Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

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 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

State/Territory: IOWA

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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.

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.

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.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

L. 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

Other Provider-Preventable Conditions

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

__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:

Claims data with dates of service on or after September 1, 2011 will be reviewed retroactively and those fitting the criteria for PPCs will be identified. Providers will be supplied information identifying claims with the potential PPCs and will be given the opportunity to review and respond to any discrepancies. For any provider-confirmed PPCs payment will be adjusted by recouping payment for the patient day(s) in which the PPC event occurred. Recoupment will be for the amount of the per diem that was in effect for the date(s) of service that the PPC event occurred.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

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.

29. 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

Other Provider-Preventable Conditions

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

__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:

Medical claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (4) diagnoses codes on the claim.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

22. 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

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Supplement 2 to Section(s) 4.19(B)

__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:

Outpatient hospital claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (5) diagnoses codes on the claim.

OS Notification

State/Title/Plan Number:	**IA 11-018**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**05/31/2012**
Fiscal Impact:	**FY 2011 ($ 144,894)** **FY 2012 ($1,685,429)**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective September 1, 2011, this SPA eliminates graduate medical education payments to out-of-state hospitals, reduces graduate medical education payments to in-state hospitals, and imposes payment reductions for health care-acquired conditions. In regards to the health care-acquired conditions, this SPA imposes payment reductions in inpatient hospitals for HACs as identified by Medicare (with the DVT/PE exception) and the 3 mandatory other provider preventable conditions, and for outpatient hospitals and nursing facilities it imposes payment reductions for the 3 mandatory OPPCs. Tribal consultation was conducted for this amendment. Public notice was timely. The funding question responses were satisfactory. The State does not believe access to care will be affected for the following reasons: GME payments are being eliminated to 4 Omaha Nebraska hospitals. These hospitals already receive GME payments from Nebraska, plus these hospitals will benefit from increased payment rates due to a rebasing effective 11/1/12 (Pending in SPA 11-28). For in-state hospitals, the GME payment reductions are off-set by rate increases proposed in SPA 11-022 and the rate rebasing effective 11/1/12. Overall, payments to hospitals will increase in Iowa in SFY 2012 through the combined effects of SPAs 11-018, 11-022, and 11-028. The State has also not been contacted by any providers expressing concern regarding the payment reductions for HACs.

Other Considerations:	**This OSN has been reviewed in the context of the Affordable Care Act (ACA) and approval of the OSN is not in violation of the ACA provisions.** **We do not recommend the Secretary contact the governor.**
CMS Contact:	**Tim Weidler, NIRT 816-426-6429**