indirect medical education percentage formula of: $1.35 * ((1 + \text{the ratio of interns and resident to beds})^{0.405} - 1)$. Medicaid cost data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in calculating Iowa-specific weights.

One weight is determined for each DRG except for Medicaid-certified special units, as defined in Section 19. There are multiple weights for the DRGs affected by those Medicaid-certified special units. The weight used for payment corresponds to the certification level of the specific hospital. Weights are determined as follows:

1. Determine the statewide geometric mean cost for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean cost for each DRG by multiplying the statewide geometric mean cost for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean costs for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean cost for all DRGs.

4. Divide the statewide geometric mean cost for each DRG by the weighted average geometric mean cost for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

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b. The hospital-specific case-mix index is computed by taking each hospital's trimmed claims from the hospital's base-year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid trimmed claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals. For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index is computed for any hospital that qualified for a disproportionate share payment only as a children's hospital, using only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospitals where services are provided predominantly to children under 18 years of age.

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12. Calculation of Hospital-Specific DRG Payment

The final payment rate, as defined in Section 2, is used to determine the final payment made to a hospital. This final payment rate is multiplied by the weight associated with the patient's assigned DRG. The product of the final payment rate times the DRG weight results in the dollar payment made to a hospital.

13. Explanation of Additional or Reduced Payment to a Facility

Additional payment is made for approved cases meeting or exceeding the Medicaid criteria for day and cost outliers for each DRG. For claims with dates of services ending July 1, 1993, and after, 100% of outlier costs are paid to facilities at the time of remittance. Thresholds for the determination of these outliers are computed during the calculation of the Iowa-specific weights and rebasing. Reduced payments are incurred by a facility due to a patient's unusually short length of stay (short-stay outliers).

Long-stay outliers are incurred when a patient's stay exceeds the upper day-limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG calculated geometrically. Reimbursement for long-stay outliers is calculated at 60% of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long-stay outliers is made at 100% of the calculated amount and is made when the claim is originally filed for DRG payment. Short-stay outliers are incurred when a patient's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200% of the average daily rate for each day the patient qualifies up to the full DRG payment. Short-stay outlier claims are subject to QIO review and payment denied for inappropriate admissions.

Cases qualify as cost outliers when costs of service in a given case exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $75,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base-year cost reports.

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Additional payment for cost outliers is 80% of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100% of the calculated amount and made when the claim is paid.

Hospitals that are notified of any outlier review initiated by the Iowa Medicaid Enterprise Medical Services Unit must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped.

In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

To verify that outlier costs are medically necessary and reasonable, the QIO selects a 10% random sample of outlier cases identified from Medicaid claims data for all Iowa hospitals and bordering state hospitals. This is a non-intensified review.

QIO staff review the cases to perform admission review, quality review, discharge review, and DRG validation. Questionable cases are referred to a physician reviewer for medical necessity and quality of care concerns. Day outlier cases are reviewed to identify any medically unnecessary days, which are "carved out" if determining the qualifying outlier days.

Cost outlier cases are reviewed for medical necessity of all services provided, to ensure that services were not duplicatively billed, to determine if services were actually provided, and to determine if a physician ordered all services. The hospital's itemized bill and remittance statement are reviewed in addition to the medical record.

On a quarterly basis, the QIO calculates denial rates for each facility based on completed reviews during the quarter. All outlier cases reviewed are included in the computation or error rates. Cases with denied charges that exceed $1,000 for inappropriate or non-medically necessary services or days are counted as errors.

Intensified review may be initiated for hospitals whose error rate reaches or exceeds the norm for similar cases in other hospitals. The error rate is determined based on the completed outlier reviews in a quarter per hospital and the number of those cases with denied charges exceeding $1,000. The number of cases sampled for hospitals under intensified review may change based on further professional judgment and the specific hospital's outlier denial history.

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Specific areas for review will be identified based on prior outlier experience. When it is determined that a significant number of errors identified for a hospital is attributable to one source, review efforts will be focused on the specific cause of the error. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter.

Providers continue to be notified of all pending adverse decisions before a final determination by the QIO. If intensified review is required, hospitals are notified in writing and provided with a list of the cases that met or exceeded the error rate threshold. When intensified review is no longer required, hospitals are notified in writing.

Hospitals with cases under review must submit all supporting data from the medical record to the QIO within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited.

Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

14. Payment for Transfers

a. Hospitals

When a Medicaid patient is transferred, the transferring hospital or unit is paid 100% of the average daily rate of that hospital's payment for each day the patient remained in that hospital or unit, up to 100% of the DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

b. Medicaid-Certified Substance Abuse

When a patient is discharged to or from an acute care hospital and is admitted to or from a Medicaid-certified substance abuse unit, both the discharging and admitting hospitals receive 100% of the DRG payment.

c. Medicaid-Certified Physical Rehabilitation and Psychiatric Units

When a patient requiring medically necessary physical rehabilitation or psychiatric services is discharged from an acute care hospital and admitted to a Medicaid-certified rehabilitation or psychiatric unit, payment is made to the unit by a per diem rate. The discharging acute care hospital will receive 100% of the DRG payment. When a patient is discharged from a physical rehabilitation or psychiatric unit to an acute care hospital, the acute care hospital receives 100% of the DRG payment.

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Readmission Policy

When a patient is discharged/transferred from an acute care hospital, and is readmitted to the same acute care hospital within thirty (30) days for symptoms related to, or for evaluation and management of, the prior stay's medical condition, the original claim generated by the original stay will be adjusted by combining the original and subsequent stay onto a single claim.

The readmission policy does not apply to the following:

- Readmissions that are planned readmissions for repetitive or periodic treatments
- Critical access hospitals

15. Recalibration of Iowa-Specific weights and Recalculation of Base Amounts and Capital Cost Add-ons

Iowa-specific weights are calculated with Medicaid cost data from the Medicaid claim set. The DRG weights are recalibrated in the implementation year and every three years thereafter. All hospital base amounts plus the capital cost add-on are rebased in the implementation year and every three years thereafter. Cost reports used in rebasing will be the hospital fiscal year-end form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submissions timelines for the hospital fiscal year ending during preceding calendar year. If a hospital does not provide this cost report to the Medical fiscal agent by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the additional of a hospital market basket index inflation factor. The hospital market basket index inflation factor will be taken from the Health-Care Cost Review published by Global Insight, Inc. and shall consist of the percent change yearly average for the "Global Insight Hospital Market Basket." Hospitals receiving reimbursement as critical access hospitals do not have base amounts rebased.

16. Groupings or Classification of Providers

No special groupings or classifications of providers are established under this reimbursement methodology except state-owned facilities, as described in Section 8, Calculation of Indirect Medical Education Rate.

17. Exceptions or Exemptions to the Rate-Setting Process

Exceptions to the rate-setting process will be made under the following circumstances:

a. New, Expanded or Terminated Services

Hospitals may offer new or expanded services or permanently terminate a service. This may include the purchase of capital assets requiring certificate of need approval.

Hospitals shall submit a budget or other financial and statistical information no later than 180 days before the effective date of the recalculation of the DRG rates. Budgets should be submitted following the completion of a project requiring the certificate of need or Section 1122 approval by the Iowa Department of Public Health according to rules at 641 Iowa Administrative Code, Chapters 201 and 202.

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These budgets and related information are subject to desk review and field audit where deemed necessary. Upon completion of the audits, DRG rates may be adjusted as indicated.

Failure of a hospital to submit the required information timely will result in no rate increase associated with these assets or services when rebasing of base amounts and capital cost add-ons is performed. When the hospital files documentation in a timely manner, the new rate will be made effective at the time new rates are established.

b. **Fraud and Abuse**

In cases where fraud and abuse have been verified, the hospital's DRG payment rate will be adjusted. If the hospital's base-year payment rate is subsequently determined to have been based upon false or misleading information, an appropriate adjustment will be made to the base-year rate, and all resulting overpayments will be recouped.

If the hospital's DRG rate in any future period is determined to be changed based on false or misleading information, an appropriate adjustment will be made retroactive to the effective date of the rate change and all resulting overpayments will be recouped. The fiscal agent does this by subtracting the recoupment amount from payments to be made until the recovery is complete.

If, after the rate-setting process is completed, an error is discovered which materially affects the cost report data used to calculate the hospital's payment rate, the payment rate may be adjusted accordingly. This will be done if the error amounts to 5% or more of the hospital-specific, case-mix-adjusted cost per discharge.

The dollar amount of all such adjustments will be determined according to the facts in each case, using generally accepted accounting principles deemed permissible by the American Institute of Certified Public Accountants or Medicare principles of reimbursement.

18. Rate-Setting Processes for Out-of-State Hospitals

Reimbursement of out-of-state hospitals 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 that elect to receive payment based on the Iowa statewide average base and capital rates (Option A) may still qualify for disproportionate-share payments if the hospital qualifies within its home state using the calculation of the Medicaid inpatient utilization rate. Payment for disproportionate share will be according to the standards described in Section 29.

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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 patients 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.

Hospitals that qualify for disproportionate share payments based upon their home state's definition for the calculation of the Medicaid inpatient utilization rate are eligible to receive disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund.

Out-of-State hospitals do not qualify for direct or indirect medical education payments or disproportionate share hospital (DSH) payments from the Graduate Medical Education and Disproportionate Share Fund.

19. Payment for Medicaid-Certified Special Units

Medicaid certification of substance abuse, psychiatric and rehabilitation units is based on the Medicare reimbursement criteria for these units. The Department of Inspection and Appeals is responsible for Medicaid certification of these units for Iowa hospitals. Certification for reimbursement is done by the Iowa Medicaid Enterprise (IME) Provider Services Units. Without reimbursement certification, no physical rehabilitation, psychiatric or substance abuse units will receive reimbursement at the higher certified rates.

To become certified for reimbursement for either a physical rehabilitation unit or a psychiatric unit, the hospital must forward the Medicare PPS exemption notice to the IME Provider Services Unit every fiscal year when it becomes available. Supplemental Form 2977, indicating all the various certified programs for which the hospital may become certified, must also accompany the other notices. This form is available from the IME Provider Services Unit as part of the enrollment process or on request.

Medicaid-certified inpatient psychiatric units will be paid a per diem rate based on historical costs. The per diem rate will be rebased in the implementation year and every three year thereafter using the base year cost report. In non-rebasing years, the per diem rate will be trended forward using the factor in Section 9 of Attachment 4.19-A. The inpatient psychiatric per diem rate is calculated as total Medicaid inpatient

psychiatric unit cost divided by inpatient psychiatric unit discharges. Medicaid inpatient psychiatric per diem cost is determined based upon Medicare principles of cost reimbursement and is identified through the step down cost apportionment process on the CMS 2552-96 using inpatient psychiatric unit patient days and cost to charge ratio. Medicaid supplemental cost report schedules detailing Medicaid patient days and Medicaid charges by line item are required to be submitted by hospitals with the CMS 2552-96. In addition, Medicaid charges are available from the Medicaid PS&R.

Medicaid inpatient psychiatric routine service cost is calculated based on patient days by multiplying Medicaid inpatient psychiatric days times the inpatient psychiatric routine per diem. Inpatient psychiatric routine per diem is total hospital inpatient psychiatric routine operating costs divided by total hospital inpatient psychiatric patient days. Medicaid inpatient psychiatric ancillary service cost is determined by multiplying Medicaid charges, per Medicaid cost report line item, by the ancillary Medicaid cost to charge ratio for each Medicare ancillary service cost center.

Hospitals shall submit requests for certification with documentation that the certification requirements are met. The IME Provider Services Unit will notify the facility of any additional documentation needed after review of the submitted documentation. Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the IME Provider Services Unit received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make timely request for certification. In-state hospitals will be reimbursed for neonatal and substance abuse units at the level of certification for corresponding DRGs. There will be no retroactive payment adjustment made (to a certified higher level payment) when the hospital fails to make timely application for reimbursement certification.

All hospital special units and physical rehabilitation hospitals must be certified by the IME Provider Services Unit to qualify for Medicaid reimbursement as a special payment unit or physical rehabilitation hospital.

Both in-state and out-of-state psychiatric units may be certified for Medicaid reimbursement if the hospital is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to August 1, 2002.

A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

To become certified for substance abuse treatment, an in-state substance abuse unit may be certified for Medicaid reimbursement if the unit's program is licensed by the department of public health as a substance abuse treatment program. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served. An out-of-state substance abuse unit may be certified for Medicaid reimbursement if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

A neonatal intensive care unit may be certified for Medicaid reimbursement if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The IME Provider Services Unit shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the department of public health. Out-of-state units shall submit proof of level II or level III certification.

20. Patients Receiving Services at a Lower Level of Care and Appropriateness of Admission Criteria

Payment to acute hospitals for patients for whom the QIO has determined that a lower level of care is medically necessary is made as follows:

- For patients who are determined to require skilled nursing level of care, per diem payment is made in an amount equal to the sum of:
  - The direct care patient-day-weighted median for hospital-based Medicare-certified nursing facilities times 120 percent, plus
  - The non-direct care patient-day-weighted median for hospital-based Medicare-certified nursing facilities times 110 percent.
- For patients who are determined to require nursing facility level of care, per diem payment is made in an amount equal to the sum of:
  - The direct care patient-day-weighted median for non-state-owned nursing facilities times 120 percent, plus
  - The non-direct care patient-day-weighted median for non-state-owned nursing facilities times 110 percent.

Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short-stay outliers and all Medicaid patients readmitted within seven days.

21. Provider Appeals

In accordance with 42 CFR 447.253(e), a provider of service who is dissatisfied with a rate determination may file a written appeal. This appeal must clearly state the nature of the appeal and be supported with all relevant data. The Department of Human Services (DHS) contracts with the Department of Inspections and Appeals (DIA) to hold appeal hearings. Based upon a proposed decision issued by DIA, DHS makes a decision regarding the appeal and advises the provider accordingly within a period of 120 days.

22. Cost Reporting

Each participating Medicare provider must file a CMS-2552, Hospital Healthcare Complex Cost Report or a CMS-accepted substitute. Supplemental information sheets are also furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the IME Provider Cost Audit and Rate Setting Unit within five months after the close of the provider's fiscal year.

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23. Audits

In accordance with 42 CFR 447.253(g), each participating hospital is subject to a periodic audit of its fiscal and statistical records. DHS has agreements for exchange of Medicare and Medicaid information with the following 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)

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24. Hospital-Based Physician Cost Component

Medicaid reimbursement regulations require split billing of all hospital professional services. The professional component of all such bills must be billed on the CMS-1500 claim form. In accordance with 43 CFR 415.55 as amended to December 8, 1995, there are certain circumstances when Medicare will allow a facility with an approved teaching program to combine these components when billing for services. If Medicare has approved a provider to bill in this manner, Iowa Medicaid also allows the provider to bill in this manner.

25. 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 weekly payments to the provider.

26. Reserved for Future Use

27. Rate Adjustments for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rate plus the capital cost add-on are revised to reflect this new entity. Financial information from the original cost reports and original rate calculations is added together and averaged to form the new rate for that entity.

28. Interim Payment for Long-Stay Patients

Normal DRG reimbursement is made upon the patient's discharge from the hospital. If a patient has an extremely long stay, partial reimbursement to the hospital may be requested. A hospital can request an interim payment if the patient has been hospitalized 120 days and is expected to remain hospitalized for a minimum of an additional 60 days. Payment to the hospital is calculated at the same rate as normal DRG payments.

29. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for September 1, 2011, through June 30, 2012, is $6,265,918.94. Thereafter, the total annual amount of funding that is allocated is $7,519,102.73. Effective July 1, 2013, the total annual amount of funding that is allocated is $7,594,294.03

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

c. Distribution to Qualifying Hospitals for Direct Medical Education

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

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1. Multiply the total of all DRG weights from the GME/DSH Fund apportionment claim set, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

d. Qualifying for Indirect Medical Education

Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

e. Allocation to Fund for Indirect Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for September 1, 2011, through June 30, 2012, is $11,097,594.96. Thereafter, the total annual amount of funding that is allocated is $13,317,113.95. Effective July 1, 2013, the total annual amount of funding that is allocated is $13,450,285.14.

A reduction of this amount will be made if a hospital fails to qualify for indirect medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

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f. Distribution to Qualifying Hospitals for Indirect Medical Education

Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights from the GME/DSH Fund apportionment claim set, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

g. Qualifying for Disproportionate Share

Hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under Section 29j. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of:

- 2 ½ percent, or
- The product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

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For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2 ½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of:

- 2 ½ percent, or
- The product of 2 ½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

Information contained in the hospitals' base-year cost report is used to determine the hospital's low-income utilization rate and the hospital's inpatient Medicaid utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need ob obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients do not qualify for disproportionate share hospital payments from the fund.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

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h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for December 1, 2009, through June 30, 2010, is $6,890,959. Thereafter, the total annual amount of funding that is allocated is $6,890,959. Effective July 1, 2013, the total annual amount of funding that is allocated is $6,959,868.59.

i. Distribution to Qualifying Hospitals for Disproportionate Share

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims from the GME/DSH Fund apportionment claim set, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and the Medicaid utilization rate (or for children's hospitals during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered 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 will be used in the forgoing formula.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and enhanced disproportionate share payments describe in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

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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 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 Rate Setting 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 on a monthly basis.

Direct medical education and indirect medical education payments have been included in all managed care capitation payments as part of the rate-setting methodology.

At the end of the state fiscal year, the Department will reconcile the managed care payments to the total amount for graduate medical education for each qualifying hospital. If the payments made under managed care exceed the total amount, the Department will recoup the overpayment. If the payments made under managed care are less than the total amount, the Department will pay the difference.

Disproportionate share payments have been excluded from all managed care capitation payments as part of the rate-setting methodology.

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31. Reserved for future use

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 to the Iowa state-owned teaching hospital disproportionate-share fund is as follows:

- $19,975,072.50 for July 1, 2015 through March 31, 2016
- $9,133,357.50 for April 1, 2016 through June 30, 2016
- $36,533,430 for July 1, 2016 through June 30, 2017
- Funding shall be equal to the maximum amount allowed under Section 1923(g) of the Social Security Act less the DSH payments made from the Graduate Medical Education and Disproportionate share Fund on an annual basis for July 1, 2017 through June 30, 2021
- $0 for July 1, 2021 and after

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

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 all disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234 and shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

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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 Section 30.a 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 funding that is allocated to the non-state government-owned acute care teaching hospital disproportionate share payment fund shall be equal to the maximum amount allowed under Section 1923(g) of the Social Security Act
less the DSH payments made from the Graduate Medical Education and Disproportionate Share Fund on an annual basis. The Department's total year end DSH obligations to a qualifying hospital will be calculated following completion of the CMS Form 2552, Hospital and Healthcare Complex Cost Report desk review or audit.

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 Section 1923(f) of the Social Security Act. In addition, the total amount of all disproportionate-share payments shall not exceed the hospital-specific disproportionate-share limits under Section 1923(g) of the Social Security Act.

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

Indian Health Service or Tribal 638 Health Facilities will be paid at the most current inpatient hospital per diem rate established by the Indian Health Service which is published periodically in the Federal Register for established services provided in a facility that would ordinarily be covered services through the Iowa Medicaid Program.

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35. Final Settlement for Iowa State-owned Teaching Hospital

For dates of service July 1, 2010, through, June 30, 2015:

Final payment made to an Iowa state-owned teaching hospital shall be a methodology based on 100% of allowable medical assistance program cost not to exceed the sum of the following:

- Payments for inpatient hospital services calculated in accordance with the methods and standards for establishing payment rates per Attachment 4.19-A including graduate medical education payments;
- Payment for outpatient hospital services calculated in accordance with the methods and standards for establishing payment rates per Attachment 4.19-B and Supplement 2 to Attachment 4.19-B including graduate medical education payments ;
- $9,900,000.

The distribution of the additional $9,900,000 shall be made on a monthly basis and shall equal one-twelfth of the annual amount. The Iowa Medicaid Enterprise shall complete a final settlement based on the hospital's Medicare cost report.

Distribution methodology for the $9,900,000

The $9,900,000 will first be applied to bring inpatient hospital reimbursement (interim payments plus GME) to 100% of inpatient hospital cost (calculated in accordance with Attachment 4.19-A). The remaining amount of the $9,900,000 will then be applied to bring outpatient hospital reimbursement to 100% of outpatient hospital cost (calculated in accordance with Attachment 4.19-B and Supplement 2 to Attachment 4.19-B).

If the total $9,900,000 is used in bringing inpatient hospital reimbursement to 100% of inpatient cost, then no further outpatient payments will be made.

In no case will total inpatient hospital payments exceed 100% of inpatient cost.

If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100% of allowable inpatient and outpatient cost the amount by which payments exceed actual medical assistance program costs will be requested and collected from the hospital. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment will be made.

For dates of service July 1, 2015, through March 31, 2016:

The additional amount shall be $7,425,000. The same distribution methodology as described above shall apply.

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36. Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired conditions for non-payment under section 4.19(A)

_X_ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

For claims with dates of admission on and after January 1, 2010, the state does not make additional payments for services on inpatient hospital claims that are attributable to Hospital-Acquired Conditions (HAC) and are coded with Present on Admission Indicator codes "N" or "U". For HAC claims which fall under the DRG payment basis, the state does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

Charges and days related to the CC or MCC will be excluded from the outlier payment calculation described in this section 13 of Attachment 4.19-A.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(A)

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable conditions identifies below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

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If there are covered services or procedures provided during the same stay as the serious adverse event service, then the facility must submit two (2) claims; one (1) claim with covered services unrelated to the OPPC event and the other claim for any and all services related to the OPPC event with a type of bill 0110.

The claim must also contain one (1) of the diagnosis codes indicating wrong surgery, wrong patient, or wrong body part within the first five (5) diagnosis codes listed on the claim.

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36. Rural 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 rural hospital disproportionate-share fund if they chose to participate in the fund. A one-time payment will be made to qualifying hospitals under this provision. The total amount of funding that is paid from the rural hospital disproportionate-share fund is $257,931.78.

Hospitals qualify for rural hospital disproportionate-share payments if they meet the disproportionate share qualifications defined in Section 29.g of the approved Iowa Medicaid State Plan Attachment 4.19-A and being an Iowa hospital not located in a metropolitan statistical area (MSA) as defined by the Centers for Medicare and Medicaid Services (CMS).

The amount of disproportionate share payment shall be allocated as follows:

- Keokuk Area Hospital (Keokuk, IA) - $257,931.78

The total amount of disproportionate-share payments from the Graduate Medical Education and Disproportionate Share Fund, Iowa State-Owned Teaching Hospital Disproportionate Share Fund, Iowa Non-State Government-Owned Acute Care Teaching Hospital Disproportionate-Share Fund, and the rural 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.

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37. Iowa State-Owned Teaching Hospital Graduate Medical Education Supplemental Payments

This section of the state plan contains the provisions for making supplemental Medicaid payments to recognize the additional direct and indirect costs incurred by Iowa state-owned hospitals with approved graduate medical education (GME) programs.

In addition to payments from the Graduate Medical Education fund under section 29, payment will be made to Iowa hospitals as follows:

A. Qualifying Criteria

Iowa-state owned hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of GME activities. To qualify for these additional payments, the hospital must meet the following criteria:

1. Be eligible to receive GME payments from the Medicare program (Title XVIII of the Social Security Act) under provision of 42 C.F.R. §413.75.
2. Have more than 500 beds
3. Have eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education (ACGME) that participate in the Medicaid program.

B. Direct Graduate Medical Education Definitions

1. Direct Graduate Medical Education Cost – is the Medicaid allowable inpatient direct graduate medical education cost as reported on CMS form 2552, Hospital Cost Report; worksheet B, part I, line 21, column 1, and line 22, column 22.

2. Medicaid Managed Care Patient Load – is the ratio of Medicaid Managed Care inpatient days to total hospital inpatient days. This ratio is determined by the following; Medicaid Managed Care inpatient days as reported on CMS form 2552, worksheet S-3, part I, lines 2, 3, and 4, column 7 is divided by the hospital's total inpatient days, as reported on worksheet S-3, part I, lines 14, 16, and 32, column 8. Medicaid Managed Care inpatient days and total inpatient days include psychiatric and labor/delivery.

C. Methodology for Determining Direct Graduate Medical Education Payments

The hospitals that qualify for GME payments will have their hospital specific payment amount determined as follows:

1. The current year direct graduate medical education cost is multiplied by the Medicaid Managed Care Patient Load

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2. Subtract payments from the Graduate Medical Education Fund under section 29(b) from the results in (1.) of this subsection.

D. Indirect Graduate Medical Education Definitions

1. Current year allowable FTEs – is the number of full-time equivalent (FTE) Allopathic & Osteopathic Program interns and residents as reported on CMS form 2552, worksheet E, part A, line 10, column 1 plus the number of FTE Dental & Podiatric Program interns and residents as reported on CMS form 2552, worksheet E, part A, line 11, column 1.

2. Bed Days Available – is the total number of bed days available as reported on CMS form 2552, worksheet E, part A, line 4, column 1.

E. Methodology for Determining Indirect Graduate Medical Education Payments

The hospitals that qualify for GME payments will have their hospital specific payment amount determined as follows:

1. Calculate the hospital's ratio of interns and residents to beds (IRB). Divide the number of current year allowable FTEs by Bed Days Available.

2. Add 1.00 to the results in (1.) of this subsection.

3. The results in (2.) of this subsection raised to the 0.405 power.

4. Subtract 1.00 from the results in (3.) of this subsection.

5. Multiply the results in (4.) of this subsection by 1.35.

6. Multiply the results in (5.) of this subsection by the hospital's Medicaid Managed Care inpatient payments.

7. Subtract payments from the Graduate Medical Education Fund under section 29(e) from (6.) of this subsection.

F. Interim Payment

The qualifying hospital will be paid monthly interim direct and indirect medical education payments. The purpose of the interim payments is to provide a monthly payment of the approximate annual qualifying hospital's Medicaid direct and indirect graduate medical education costs. A computation to establishing a monthly interim payment will be performed annually at the start of each state fiscal year and in a manner consistent with the instructions below.

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1. The monthly interim direct and indirect graduate medical education payments will be determined using data submitted by the qualifying hospital and most current CMS Form 2552 on file as of July 1 of each state fiscal year.

2. Using data and CMS Form 2552, from (1.) in this subsection, determine the annual cost of direct graduate medical education cost using the formula in subsection (C.)

3. Using data and CMS Form 2552, from (1.) in this subsection, determine the annual cost of indirect graduate medical education cost using the formula in subsection (E.)

4. Divide the results of (2.) and (3.) of this subsection, by twelve.

5. The interim payments will be reconciled to the qualifying hospital's filed CMS Form 2552, from the year, in which the interim payments were made. If, at the end of the interim reconciliation process, it is determined the hospital received an overpayment, the overpayment will be recouped by the Department. If, at the end of the interim reconciliation process, it is determined the hospital received an underpayment, the underpayment will be paid to the qualifying hospital.

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Acute Care Psychiatric Hospitals

1. Introduction

Medicaid reimburses inpatient, acute care, psychiatric hospitals for approved Medicaid services provided to Medicaid-eligible persons residing in these hospitals.

2. Definition of Allowable Costs and Reimbursement Principles

Iowa Medicaid follows and complies with the Medicare definitions of allowable costs as contained in HIM 15.

Hospitals will be paid an interim per diem rate based on estimated allowable costs. At the end of the cost reporting period, the aggregate payments made to such facilities will be 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, aggregate payments include amounts received from the Medicaid program, 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. If the aggregate payments are less than the hospital's actual medical assistance program costs, the amount by which payments are less than actual costs will be paid to the hospital.

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

3. Reserved

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Acute Care Psychiatric Hospitals

4. Exceptions or Exemptions to the Rate-Setting Process

Under this plan, there are no exceptions or exemptions to the specified rate-setting procedures.

5. Hospital Patients Receiving Services at an Inappropriate Level of Care

Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate applicable to a Medicare skilled nursing facility or an intermediate care nursing facility. This payment will be the statewide average interim rate for hospital-based skilled nursing facility care or the Iowa Medicaid statewide average rate for intermediate care nursing facilities.

6. Provider Appeals

In accordance with 42 CFR 447.253(C), if a provider of service is dissatisfied with a reimbursement, that provider may file a written appeal. This written appeal must clearly state the nature of the appeal and be supported with all relevant data. The Department of Human Services (DHS) contracts with the Department of Inspections and Appeals

Proposed decisions may be appealed to the Director of DHS by a hospital or be reviewed at the Department's request. A final decision is issued by the Director within 120 days.

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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.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Acute Care Psychiatric Hospitals

a. Qualifying Criteria for Enhanced Disproportionate Share Payments

Hospitals qualify for enhanced disproportionate share payments if they meet the disproportionate share qualifications defined in Section 29.g and meet one of the following:

- Being an Iowa-state-owned hospital with more than 500 beds, having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.
- Being a non-state government-owned acute care teaching hospital located in a county with a population over three hundred fifty thousand.
- Being an Iowa-state-owned hospital for persons with mental illness.

b. Enhanced Disproportionate Share Payments

The total amount of disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund and Enhanced Disproportionate Share will not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund and enhanced disproportionate share payments will not exceed the hospital-specific DSH caps under Public Law 103-666.

The amount available for enhanced disproportionate share payments will be the federal allotment less disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund. In the event that the DSH allotment for enhanced payments is insufficient to pay 100% of cost eligible for DSH payments, the allotment will be allocated among qualifying hospitals using their eligible cost as an allocation basis.

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Acute Care Psychiatric Hospitals

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The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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A critical access hospital is a hospital that:

- Meets Medicare guidelines established in 42 CFR Part 485, Subpart F, and state hospital licensure requirements established in 481 Iowa Administrative Code 51.52(135B) as a hospital that serves a rural or vulnerable population, and
- Is necessary to the economic health and well being of the surrounding community.

Hospitals applying for critical access status are inspected, licensed, and certified as critical access hospitals, using Medicare criteria, by the Iowa Department of Inspections and Appeals.

Critical access hospital providers are reimbursed prospectively on a diagnosis-related-group (DRG) basis for inpatient care, pursuant to 441 Iowa Administrative Code 79.1(5), which defines a DRG as a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Retrospective adjustments will be made based on each critical access hospital's annual cost reports submitted to the Department at the end of the hospital's fiscal year. The retroactive adjustment equals the amount by which the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), determined in accordance with Medicare cost principles, and exceeds Medicaid fee-for-service reimbursement received on the diagnosis-related-group basis.

The DRG base rate for each critical access hospital will change for the coming year based on payments made to the critical access hospital for the previous year. The base rate upon which the DRG payment is built shall be changed after cost settlement to reflect, as accurately as is possible, the anticipated payment to the facility under Iowa Medicaid for the coming year using the most recent utilization as submitted to the fiscal agent. Once a hospital begins receiving reimbursement as a critical access hospital, DRG payments are not subject to rebasing.

Effective 7/1/2019, a CAH Adjustment Factor (CAF) will be applied to CAH reimbursement for the inpatient discharges on or after 7/1/2019. The hospital specific CAF is a prospective factor calculated using cost report data from previous years. The factor for year one will be calculated using Medicaid cost reports for provider fiscal year ends 9/30/17, 12/31/17, and 6/30/18. Year two will be calculated using 9/30/18, 12/31/18, and 6/30/19 cost reports and so forth. The funds associated with the CAF are capped prospectively with hospital specific factors.

The CAF is calculated as the difference between each hospital's incurred costs and payments received as a ratio to total payments received and applied on an individual claim basis. The period for this calculation is as referenced in the above paragraph.

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The provider-specific CAF amount will be calculated as follows:

Cost-to-Charge Ratio (CCR)	**A**	**This is calculated from the Medicare Cost Report (MCR) Worksheet C. CCRs are provider-specific and applied at the revenue code level**
Covered Medicaid FFS/MCO Charges	B	Covered charge amount from Medicaid FFS/MCO paid claims data
Medicaid FFS/MCO Cost	C=A*B	Covered Medicaid FFS/MCO charges times the CCR
Medicaid FFS/MCO Paid Amount	D	Medicaid paid amount from Medicaid FFS/MCO paid claims data
Third Party Payment Amount	E	Third party payment amount from Medicaid FFS/MCO paid claims data
Patient Shared Cost	F	Spenddown and copay amount from Medicaid FFS/MCO paid claims data
Uncompensated Care Cost Amount (UCC)	G=Max(0,C-D-E-F)	Difference in calculated Medicaid FFS/MCO cost and all payment amounts. This cannot be less than zero
Distribution	H=(G/Aggregate UCC Amount)	Calculated by dividing the provider-specific UCC by the aggregate UCC amount
Distributed Provider-Specific CAF Amount	I=H*Budget-Neutral Target Amount	The distribution percentage of total multiplied by the budget-neutral amount.

Hospitals that have a negative settlement ("Amount Due State") will receive a distributed CAF of zero percent.

Beginning 7/1/2020 and annually thereafter, an adjustment to the CAF will be included for prior year overpayment or underpayment that may have occurred in the aggregate relative to the estimated cap. CAHs will always receive at least the cost based interim rates as calculated annually by review of the cost report.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

Reserved for future use

Methods and Standards for Establishing Payment Rates for Inpatient Psychiatric Services for Individuals Under 21 Years of Age

1. **Non-State Owned Providers**

For services provided by non-state-owned providers on July 1, 2014 and after, inpatient psychiatric services for individuals under 21 years of age will be reimbursed according a fee schedule without reconciliation. The agency's fees were set as of July 1, 2021 and are effective for dates of service provided on or after July 1, 2021.

2. **State-Owned Providers**

The basis of payment for state-owned providers of inpatient psychiatric services for individuals under 21 years of age is 100 percent of actual and allowable cost. Actual and allowable cost is based on the cost report information the facility submits to the Department on Form 470-0664, Financial and Statistical Report. Rates are calculated as total actual and allowable cost divided by total patient days on a retrospective cost-related basis and adjusted retroactively.

Interim Rates

Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated cost per day.

Retroactive Cost Adjustment

Reimbursement payments made to state-owned psychiatric institution providers for services on or after July 1, 2009, shall be cost settled to actual cost. Following completion of a cost report desk review, cost settlement will be calculated using reasonable and proper actual cost per day from a 12-month period through retroactive adjustments. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of service rendered, not to exceed the maximum reimbursement rate. Providers will receive advance notice of the retroactive adjustments and will also receive transaction detail after the adjustments have been completed.

Definition of Allowable Costs and Reimbursement Principles

The actual and allowable costs of services rendered to Medicaid recipients are those that meet the principles specified in OMB Circular A-87 and the Medicare Provider Reimbursement Manual (CMS Publication 15-1). Actual and allowable costs must be reasonable and directly related to patient care.

Costs reported under inpatient psychiatric services shall not be reported as reimbursable costs under any other funding source. Cost incurred for other services shall not be reported as reimbursable costs under inpatient psychiatric services. Mileage reimbursement shall be limited to the maximum reimbursement rate allowed State employees at the time of service provision.

Cost Reporting Requirements

All state-owned providers shall submit the Medicaid cost report, Form 470-0664, *Financial and Statistical Report*, on an annual basis. Financial information shall be based on the provider's financial records. When records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in adjustment to the reimbursement rate, claim denial, recoupment or termination of the provider's enrollment with the Iowa Medicaid program. The Department may require that an opinion of a certified public accountant accompany the report when a provider has a history of cost report adjustments or inability to support cost report data.

Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, IA 50315. Cost reports shall be submitted on or before the last day of the third month after the end of the provider's fiscal year end. Hospital-based providers will be required to submit their cost report within five months from the end of the provider's fiscal year end. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

If a provider fails to submit a complete cost report, including the working trial balance, the department shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

3. **Provider Appeals**

In accordance with 42 CFR 447.253(c), if a provider of service disagrees with the reimbursement determination, the provider may file an appeal and request reconsideration from the Administrator of the Division of Medical Services in the Department. The appeal must be in writing, clearly state the nature of the appeal, and be supported with all relevant data. Appeals must be submitted within 30 days of the date of the decision.

The Administrator of the Division of Medical Services will review the material submitted, render a decision and advise the provider accordingly within a period of 90 days.