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SUPPLEMENT 2 TO ATTACHMENT 4.19-B

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care

1. Definitions

The following definitions are provided to ensure understanding among all parties.

"Allowable costs" are those defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, 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.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary services" means those tests and procedures ordered by a physician to assist in patient diagnosis or treatment. Ancillary procedures, such as immunizations, increase the time and resources expended during a visit, but do not dominate the visit.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report" for rates effective January 1, 2012, shall mean the hospital's cost report with fiscal year ending on or after January 1, 2010, and before January 1, 2011. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in determining the statewide base APC rate.

State Plan TN #	IA-12-006	Effective	JAN 0 1 2012
Superseded TN#	MS-08-028	Approved	NOV 3 0 2012

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"Healthcare common procedures coding system" or "HCPCS" means the national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS), which incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International Classification of Diseases" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"IowaCare Waiver" means a Section 1115 Demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS) to operate from July 1, 2005 through December 31, 2013. Under this waiver, a limited benefit package, provided by a limited number of providers, will be made available to persons who don't otherwise qualify for Medicaid, and who are: ages 19 through 64, with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL); or pregnant women with income below 300 percent of the FPL. Additionally, the waiver provides for coverage of expenditures for certain Medicaid State Plan services provided to individuals in eligibility groups receiving only limited benefits.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing a single service.

"Observation services" means a set of clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or is able to be discharged from the hospital.

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Indicator	Item, Code, or Service	OPPS Payment Status
K	Non-pass-through drugs and nonimplantable biological, including therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.
		 Paid based on the Iowa Medicaid fee schedule for outpatient hospital services when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services.
		If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
М	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals services.
		If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria.	Paid under OPPS APC. Payment is included with payment for other services, including outliers; therefore, no separate payment is made.

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Indicator	Item, Code, or Service	OPPS Payment Status
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX - packaged codes.	Paid under OPPS APC.
		Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S", "T", "V", or "X".
,		In all other circumstances, payment is made through a separate APC payment.
Q2	T – packaged codes	Paid under OPPS APC.
		Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T".
		In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.
		If not covered by Iowa Medicaid, the codes is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.
1_		If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

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Indicator	Item, Code, or Service	OPPS Payment Status
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.
		If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
· U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.
		If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.
•		If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Х	Ancillary services	If covered by Iowa Medicaid, the service is aid under OPPS APC with separate APC payment.
		If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

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Outpatient Hospital Care (Cont.)

Indicator	Item, Code, or Service	OPPS Payment Status
Y Nonimplantable durable medical equipment		For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services.
		For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

4. Calculation of case-mix indices

Hospital-specific and state-wide case-mix indices shall be calculated using the Medicaid claim set.

- a. Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.
- b. The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

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Superseded TN #	MS-08-028	Approved	NOV 3 0 2012

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Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

- 5. Calculation of the hospital-specific base APC rates
 - a. The final payment rate for the current rebasing uses the hospital's base-year cost report. 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 1.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on July 1, 2010, rates effective June 30, 2010, shall be increased by 13.74% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 3.38% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on January 1, 2012, rates effective December 31, 2011, shall be increased by 11.14% except for the University of Iowa Hospital and clinics and out-of-state hospitals. This rate increase is effective for services rendered during January 1, 2012-June 30-2012.

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

- b. Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.
- c. The cost to charge ratios are applied to each line item charge reported on claims in the Medicaid claim set, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

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- d. The following items are subtracted from the hospital's total outpatient Medicaid costs:
 - (1) The total calculated Medicaid direct medical education costs for interns and residents based on the hospital's base-year cost report. The reimbursement for direct medical education is allocated to the Graduate Medical Education and Disproportionate Share Fund and is not paid on a per-claim basis. The requirements to receive payments from the fund, the amount allocated to the fund, and the methodology used to determine the distribution amounts from the fund are found in Section 17.
 - (2) The total calculated Medicaid cost for non-inpatient program services.
 - (3) The total calculated Medicaid cost for ambulance services
 - (4) The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

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