ARC 6889B

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency After Notice

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 92, "IowaCare," Iowa Administrative Code.

These amendments change the Medicaid reimbursement methodology for outpatient hospital services. Iowa Medicaid has been reimbursing for outpatient hospital services based on a combination of prospectively set payments through a combination of a cost-based payment methodology based upon ambulatory patient groups (APGs) and Medicaid-determined fee schedules for noninpatient programs, ambulance services, observation beds, and clinical diagnostic laboratory services. The hospital-specific base rates and Iowa-specific APG weights are updated (rebased) every three years and are inflated during nonrebasing years as approved by the Iowa General Assembly. The last rebasing was effective October 1, 2005.

Provisions of 2008 Iowa Acts, Senate File 2425, section 32, authorize the Department to implement the Medicare ambulatory payment classification methodology for reimbursement of outpatient hospital services and provide that any change in hospital reimbursement shall be budget-neutral. Under these amendments, hospital outpatient services will be paid based on a combination of:

• Medicaid-determined fee schedules; and

• Medicare's outpatient prospective payment system (OPPS), as mandated for Medicare by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

The Medicaid payment for hospital outpatient services paid based on the OPPS will be made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). Each ambulatory payment classification is 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. The relative weight assigned to the APC measures the resource requirements of the service.

The Centers for Medicare and Medicaid Services publish relative weights for ambulatory payment classifications annually in the Code of Federal Regulations. These amendments adopt and incorporate by reference the OPPS APCs and relative weights effective January 1, 2008, published as final regulations on November 27, 2007, in the Federal Register at Volume 72, No. 227, page 66579.

Each service represented by a current procedural terminology (CPT) or healthcare common procedures coding system (HCPCS) code is assigned an OPPS APC payment status indicator that indicates whether a service is payable under an OPPS APC or another payment system and also whether particular OPPS policies apply to the code. Services that do not have an assigned weight will be paid based on the Iowa Medicaid fee schedule.

The APC payment is calculated by multiplying the assigned APC relative weight by the blended base APC rate. The blended base APC rate reflects a 50/50 blend of statewide and hospital-specific base APC rates. The statewide and hospital-specific base APC rates are calculated using the hospitals' base-year cost reports and arithmetical hospital-specific and statewide case-mix indices that measure the relative average costliness of outpatient cases treated in a hospital compared to the statewide average cost. To limit aggregate expenditures to available funding, a budget factor is applied when the statewide and hospital-specific base APC rates are calculated.

Outpatient hospital services that have been assigned to an APC with an assigned weight will be reimbursed based on the APC to which the services provided are assigned. A discount factor is usually applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). However, not all APCs are subject to a discount factor. For procedures started but discontinued before completion, the payment will be 50 percent of the APC for

those services. A cost outlier payment is made for services provided during a single visit that have an extraordinarily high cost and is considered an additional payment beyond the base APC payment.

Some services or groups of services that are assigned an APC are "packaged" with other services. Packaged services are services that are secondary to other services but considered an integral part of another service. Generally, separate payment is not made for packaged services. However, there are limited instances where separate payment under the OPPS APC payment criteria will be made for packaged services.

OPPS APC relative weights will be updated annually in January. Effective January 1, 2009, and every three years thereafter, base APC rates and case-mix indices will be updated. During years when no update is made, inflation will be applied only to the extent the Iowa General Assembly provides funding.

These amendments change the interim payment methodology for outpatient services provided by critical access hospitals to payment based on the hospital's cost-to-charge ratio. The final payment rate is still determined by the retrospective adjustment to 100 percent of allowable cost. Noninpatient programs, ambulance services, and clinical diagnostic laboratory services will continue to be paid based on the Medicaid-determined fee schedule.

These amendments do not provide for waivers in specified situations. A hospital may request a waiver under the Department's general rule on exceptions at rule 441—1.8(17A,217).

Notice of Intended Action on these amendments was published in the Iowa Administrative Bulletin on March 12, 2008, as **ARC 6629B**. The Department received one comment on the Notice of Intended Action, asking that the Department clarify the application of these amendments to critical access hospitals. In response to this comment, the Department has made the following changes to the amendments as published under Notice of Intended Action:

• Amended paragraph 79.1(1)"g" to remove references to the basis for prospective payments for critical access hospitals and to replace language about how those payments are adjusted with cross references to the specific rules on reimbursement of inpatient and outpatient services.

• Removed proposed references to APC payment in paragraph 79.1(5)"aa."

• Removed the last sentence from the proposed introductory paragraph of 79.1(16)"b."

• Inserted new paragraph 79.1(16)"h" to explain reimbursement for outpatient services in a critical access hospital and relettered proposed paragraph "h" as paragraph "i." Interim payments to critical access hospitals for outpatient services are based on the hospital's outpatient Medicaid cost-to-charge ratio. These payments are adjusted retroactively based on the reasonable cost of services, which is determined based on the hospital's cost report and Medicare cost principles.

• Added a reference to new paragraph 79.1(16)"h" in subparagraph 79.1(16)"c"(2) to clarify that critical access hospitals are excluded.

• Struck subparagraph 79.1(16)"j"(5).

• Amended paragraph 79.1(16)"o" to clarify that critical access hospitals are excluded.

Other changes to the Notice of Intended Action are as follows:

• Subrule 78.3(5) and paragraphs 78.31(2)"h" and 79.1(8)"d" are amended to remove references to APG payments and to reference "Medicaid members" instead of "Medicaid recipients." Subrule 78.3(5) is also updated to correct cross references for drug coverage.

• Subparagraph 92.8(3)"a"(2) is amended to define IowaCare covered services for pregnant women without referring to APG coding.

The Council on Human Services adopted these amendments on June 11, 2008.

The Department finds that these amendments confer a benefit on hospitals by streamlining billing procedures. Therefore, these amendments are filed pursuant to Iowa Code section 17A.5(2)"b"(2), and the normal effective date of these amendments is waived.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments became effective on July 1, 2008.

The following amendments are adopted.

ITEM 1. Amend subrule 78.3(5) as follows:

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in ~~78.1(2)*"a"*(2) and (3)~~ 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in ~~78.1(2)~~ 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through ~~the APG reimbursement~~ a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. Hospitals ~~which~~ that wish to administer vaccines which are available through the vaccines for children program to Medicaid ~~children~~ members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid ~~recipients~~ members.

ITEM 2. Amend paragraph **78.31(2)"h"** as follows:

h. Hospital outpatient programs ~~which~~ that wish to administer vaccines which are available through the vaccines for children program to Medicaid ~~recipients~~ members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid ~~recipients~~ members. Hospital outpatient programs receive payment via the ~~APG~~ APC reimbursement for the administration of vaccines to Medicaid ~~recipients~~ members.

ITEM 3. Amend paragraph **79.1(1)"g"** as follows:

g. Retrospectively adjusted prospective rates. Critical access ~~hospital providers~~ hospitals are reimbursed prospectively ~~on a DRG basis for inpatient care and an APG basis for outpatient care, pursuant to subrule 79.1(5)~~, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid ~~recipients~~ members (excluding ~~recipients~~ members in managed care), determined in accordance with Medicare cost principles, and the Medicaid ~~fee-for-service~~ reimbursement received ~~on the DRG and APG basis~~. Amounts paid ~~prior to adjustment~~ that exceed reasonable costs shall be recovered by the department. ~~The base rate upon which the DRG and APG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audits and rate-setting unit and Medicare cost principles.~~ See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

~~Once a hospital begins receiving reimbursement as a critical access hospital, prospective DRG and APG payments are not subject to the inflation factors, rebasing, or recalibration as provided in 441—paragraph 79.1(5)*"k"* and 441—paragraph 79.1(16)*"j."*~~

ITEM 4. Amend paragraph **79.1(5)"aa"** as follows:

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid ~~recipients~~ members (excluding ~~recipients~~ members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid ~~prior to~~ before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG ~~and APG~~ payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid ~~recipients~~ members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost ~~audits~~ audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG ~~and APG payments are~~ base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ITEM 5. Amend paragraph **79.1(8)"d"** as follows:

d. All hospitals ~~which~~ that wish to administer vaccines which are available through the vaccines for children program to Medicaid ~~recipients~~ members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid ~~recipients~~ members. Hospitals receive reimbursement for the administration of vaccines to Medicaid ~~recipients~~ members through the DRG reimbursement for inpatients and ~~APG~~ APC reimbursement for outpatients.

ITEM 6. Amend paragraph **79.1(16)"a"** as follows:

a. Definitions.

"Allowable costs" means the costs 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 patient group (APG)"* shall mean a group of similar outpatient procedures, encounters or ancillary services which are combined based on patient clinical characteristics and expected resource use. Data used to define APGs include ICD-9-CM diagnoses codes and CPT-4 procedure codes.~~

"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 service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

~~*"Ancillary services"* shall mean 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.

~~*"APG relative weight"* shall mean a number that reflects the expected resource consumption for cases associated with each APG, relative to the average APG. That is, the Iowa-specific weight for a certain APG reflects the relative charge for treating all singleton cases classified in that particular APG, compared to the average charge for treating all Medicaid APGs in Iowa hospitals.~~

~~*"Assessment payment"* shall mean an additional payment made to a hospital for only the initial assessment and determination of medical necessity of a patient for the purpose of determining if the ER is the most appropriate treatment site. This payment shall be equal to 50 percent of the customary reimbursement rate for CPT-4 code 99281 (Evaluation and Management of a Patient in the Emergency Room) as of December 31, 1994.~~

"Base-year cost report," for rates effective ~~October~~ July 1, ~~2005~~ 2008, shall mean the hospital's cost report with fiscal year end on or after January 1, ~~2004~~ 2006, and before January 1, ~~2005~~ 2007 ~~,~~ ~~except as noted in paragraph *"s."*~~. Cost reports shall be reviewed using Medicare's cost-reporting and cost reimbursement principles for those cost-reporting periods.

"Blended base ~~amount~~ APC rate" shall mean the ~~case-mix-adjusted,~~ hospital-specific ~~operating cost per visit associated with treating Medicaid outpatients~~ base APC rate, plus the statewide ~~average case-mix-adjusted operating cost per Medicaid visit~~ base APC rate, divided by two. ~~This basic amount is the value to which inflation is added to form a final payment rate.~~ The costs of 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 determining the statewide ~~average case-mix-adjusted operating cost per Medicaid visit~~ base APC rate.

~~*"Case-mix adjusted"* shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.~~

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

~~*"Consolidation"* shall mean the process by which the APG classification system determines whether separate payment is appropriate when a patient is assigned multiple significant procedure APGs. All significant procedures within a single APG are suppressed (or grouped) for payment purposes, into one APG. Multiple, related significant procedures in different APGs are consolidated into the highest weighted APG for reimbursement purposes. Multiple, unrelated significant procedures in different APGs are not consolidated; thus, each receives separate payment.~~

"Cost outlier" shall mean ~~cases which~~ services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and~~, thus,~~ are therefore eligible for additional payments above and beyond the base ~~APG~~ APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 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" shall mean 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" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate 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.

~~*"Discounting"* shall mean a reduction in standard payment when related procedures or ancillary services are performed during a single visit. Discount rates are defined in paragraph *"h."*~~

~~*"Final payment rate"* shall mean the blended base amount that forms the final dollar value used to calculate each provider's reimbursement amount, when multiplied by the APG weight. These dollar values are displayed on the rate table listing.~~

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

~~*"Grouper"* shall mean the Iowa-specific Version 2.0 Grouper software developed by Minnesota Mining and Manufacturing (3M) for the Centers for Medicare and Medicaid Services, with modifications for payable APGs made to support Medicaid program policy in Iowa. (See paragraph *"i."*)~~

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that 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.

~~*"Inlier"* shall mean those cases where the cost of treatment falls within the established cost boundaries of APG payment.~~

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" 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.

~~*"Invalid claims or visits"* shall mean claims or visits that are not priced and paid using the ambulatory patient group (APG) system.~~

"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 that service by itself.

~~*"Net number of Iowa Medicaid valid visits"* shall mean total visits plus the incremental portion of visits that resulted in outliers less invalid visits.~~

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

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single ~~UB-92~~ claim form~~, and which occur within 72 hours of initiation of service, with exceptions as noted in paragraph *"m."*~~.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

~~*"Packaging"* shall mean the inclusion of routinely performed ancillary services in the reimbursement of an APG. In the APG classification system, there are many routine, low-cost ancillary procedures or tests, such as routine urinalysis which are customarily ordered and performed during a visit. When this ancillary service is packaged, this indicates that the relative APG weight has been set to reflect the inclusion of the costs of the related ancillary procedures. The packaged APGs are 310 (plain film), 332 (simple pathology), 343 (simple immunology), 345 (simple microbiology), 347 (simple endocrinology), 350 (basic chemistry), 349 (simple chemistry), 351 (multichannel chemistry), 359 (urinalysis), 356 (simple clotting), 358 (simple hematology), 360 (blood and urine dipstick), 371 (simple pulmonary function tests), 373 (cardiogram), 383 (introduction of needles and catheter), 384 (dressings and other minor procedures), 385 (other ancillary procedures), and 321 (anesthesia).~~

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

~~*"Rate table listing"* shall mean a schedule of rate payments maintained by the department for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate APG weight.~~

"Rebasing" shall mean the redetermination of the blended base ~~amount or other applicable components of the final payment rate from~~ APC rate using more recent Medicaid cost report data.

~~*"Recalibration"* shall mean the adjustment of all APG weights to reflect changes in relative resource consumption.~~

"Significant procedure ~~APG~~" shall mean ~~a~~ the procedure ~~which~~, therapy, or service provided to a patient that constitutes the primary reason for the visit and ~~which~~ dominates the time and resources expended during the visit.

~~*"Singleton APG"* shall mean those APGs on a patient claim which, following consolidation of significant procedures and packaging of ancillaries, are part of a visit with no remaining multiple significant procedures. These singletons, as well as medical and ancillary visits, are used to calculate relative weights in the procedure described in paragraph *"d."*~~

~~*"Statewide visit expected payment (SVEP)"* shall mean the expected payment for an outpatient visit, for use in defining cost outliers. This payment equals the sum of the statewide average case-mix adjusted operating cost per Medicaid visit multiplied by the relative weight for each valid APG within a visit (following packaging and discounting), which includes the applicable fee schedule amounts.~~

"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.

~~*"Valid claims or visits"* shall mean those claims or visits that are priced and paid using the ambulatory patient group (APG) system.~~

ITEM 7. Rescind paragraphs **79.1(16)"b"** to **79.1(16)"e"** and adopt the following **new** paragraphs in lieu thereof:

b. 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 in this subrule.

(1) 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 415.162 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 with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) 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.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa

Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) 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 by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services 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. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a bill type other than outpatient hospital. ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.

C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	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 hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.

K	Blood and blood products Brachytherapy sources Non-pass-through drugs and biologicals 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 established pursuant to 79.1(1)*"c"* 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 hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	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 hospital services established pursuant to 79.1(1)*"c."* 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, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria. If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.
S	Significant procedure, not discounted when multiple	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.

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.
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.
X	Ancillary services	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.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(1) 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.

(2) 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.

e. Calculation of the hospital-specific base APC rates.

(1) 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.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, 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.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

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.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

ITEM 8. Rescind paragraph **79.1(16)"f"** and adopt the following **new** paragraph in lieu thereof:

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

ITEM 9. Amend paragraph **79.1(16)"g"** as follows:

g. ~~Outlier~~ Cost outlier payment policy. Additional payment is made for ~~approved cases meeting or exceeding~~ services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each ~~APG~~ APC. Outlier payments are determined on an APC-by-APC basis.

(1) ~~Cases qualify~~ An APC qualifies as a cost ~~outliers~~ outlier when ~~costs~~ the cost of the service ~~in a given case exceed~~ exceeds both the ~~cost~~ multiple threshold and the fixed-dollar threshold. ~~For visits with a "statewide visit expected payment (SVEP)" equal to or between $150 and $700, this cost threshold is determined to be two times the statewide average APG-based payment or SVEP for that visit. For SVEPs greater than $700, the outlier cost threshold for a hospital outpatient visit equals the statewide average payment plus $500. There is no outlier threshold (or additional payment) for hospital visits with an SVEP less than $150.~~

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) ~~Costs are~~ The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ~~ratios~~ ratio determined ~~in~~ from the base year cost ~~reports~~ report. ~~Additional payment for cost outliers is 60 percent of the excess between the hospital's cost for the visit and the cost threshold established to define cost outliers.~~ Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

ITEM 10. Rescind paragraphs **79.1(16)"h"** and **79.1(16)"i"** and adopt the following **new** paragraphs in lieu thereof:

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible

fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

ITEM 11. Amend paragraphs **79.1(16)"j"** to **79.1(16)"l"** as follows:

j. ~~Inflation factors, rebasing, and recalibration~~ Rebasing.

(1) ~~Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.~~ Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) ~~Base amounts~~ Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased ~~and APG weights recalibrated in 2005 and every three years thereafter~~. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost ~~audits~~ audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used ~~with the addition of a hospital market basket index inflation factor~~.

(3) ~~Case~~ Effective January 1, 2009, and every three years thereafter, case-mix indices shall be ~~calculated~~ recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) No change.

~~(5) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.~~

k. Payment to out-of-state hospitals. ~~Payment made to out~~ Out-of-state hospitals providing care to ~~beneficiaries~~ members of Iowa's Medicaid program ~~is equal to either the~~ shall be reimbursed in the same manner as Iowa ~~statewide average case-mix-adjusted base amount or~~ hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide ~~average case-mix-adjusted~~

base ~~amount~~ APC rate or the Iowa blended ~~with the hospital-specific~~ base ~~amount~~ APC rate for the out-of-state hospital.

(1) ~~Hospitals~~ For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will ~~receive a case-mix-adjusted~~ be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data ~~and the Iowa statewide average cost per visit amount~~. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If ~~a~~ an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement ~~purposes in~~ from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services ~~which~~ that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the ~~UB-92~~ claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted ~~for payment~~ without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

ITEM 12. Rescind and reserve paragraph **79.1(16)"m."**

ITEM 13. Amend paragraph **79.1(16)"o"** as follows:

o. Inpatient admission after outpatient services. ~~A patient may be admitted to the hospital as an inpatient after receiving outpatient services.~~ If ~~the~~ a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

ITEM 14. Rescind and reserve paragraph **79.1(16)"r."**

ITEM 15. Amend paragraphs **79.1(16)"s"** to **79.1(16)"u"** as follows:

~~*s.* Rescinded IAB 7/31/96, effective 10/1/96.~~

~~*t.*~~ *s. ~~Limitations~~ Limit on payments.*

~~(1) Ambulatory patient groups~~ Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper ~~limits~~ limit rules set forth in 42 CFR 447.321~~,~~ as amended to September 5, 2001, and 447.325~~,~~ as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare. ~~In aggregate, the total Medicaid payments may not exceed the total payments received by all providers from recipients, carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.~~

~~(2)~~ *t. Government-owned facilities.* Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the ~~ambulatory patient group~~ APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid ~~recipients~~ members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

ITEM 16. Amend subparagraph **92.8(3)"a"(2)** as follows:

(2) ~~Outpatient hospital~~ Obstetrical services provided in an outpatient hospital setting when ~~the ambulatory patient group (APG) submitted for payment is 175, 304, 305, 492, 493, or 494 and the~~ primary or secondary diagnosis code is V22 through V24.9.

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