Revised Submission 7.8.13

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 July 1, 2008, shall mean the hospital's cost report with fiscal year ending on or after January 1, 2006, and before January 1, 2007. 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.

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"Case-mix index" means an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean serviced provided during a single visit that have an extraordinarily high cost and therefore eligible for additional payments above and beyond the base APC payment.

"Current Procedural Terminology – (CPT)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"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 outpatient 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 base year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rule is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"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 costs associated with the operation of graduate medical education programs.

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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 - (ICD)" 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 June 30, 2010. 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Requirements for Third Party Liability – Identifying Liable Resources

1. FREQUENCY OF DATA EXCHANGES

A. State Wages and Income Collection Agencies (SWICA) and Social Security Administration (SSA) Wage and Earning Files

Exchanges with SWICA and SSA wage and earnings files are conducted consistent with IEVS regulations. The SWICA exchange is conducted upon Medicaid application and quarterly on all recipients. Exchanges on absent parents are conducted monthly. The SSA data exchange is conducted consistent with IEVS.

B. Industrial Commission Data Exchange

DHS determined that it was not cost effective to maintain this match, due to the fact the DHS' effective Trauma Edit Project was a duplicate effort. (See D)

C. State Motor Vehicle Data Exchange

There is currently no DMV match, although if an auto accident were identified via a Trauma Lead Letter, the IME Revenue Collections Unit would review the Trauma Lead Letter and create a lien case to pursue recovery.

D. Diagnosis and Trauma Code Edits

On a monthly cycle, members with paid claims showing ICD trauma diagnosis codes are reported by the IME Core Unit. A questionnaire is sent to each member requesting verification as to the accident or injury. Upon receipt of member responses, the IME Revenue Collections Unit follows up and contacts liable third parties, initiates recovery action, and tracks all efforts.

2. FOLLOW-UP

A. Absent Parents

The names, social security numbers, and possible third party resources of noncustodial and custodial parents are obtained by the Child Support Recovery Unit (CSRU) and entered into the TPL Subsystem of the MMIS on a weekly basis. The above-referenced information is also requested on the Supplemental Insurance Questionnaire (SIQ). When information is obtained from the SIQ, it is verified via telephonic or web site verification and loaded via electronic processes into the MMIS or entered directly into the TPL Subsystem of the MMIS.

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Requirements for Third Party Liability – Identifying Liable Resources

2. FOLLOW-UP (Cont.)

A. Absent Parents (Cont.)

The Child Support Recovery Unit sends a weekly file to the IME Revenue Collections Unit, which includes insurance information when coverage is provided by a noncustodial parent.

B. Industrial Commission

DHS determined that it was not cost effective to maintain this match, due to the fact that DHS' effective Trauma Code Edit Project was a duplicate effort. (See 4.22-A, page 1, item 1 D.)

C. State Motor Vehicle Accident File

Not applicable. See Section 1, paragraph C.

D. Diagnosis and Trauma Code

Diagnosis and trauma code edits are being conducted for all ICD trauma diagnosis codes, consistent with applicable Federal guidelines.

Casualty claims threshold is set at $250.00.

For casualty claims, the IME Revenue Collections Unit proactively prioritize cases with higher claim values, but reactively work any and all cases where an attorney or insurance company contacts us to request claim recovery information.

Casualty and trauma claims are accumulated from the date of the accident and are added together for one (1) year to compare to the $250.00 threshold.

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2. FOLLOW-UP (Cont.)

D. Diagnosis and Trauma Code (Cont.)

Casualty or liability recoveries are initiated by many sources. Referrals are received from members, questionnaires (trauma), data matches, providers, attorneys, and many other sources. When a casualty/liability case is discovered, the parties are notified of Medicaid's subrogation and lien rights in writing. A claims summary printout is obtained from the MMIS system. Claims paid by Medicaid are reviewed and the claims determined to be related to the casualty/liability case are calculated. The Revenue Collections Unit files a lien for the amount of related paid claims with the County Court where the member resides. Updated liens are filed as necessary to ensure Medicaid's lien is current.