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

Outpatient Care Provided by Critical Access Hospitals

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 based on the hospital's outpatient Medicaid cost-to-charge ratio. 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 based on the hospital's outpatient Medicaid cost-to-charge ratio.

The Medicaid outpatient cost-to-charge ratio upon which the outpatient hospital 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 members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

Once a hospital begins receiving reimbursement as a critical access hospital, the prospective outpatient Medicaid cost-to-charge ratio is not subject to inflation factors and rebasing

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State/Territory: IOWA

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Effective 7/1/2019, a CAH Adjustment Factor (CAF) will be applied to CAH reimbursement for outpatient services 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.

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.

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