State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Inpatient Psychiatric Services for Individuals Under 21 Years of Age

1. Non-State Owned Providers

The basis of payment for non-state owned providers of inpatient psychiatric services for individuals under 21 years of age is actual and allowable cost up to a maximum reimbursement rate. Actual and allowable cost is based on the cost report information the facility submits to the Department on Form 470-0664, *Financial and Statistical Report*. Rates are calculated as total actual and allowable cost divided by total patient days.

2. Maximum Reimbursement Rate Calculation

The maximum reimbursement rate is calculated at 103 percent of the patient-day weighted statewide average of reasonable cost of psychiatric institution providers located within the state of Iowa, excluding state-owned providers. Beginning in 2009 and annually thereafter, the maximum reimbursement rate effective July 1 will be calculated using finalized cost reports received by the Department for the preceding fiscal year ending on June 30 or before. Inflation will be applied from the midpoint of the cost report period to the midpoint of the rate year using the Medicare Economic Index.

3. Interim Rates

Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of service costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid Enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

4. Retroactive Cost Adjustment

Reimbursement payments made to psychiatric institution providers for the fiscal year beginning July 1, 2009 and ending June 30, 2010, shall be cost settled to actual cost, not to exceed the maximum reimbursement rate for the fiscal year. Following completion of a cost report desk review, cost settlement will be calculated using reasonable and proper actual cost per unit from a 12-month period through retroactive adjustments. The retroactive adjustment represents the difference between the amount received by the provider during the year for

covered services and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of service rendered. Retroactive adjustments will be applied only to the portion of a provider's fiscal year occurring between July 1, 2009 and June 30, 2010. Providers will receive advance notice of the retroactive adjustments and will also receive transaction detail after the adjustments have been completed.

5. State-Owned Providers

The basis of payment for state owned providers of inpatient psychiatric services for individuals under 21 years of age is 100 percent of actual and allowable cost. Actual and allowable cost is based on the cost report information the facility submits to the Department on Form 470-0664, *Financial and Statistical Report*. Rates are calculated as total actual and allowable cost divided by total patient days on a retrospective cost-related basis and adjusted retroactively.

6. Definition of Allowable Costs and Reimbursement Principles

The actual and allowable costs of services rendered to Medicaid recipients are those that meet the principles specified in OMB Circular A-87 and the Medicare Provider Reimbursement Manual (CMS Publication 15-1). Actual and allowable costs must be reasonable and directly related to patient care.

Costs reported under inpatient psychiatric services shall not be reported as reimbursable costs under any other funding source. Cost incurred for other services shall not be reported as reimbursable costs under inpatient psychiatric services. Mileage reimbursement shall be limited to the maximum reimbursement rate allowed State employees at the time of service provision.

7. Cost Reporting Requirements

All providers shall submit the Medicaid cost report, Form 470-0664, *Financial and Statistical Report*, on an annual basis. Financial information shall be based on the provider's financial records. When records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in adjustment to the reimbursement rate, claim denial, recoupment or termination of the provider's enrollment with the Iowa Medicaid program. The Department may require that an opinion of a certified public accountant accompany the report when a provider has a history of cost report adjustment or inability to support cost report data.

Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, IA 50315. Cost reports shall be submitted on or before the last day of the third month after the end of the provider's fiscal year end. Hospital-based providers will be required to submit their cost report within five months from the end of the provider's fiscal year end. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

If a provider fails to submit a complete cost report, including the working trial balance, the department shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

8. Provider Appeals

In accordance with 42 CFR 447.253(c), if a provider of service disagrees with the determination of the retrospective cost-based reimbursement rate, the provider may file an appeal and request reconsideration from the Administrator of the Division of Medical Services in the Department. The appeal must be in writing, clearly state the nature of the appeal, and be supported with all relevant data. Appeals must be submitted within 30 days of the date of the decision.

The Administrator of the Division of Medical Services will review the material submitted, render a decision and advise the provider accordingly within a period of 90 days.

9. Audits

Each participating facility is subject to a periodic audit of its fiscal and statistical records.

OS Notification

State/Title/Plan Number: Iowa 09-018

Type of Action: SPA Approval

Required Date for State Notification: May 4, 2010

Fiscal Impact:

FY 2009	$-578,198
FY 2010	$-2.163833

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: No

Reduces Benefits: No

Detail: Effective July 1, 2009, this amendment (SPA) increases Medicaid payment rates to reasonable cost for inpatient psychiatric hospital services furnished by psychiatric residential treatment facilities. The State is increase rates in the hope that facilities will be able to offer more comprehensive services so that that State avoids out-of-State placements.

Other Considerations:

During the review, CMS became aware of a billing issue involving ancillary services needed by children who were patients in an IMD. In certain cases, while the services were necessary to care for the child, the services were furnished by outside providers and billed directly by them under their provider number. CMS advised the State that these services needed to be billed by the inpatient facility to be considered part of the psychiatric under 21 benefit. CMS also advised that the current arrangement is problematic with IMD exclusion.

This OSN has been reviewed in the context of the ARRA and approval of the

OSN is not in violation of ARRA provisions.

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