Attachment A: Relevant Statutory and Regulatory Authorities

- Section 1902(a)(2) of the Social Security Act requires that States ensure non-federal financial participation of Medicaid expenditures. Medicaid reimbursement methodologies that do not take into account amounts that are refunded are not consistent with Section 1902(a)(2). Such payment practices overstate the non-federal financial participation.

- Section 1902(a)(30)(A) of the Act requires that payment rates must be consistent with "efficiency, economy and quality of care." Medicaid reimbursement methodologies that require a refund of payments indicate that the full payment amount is not required by the facilities to ensure Medicaid beneficiaries access to services and are thus not consistent with "efficiency, economy and quality of care." To be consistent with Section 1902(a)(30)(A), Medicaid reimbursement methodologies must allow the provider to receive and retain the full amount of the Medicaid payment.

- Section 1902(a)(19) of the Act requires that care and services will be provided consistent with "simplicity of administration and the best interests of the recipients." The best interest of recipients is not served by a payment structure that diverts a portion of the rate required by the State plan to be made to providers for other purposes. The best interest of recipients requires that the full amount of Medicaid payments should be available to support access to quality Medicaid care and services.

- Medicaid reimbursement methodologies must be consistent with the basic Federal and State financial partnership of the Medicaid program set forth by the Congress. Sections 1903(a)(1) and 1905(b) of the Act specify how the Federal medical assistance percentage (FMAP) will be calculated and paid, and provides for a matching non-federal expenditure. Reimbursement methodologies that require a return of payments would not include a sufficient non-federal share and would not be consistent with the Federal and State financial partnership set forth in section 1905(b) of the Act.

- Regulations at 42 C.F.R 433.51 permit that public funds may be considered as the State's share in claiming federal financial participation (FFP) if the public funds are transferred from other public agencies to the State or local agency and are under its administrative control. The State agency must have the non-Federal share of the Medicaid payments under its administrative control before payment is made for Medicaid services.

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.

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: Iowa 10-020

Type of Action: SPA Approval

Required Date for State Notification: 6/12/2011

Fiscal Impact: FFY 10 $5,794,853 FFY 11 $25,532,913

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: Yes or **Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective July 1, 2010, this amendment revises Attachment 4.19-A of the Iowa Medicaid State plan to increase inpatient hospital payment rates by 20.46%. The rate increase is applicable to all hospitals except for the University of Iowa Hospital and Clinics, out-of-state hospitals, and critical access hospitals. The rate increase is funded by a new inpatient and outpatient hospital provider tax that has been reviewed and approved by CMS. The State has responded satisfactorily to the standard funding questions. Tribal consultation was not necessary as the proposed revisions do not negatively impact access to care for AI/AN's.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. 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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