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 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. For services beginning on July 1, 2012, rates effective June 30, 2012, shall be increased by 9.89%, except for the University of Iowa Hospital and Clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.

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.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

In accordance with 42 CFR 447.271, as part of the final settlement process, the IME Provider Cost Audit and Rate Setting 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.