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 November 1, 2011. The current DRG payment is established through a base-year rate (2010) 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, 2010 and before January 1, 2011. 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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"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, 2011 through June 30, 2012.

"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 November 1, 2011.

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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, 2009 through December 31, 2010 and paid through March 31, 2011.

"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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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 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0.0% for SFY 2003, 0.0% for SFY 2004, 0.0% for SFY 2005, 3.0% for SFY 2006, 3.0% for SFY 2007, 0.0% for SFY 2008, and 11.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on October 1, 2010, rates effective June 30, 2010, shall be increased by 20.46% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 76.94% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. For services beginning on October 1, 2011, rates effective September 30, 2011, shall be decreased by 41.18% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

Rates effective November 1, 2011, and thereafter, have been trended forward by 5.72%. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

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.

In accordance with 42 CFR 447.271, as part of the final settlement process, the IME Provider Cost Audit and Ratesetting 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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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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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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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.

OS Notification

State/Title/Plan Number:	**IA 11-028**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**09/13/2012**
Fiscal Impact:	**FY 2012 $9,528,275** **FY 2013 $10,395,136**

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: Yes

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

Detail:

Effective November 1, 2011, this SPA proposes to implement the triennial inpatient hospital diagnosis-related group payment system rebase and recalibration. This rebase and recalibration is required under current provisions of the Iowa Medicaid State Plan. Additionally, this amendment proposes to trend inpatient hospital rates forward by 5.72%. Tribal consultation requirements were met for this amendment. Public notice was timely. The funding question responses were satisfactory. The SFY 2012 UPL demo was reviewed in depth and found to be acceptable with adequate room to accommodate the proposed increased Medicaid payments.

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**