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State/Territory Name: IA

State Plan Amendment (SPA) #: 16-0023

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

July 29, 2016

Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut Street, 5th Floor
Des Moines, IA 50319-0114

Dear Mr. Palmer:

On May 5, 2016, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #16-0023, requesting approval for adding language for Iowa's managed care transition with an April 1, 2016, effective date.

This SPA 16-0023 was approved on July 28, 2016, with an effective date of April 1, 2016, as requested by the State. Enclosed is a copy of the CMS-179 form, as well as, the approved pages for incorporation into the Iowa State plan.

If you have any questions regarding this amendment, please contact Kevin Slaven at (816) 426-5925 or Kevin.Slaven@cms.hhs.gov.

Sincerely, 7/29/2016

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosures

cc:
Mikki Stier, Medicaid Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16 — 023

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ 0
b. FFY 2017 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 2 to Attachment 4.19-B, page 3, 5, 6, 23, ~~23b~~, 24, 24c *23b (New Page)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 2 to Attachment 4.19-B, page 3, 5, 6, 23, ~~23b~~, 24, 24c *23b (New Page)

10. SUBJECT OF AMENDMENT
This modifies language for managed care transition that occurred on 4/1/16. GME payment language is also being amended. Changes are budget-neutral as there is no change in funding amounts.

11. GOVERNOR'S REVIEW *(Check One)*

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 5-5-16

16. RETURN TO
CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 5, 2016

18. DATE APPROVED: July 28, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL: //s//

21. TYPED NAME: James G Scott

22. TITLE: Associate Regional Administrator for Division of Medicaid and Children's Health Operations

23. REMARKS

*Pen and Ink changes per email from state dated 07.19.16.

FORM CMS-179 (07/92)

Instructions on Back

State/Territory: IOWA

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

Outpatient Hospital Care (Cont.)

"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.

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

Outpatient Hospital Care (Cont.)

"Status indicator " or "SI" means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

2. Outpatient hospital services

Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22, as amended to October 1, 2007, except as indicated herein. Interim payments to critical access hospitals shall be based on the hospital's outpatient Medicaid cost to charge ratio.

a. A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 162, as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined billed with the hospital service. Reasonable cost settlement for those costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

b. A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

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

Outpatient Hospital Care (Cont.)

3. Payment for outpatient hospital services

a. Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

(1) Any specific rate or methodology established in the state plan for the particular service.

(2) The OPPS APC rates established herein.

(3) Medicaid fee schedule. All Clinical Diagnostic Laboratory code series will be reimbursed at 100% of the Medicare rate including codes series 81000.

b. Outpatient hospital services that are not provided by critical access hospitals and that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. Medicaid adopts the OPPS APC relative weights and discount factors using the most current calendar year update as published by the Centers for Medicare and Medicaid Services.

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

Outpatient Hospital Care (Cont.)

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:

- Multiply the total count of outpatient visits for claims 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.

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

- Multiply each hospital's percentage by the amount allocated for direct medical education 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.

18. Relationship to Managed Care

All monetary allocations made to fund the Graduate Medical Education and Disproportionate Share Fund for direct medical education, are reimbursed directly to hospitals on a monthly basis.

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

Direct 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.

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

Outpatient Hospital Care (Cont.)

19. Reserved for future use

20. Final Settlement for Iowa State-owned Teaching Hospital

Distribution methodology for the $9,900,000 for dates of service July 1, 2010-June 30, 2015:

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 outpatient hospital payments exceed 100% of outpatient cost.

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.

State/Territory: IOWA

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

Outpatient Hospital Care (Cont.)

22. Payment for Outpatient Services Delivered in the Emergency Room

Payment for outpatient Services delivered in the emergency room will be based on the following criteria:

A. For ER visits that do not result in an inpatient admission and includes emergent diagnosis codes payment is made at 100 percent of the usual APC payment plus a triage/assessment fee schedule payment.

B. For ER visits that do not result in an inpatient admission and do not include emergent diagnosis codes, payment is made as follows:

a. For Medicaid members referred to the ER by appropriate medical personnel payment is made at 75 percent of the usual APC payment plus a triage/assessment fee schedule payment.

b. For Medicaid members not referred to the ER by appropriate medical personnel payment is made at 50 percent of the usual APC payment plus a triage/assessment fee schedule payment.

The copayment amount per Attachment 4.18-A will be deducted after APC payment reductions have been applied.