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 October 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.

Rates effective November 1, 2011, and thereafter, have been trended forward by 5.72%. 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

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

33. Iowa Non-State Government-Owned Acute Care Teaching Hospital Disproportionate-Share Payments

In addition to payments from the Graduate Medical Education and Disproportionate Share Fund, payment will be made to Iowa hospitals qualifying for the non-state government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this provision.

Hospitals qualify for non-state government-owned acute care teaching hospital disproportionate-share payments if they meet the disproportionate share qualifications defined in Section 29.g and Section 30.a and being a non-state government-owned acute care teaching hospital located in a county with a population over three hundred fifty thousand.

The total amount of disproportionate-share payments from the Graduate Medical Education and Disproportionate Share Fund and the non-state government-owned acute care teaching hospital disproportionate-share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate-share payments shall not exceed the hospital-specific disproportionate-share limits under Public Law 103-666.

The Department's total year end DSH obligations to a qualifying hospital will be calculated following completion of the CMS 2552-96, Hospital and Healthcare Complex Cost Report desk review or audit. The Department's total year end DSH obligation shall equal the difference between $71,000,000 less actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid Enterprise.

34. Inpatient Hospital Services Reimbursement to Indian Health Services or Tribal 638 Health Facilities

Indian Health Service or Tribal 638 Health Facilities will be paid at the most current inpatient hospital per diem rate established by the Indian Health Service which is published periodically in the Federal Register for established services provided in a facility that would ordinarily be covered services through the Iowa Medicaid Program.

OS Notification

State/Title/Plan Number:	**IA 12-009**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**10/18/2012**
Fiscal Impact:	**FY 2012 $-0-** **FY 2013 $-0-**

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: No

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

Detail:

Effective July 1, 2012, this SPA modifies the maximum amount of DSH payments that can be paid to Broadlawns Medical Center. Under the IowaCare Section 1115 demonstration waiver ((11-W-00189/7) and the approved Medicaid State plan, actual IowaCare expansion population claims submitted by Broadlawns must be deducted from the hospital's total yearly DSH obligation as specified in the State plan. This SPA increases the total yearly DSH obligation amount in the State plan for Broadlawns by $6 million. However, actual DSH payments to Broadlawns will not increase. The increase in the DSH obligation amount is necessary to offset increased IowaCare services provided by Broadlawns as a result of a regional reorganization approved under the waiver. The State has adequately demonstrated that the planned DSH payments to Broadlawns will remain within its hospital-specific DSH limit and that payments under the IowaCare waiver will remain within budget neutrality limits. The change in Broadlawn's DSH obligation will not affect payments to other DSH hospitals. DSH payments to Broadlawns are funded by State Medicaid appropriations.

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.** **Tribal consultation was conducted for this amendment.**

We do not recommend the Secretary contact the governor.

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