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 reasonable cost up to a maximum reimbursement rate less five percent. Reasonable 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. **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. 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.

4. **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. Reasonable cost is based on the cost report information the facility submits to the Department on Form 470-0664, *Financial and Statistical Report.* Rates are

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, 2011. 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 adjustments or inability to support cost report data.

OS Notification

State/Title/Plan Number: Iowa 09-022

Type of Action: SPA Approval

Required Date for State Notification: June 29, 2010

Fiscal Impact: FY 2010 $-537,458
FY 2011 $ 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 Decrease: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective December 1, 2009, this amendment proposes to implement a 5% rate reduction to Non-State psychiatric medical institutes for children (PMIC). The rate reduction is the result of budget cuts ordered by the Governor.

Prior to the authorization of the budget cuts, the State Medicaid program worked with the PMIC community to develop a revised reimbursement methodology that resulted in most providers receiving increased reimbursement. The revised methodology was approved under SPA 09-018 and takes effect prior to the rate decrease; it lessens the impact of the decrease for some providers and still nets an increase for others. All SPA related issues were resolved prior to the issuance of the RAI. There are no funding, rate methodology, or public process issues related to this amendment.

Other Considerations:

On access, the State reports that access to Medicaid beneficiaries will not be impacted by this rate decrease. The State reports:

1. This particular provider group is remarkably stable. The average length of enrollment for these providers is 16 years, with a median of 18 years.

2. The State's Medicaid policy staff meets with PMIC facility on a monthly basis and has discussed the rate reduction. While the providers are not enthused with the rate cut, they are aware that the State's budget constraints are impacting nearly all providers in the State. And, none have indicated that this reduction will jeopardize their ability to provide services.
3. Treatment in PMIC facilities is not covered under Medicare and private insurance typically only pays a limited benefit, i.e. the first 30 days. Medicaid is the primary payer for these facilities, so they are not likely to turn away Medicaid patients.
4. Access to care for the Medicaid population far exceeds that of the general population. Current State law allows licensure of 430 Medicaid-funded PMIC beds, but does not place limits on the number of licensed non-Medicaid funded beds which number only 95.
5. The State will monitor access changes through its licensure procedures, receiving advanced notice timely to reallocate a closing facility's beds and maintain access.
6. If this rate decrease were to result in a facility closure, the State has identified a State-Facility that operates at 75% capacity that can absorb the bed days.

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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