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 actual and allowable 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 is consistent with Medicaid's obligation to reimburse that provider's actual and allowable costs.

4. **Retroactive Cost Adjustment**
Reimbursement payments made to psychiatric institution providers for services on or after July 1, 2009, 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 actual and allowable 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, not to exceed the maximum reimbursement rate. Retroactive adjustments will be applied only to the portion of a provider's fiscal year occurring on or after July 1, 2009. 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:	**IA 11-006**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**4/3/2012**
Fiscal Impact:	**FY 2011 $36,534** **FY 2012 $212,485**

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: Yes

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

Detail:

Effective August 1, 2011, this SPA eliminates a five percent (5%) rate reduction that had been imposed on psychiatric medical institution for children (PMIC) payment rates on December 1, 2009. PMICs in Iowa are synonymous with psychiatric residential treatment facilities (PRTFs). PMICs in Iowa are funded by appropriations from the Legislature.

Other Considerations:	**Prior to submitting this SPA, the Nebraska Division of Medicaid Long-Term Care sought consultation from federally recognized Native American Tribes with the State to discuss the impact that the proposed SPA might have, if any, on the Tribes. No comments were received.** **We do not recommend the Secretary contact the governor.**
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