Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

A critical access hospital is a hospital that:

- Meets Medicare guidelines established in 42 CFR Part 485, Subpart F, and state hospital licensure requirements established in 481 Iowa Administrative Code 51.52(135B) as a hospital that serves a rural or vulnerable population, and
- Is necessary to the economic health and well being of the surrounding community.

Hospitals applying for critical access status are inspected, licensed, and certified as critical access hospitals, using Medicare criteria, by the Iowa Department of Inspections and Appeals.

Critical access hospital providers are reimbursed prospectively on a diagnosis-related-group (DRG) basis for inpatient care, pursuant to 441 Iowa Administrative Code 79.1(5), which defines a DRG as a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Retrospective adjustments will be made based on each critical access hospital's annual cost reports submitted to the Department at the end of the hospital's fiscal year. The retroactive adjustment equals the amount by which the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), determined in accordance with Medicare cost principles, and exceeds Medicaid fee-for-service reimbursement received on the diagnosis-related-group basis.

The DRG base rate for each critical access hospital will change for the coming year based on payments made to the critical access hospital for the previous year. The base rate upon which the DRG payment is built shall be changed after cost settlement to reflect, as accurately as is possible, the anticipated payment to the facility under Iowa Medicaid for the coming year using the most recent utilization as submitted to the fiscal agent. Once a hospital begins receiving reimbursement as a critical access hospital, DRG payments are not subject to rebasing.

Effective 7/1/2019, a CAH Adjustment Factor (CAF) will be applied to CAH reimbursement for the inpatient discharges on or after 7/1/2019. The hospital specific CAF is a prospective factor calculated using cost report data from previous years. The factor for year one will be calculated using Medicaid cost reports for provider fiscal year ends 9/30/17, 12/31/17, and 6/30/18. Year two will be calculated using 9/30/18, 12/31/18, and 6/30/19 cost reports and so forth. The funds associated with the CAF are capped prospectively with hospital specific factors. The CAF factor will apply to managed care and fee for service claims.

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The CAF is calculated as the difference between each hospital's incurred costs and payments received as a ratio to total payments received. The period for this calculation is as referenced in the above paragraph.

Beginning 7/1/2020, an adjustment to the CAF will be included for prior year overpayment or underpayment that may have occurred in the aggregate relative to the estimated cap.