Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

1. Introduction

Medicaid reimbursement for inpatient hospital care is based on payment according to diagnosis-related groups (DRG). These rates are rebased and the DRG weights are recalibrated once every three years. Hospitals receiving reimbursement as critical access hospitals are not subject to rebasing.

This state plan reflects the rebasing and recalibration implemented October 1, 2024. The current DRG payment is established through a base-year rate (2022) to which an annual legislative index may be applied on July 1 of each year.

The reimbursement amount is a blend of hospital-specific and statewide average costs reported by each hospital, for the routine and ancillary base and capital cost components, per Medicaid discharge.

Direct medical education, indirect medical education, and disproportionate share payments are made directly from the Graduate Medical Education and Disproportionate Share Fund. They are not added to the reimbursement for claims.

2. Definitions

Certain mathematical or technical terms may have a specific meaning used in this context. The following definitions are provided to ensure understanding amount all parties.

"Adolescent" means a Medicaid patient 17 years of age or younger.

"Adult" means a Medicaid patient 18 years of age or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base-year cost report" means the hospital's cost report with a fiscal year ending on or after January 1, 2022 and before January 1, 2023. Cost reports shall be reviewed using Medicare cost reporting and cost reimbursement principles for those cost-reporting periods.

For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15).

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"Disproportionate share percentage" means either (1) the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2 ½ percent. A separate disproportionate share percentage is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. The Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case coded as a transfer to another hospital shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"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 and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed, or nominally reimbursed patients.

"Graduate Medical Education and Disproportionate Share Fund (GME/DSH Fund) Apportionment Claim Set" means the hospital applicable Medicaid claims paid from July1, 2023 through June 30, 2024. The claim set is updated in July of every third year and is modeled using the most recently effective recalibrated weights.

"High cost adjustment" shall mean an add-on to the blended base amount (considered part of the blended base amount), which shall compensate for the high cost incurred for providing services to medical assistance patients. The high cost adjustment add on is effective for the time period of July 1, 2004 through June 30, 2005.

"Implementation Year" means October 1, 2024.

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"Inlier" means a case where the length of stay or cost of treatment falls within the actual calculated length-of-stay criteria, or the cost of treating the patient is within the cost boundaries of a DRG payment.

"Long-stay outlier" means a case that has a length of stay that is greater than the calculated length-of-stay parameters, as defined with the length-of-stay calculations for that DRG.

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments. A separate low-income utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital, where services are provided predominantly to children under 18 years of age.

"Medicaid-certified unit" means a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa Department of Inspections and Appeals on or after October 1, 1987. Medicaid certification of substance abuse, psychiatric, and rehabilitation units is based on the Medicare reimbursement criteria for these units. A Medicare-certified physical rehabilitation unit or hospital in another state is considered Medicaid-certified.

"Medicaid claim set" means the hospital applicable Medicaid claims for the period of January 1, 2021 through December 31, 2022 and paid through March 31, 2023.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients. A separate Medicaid inpatient utilization rate is determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" means a neonatal unit designated level II or level III unit using standards set forth in Section 19, Payment for Medicaid-Certified Special Units.

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9. Trending Reimbursement Rates Forward

The final payment rate for the current rebasing uses the hospital's base-year cost report. The only adjustments made to this rate are for fraud, abuse, and material changes brought about by cost report re-openings done by Medicare or Medicaid.

The rates have been trended forward using inflation indices of:

A. State Fiscal Year 2000 – 2.0%
B. State Fiscal Year 2001 – 3.0%
C. State Fiscal Year 2002 – (3.0%)
D. State Fiscal Year 2003 – 0.0%
E. State Fiscal Year 2004 – 0.0%
F. State Fiscal Year 2005 – 0.0%
G. State Fiscal Year 2006 – 3.0%
H. State Fiscal Year 2007 – 3.0%
I. State Fiscal Year 2008 – 0.0%
J. State Fiscal Year 2009 – 11.0%
K. December 1, 2009 – (5.0%)
L. October 1, 2010 – 20.46%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
M. August 1, 2011 – 76.94%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
N. October 1, 2011 – (41.18%), except for the University of Iowa Hospitals and Clinics and out-of-state hospitals.
O. November 1, 2011 – 5.72%
P. July 1, 2012 – 9.89%, except for the University of Iowa Hospitals and Clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.
Q. July 1, 2013 – 1.00%
R. October 1, 2015 – 0.0%
S. October 1, 2018 – 0.0%
T. October 1, 2021 – 0.0%
U. October 1, 2024 – 0.0%

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

For purposes of calculating the hospital inflation update factor, the original payments from the base-year Medicaid claim set are aggregated for all hospitals that submitted cost report data (excluding critical access hospitals). The total payment amount is then adjusted for any applicable legislative appropriations affecting budget neutrality. The resulting total becomes the target payment amount for budget neutrality.

The initial blended base rates are calculated with a hospital inflation factor update of 1.0. Once initial blended base rates are calculated, Medicaid claim set payments are