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State/Territory Name: Iowa

State Plan Amendment (SPA) IA: 24-0001

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

May 8, 2024

Elizabeth Matney Medicaid Director
Division of Medical Services
Department of Human Services
Iowa Medicaid Enterprise
1305 E. Walnut Street
Des Moines, IA 50319

RE: TN 24-0001

Dear Director Matney:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Iowa (IA) State Plan Amendment (SPA) to Attachment 4.19-B IA-24-0001, which was submitted to CMS on March 15, 2024. This plan amendment implements the tri-annual outpatient hospital rate rebase.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 3, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Lindsay Michael at 410-786-7197 or Lindsay.michael@cms.hhs.gov.

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 4 — 0 0 0 1</u>	2. STATE <u>IA</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 3, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR §447.200

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 \$ 0
b. FFY 25 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 2 to Attachment 4.19-B, page 1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Supersedes Supplement 2 to Attachment 4.19-B, page 1

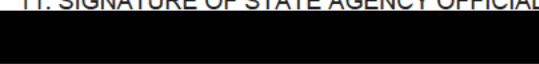
9. SUBJECT OF AMENDMENT

The proposed state plan amendment implements the tri-annual outpatient hospital rate rebase as authorized by Senate File (SF) 5

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL


12. TYPED NAME
Elizabeth Matney

13. TITLE Director, Iowa Medicaid & Division Administrator and HHS Deputy Director


14. DATE SUBMITTED
3/13/2024

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED 3/15/24	17. DATE APPROVED May 8, 2024
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL 1/3/24	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL Todd McMillion	21. TITLE OF APPROVING OFFICIAL Director, DRR

22. REMARKS

Pen and ink change approved by IA for effective date change to 1/3/24.

State/Territory:

IOWA

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, 2024, shall mean the hospital’s cost report with fiscal year ending on or after January 1, 2022 and before January 1, 2023. 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 #	<u>IA-24-0001</u>	Effective	<u>1/3/24</u>
Superseded TN #	<u>IA-21-0001</u>	Approved	<u>May 8, 2024</u>