Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

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 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0.0% for SFY 2003, 0.0% for SFY 2004, 0.0% for SFY 2005, 3.0% for SFY 2006, 3.0% for SFY 2007, 0.0% for SFY 2008, and 11.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on July 1, 2010, rates effective June 30, 2010, shall be increased by 20.46% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 76.94% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. For services beginning on October 1, 2011, rates effective September 30, 2011, shall be decreased by 41.18% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

10. Ceilings and Upper Limit Requirements

Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost. This principle is not altered by the DRG reimbursement methodology.

At the end of the cost reporting period, the aggregate covered charges for the period are determined and compared to the aggregate payments made to the hospital under the DRG payment methodology (before any subtraction of third-party payments). If the aggregate covered charges are less than the aggregate payments made using the DRG rates, the amount by which payments exceed the covered charges is requested and collected from the hospital.

This adjustment is performed each year at the end of the hospital's fiscal year, and does not have any impact upon the DRG rates that have been calculated for the next year. There is no carryover of unreimbursed costs into future periods under this DRG reimbursement methodology.

In accordance with 42 CFR 447.271, as part of the final settlement process, the IME Provider Cost Audit and Ratesetting Unit determines each hospital's total inpatient customary charges for all patients and total days for all patients during the cost reporting period. This is converted to an aggregate customary charge per day.

The total payments for Medicaid are determined as if this aggregate customary charge per day had been used. Final payment for the cost reporting period in question is made to each hospital at a per-day amount not to exceed its aggregate customary charge per day. This test is applied on a hospital-by-hospital basis.

OS Notification

State/Title/Plan Number:	**IA 11-022**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**09/04/2012**
Fiscal Impact:	**FY 2011 $7,365,370** **FY 2012 $4,538,868**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective August 1, 2011, this SPA proposes to increase inpatient hospital payment rates to all hospitals except for the University of Iowa Hospital and out-of-state hospitals. The payment increase is intended to provide relief to providers by increasing State fiscal year 2012 payments to offset reduced reimbursement received by providers in SFY 2011 due to faulty budget projections. Payment rates will be increased by 76.94% for services beginning August 1, 2011 and then scaled back to a 4.08% increase effective October 1, 2011. Tribal consultation requirements were met for this amendment. Public notice was timely. The funding question responses were satisfactory. The initial SFY 2012 cost-based upper payment limit demonstration provided with this SPA incorrectly included data for dual-eligible beneficiaries. The State revised its methodology to a Medicare payment based methodology. The revised SFY 2012 UPL demo was reviewed in depth and found to be acceptable with adequate room to accommodate the proposed increased Medicaid payments.

Other Considerations:

This OSN has been reviewed in the context of the Affordable Care Act (ACA) and approval of the OSN is not in violation of the ACA provisions.

This SPA is of particular interest to the Keokuk Area Hospital in Keokuk, IA. Keokuk Area Hospital has been in recent contact with CMS and DHHS seeking any

assistance we could provide with increasing Medicaid payments. However, we do not recommend the Secretary contact the governor.

CMS Contact: **Tim Weidler, NIRT 816-426-6429**