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%. The rates for IowaCare network providers shall not be reduced by 5.0% but shall remain trended using the inflation indices as stated above through SFY 2009. 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.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

29. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for December 1, 2009, through June 30, 2010, is $8,210,006. Thereafter, the total annual amount of funding that is allocated is $8,210,006.

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

c. Distribution to Qualifying Hospitals for Direct Medical Education

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights from the GME/DSH Fund apportionment claim set, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

d. Qualifying for Indirect Medical Education

Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

e. Allocation to Fund for Indirect Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for December 1, 2009, through June 30, 2010, is $14,415,396. Thereafter, the total annual amount of funding that is allocated is $14,415,396.

A reduction of this amount will be made if a hospital fails to qualify for indirect medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for December 1, 2009, through June 30, 2010, is $6,890,959. Thereafter, the total annual amount of funding that is allocated is $6,890,959.

i. Distribution to Qualifying Hospitals for Disproportionate Share

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims from the GME/DSH Fund apportionment claim set, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and the Medicaid utilization rate (or for children's hospitals during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in the forgoing formula.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and enhanced disproportionate share payments describe in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

PAYMENTS FOR RESERVE BEDS

Payment is made for reserving beds in care facilities for residents during their temporary absence for the purpose indicated below when this is included in the resident's plan of care. No payment for reserved beds is made to hospitals.

State-Owned and Non-State-Owned Nursing Facilities

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

   Effective December 1, 2009, payments will be made at zero percent of the actual per diem rate for hospitalization for acute conditions.

2. For periods leaves of absence for purposes of vacation or visits: Up to 18 days per year. Additional days will be allowed based on a physician's recommendation that additional days would be rehabilitative.

   Effective December 1, 2009, payments will be made at zero percent of the actual per diem rate for vacation or visit leaves of absence or for rehabilitative days.

Special Population Facilities

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

   Effective December 1, 2009, payment will be made at 42 percent of the actual per diem rate for hospitalization or acute conditions.

2. For periods of absence for purposes of vacation or visits: Up to 18 days per year. Additional days will be allowed based on a physician's recommendation that additional days would be rehabilitative.

   Effective December 1, 2009, payments will be made at 42 percent of the actual per diem rate for vacation or visit leaves of absence or for rehabilitative days.

Out-of-State Facilities

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

   Effective December 1, 2009, payments will be made at zero percent of the Iowa per diem rate for hospitalization or acute conditions.

2. For periods of absence for purposes of vacation or visits: Up to 18 days per year. Additional days will be allowed based on a physician's recommendation that additional days would be rehabilitative.

   Effective December 1, 2009, payments will be made at zero percent of the Iowa per diem rate for vacation or visit leaves of absence or for rehabilitative days.

Intermediate Care Facilities for the Mentally Retarded

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

2. For leaves of absence for purposes of vacation or visits: Up to 30 days per year. Additional days may be approved for home visits or special programs of evaluation, treatment or habilitation outside the facility if certified by a physician or qualified mental retardation professional.

Payment for period when a resident is absent for visits or hospitalization is made at 80 percent of the actual per diem rate. Facilities with 15 or fewer beds are reimbursed at 95 percent of the actual per diem rate.

Out-of-state facilities are reimbursed at 80 percent of the Iowa payment to the facility. Out-of-state facilities with 15 or fewer beds are reimbursed at 95 percent of the Iowa payment to the facility.

Medicare-Certified Hospital-Based Facilities that Provide Only Skilled-Level Care

1. For period of hospitalization for acute conditions: Up to 10 days per hospitalization per calendar month, not to exceed 10 days for any hospital stay whether or not the stay extends into a succeeding month or months.

   Effective December 1, 2009, payments will be made at zero percent of the actual per diem rate for hospitalization for acute conditions.

2. For periods of visits for participation in special social or rehabilitation programs: Up to 10 consecutive calendar days at a time with a maximum of 18 days in a calendar year. These must be approved in advance by the Department and are approved when (1) the resident or representative chooses to have the resident leave for this purpose, and (2) the family members or agency responsible for providing the alternative care can and will provide the care and make no charge to the Department for the care, and (3) the absence is approved in the physician's plan of care, and (4) the facility provides the usual medical equipment and supplies needed by the resident.

   Effective December 1, 2009, payment for approved absences shall be made at zero percent of the actual per diem rate.

Psychiatric Institutions for Children

1. For periods of hospitalization for acute conditions: Up to 10 days per hospitalization per calendar month, not to exceed 10 days for any hospital stay whether or not the stay extends into a succeeding month or months.

2. For leaves of absence for purposes of vacation or visits: Up to 30 days per year. Additional days may be allowed based on a service plan approved by the district administrator or the superintendent of the institution for children or that person's designee.

Payment for approved absence shall be made at the full Medicaid rate.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For facilities receiving both an ICF and SNF Medicaid rate on June 30, 2001, the June 30, 2001, Medicaid rate referenced above is the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

The subsections below reflect the details of this reimbursement plan.

2. Definition of Allowable Costs and Calculation of Per Diem Costs

Allowable costs are determined using Medicare methods. Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given services or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

For purposes of calculating the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, facility costs are divided into two components:

- The "direct care component" is the portion attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
- The "non-direct care component" is the portion attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

Each nursing facility's per diem allowable direct care and non-direct care cost shall be established.

Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period.

Effective December 1, 2009 through June 30, 2010, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to July 1, 2008, less three percent.

Effective July 1, 2010, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to July 1, 2008.

3. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

4. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the Medicare-certified hospital-based nursing facility rate components.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the direct care and non-direct care patient-day-weighted medians shall be calculated using the latest Medicare cost report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated, using the latest completed Medicare cost report with a fiscal year end of the preceding December 31 or earlier. For rates effective December 1, 2009 through June 30, 2010, inflation is applied from the midpoint of the cost report period to July 1, 2008, less three percent, using the SNF total market basket index. For rates effective July 1, 2010, and thereafter, inflation is applied from the midpoint of the cost report period to July 1, 2008, using the SNF total market basket index.

5. Excess Payment Allowance Calculation

The Medicare-certified hospital-based nursing facility excess payment allowance is calculated as follows:

a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):
   - The direct care patient-day-weighted median times 95 percent times the provider's Medicaid average case-mix index, minus
   - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid average case-mix index.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

However, for purposes of calculating the per diem cost for administrative, environmental, and property expenses, total patient days are the greater of the actual inpatient days or 85 percent of the facility's license capacity.

Effective December1, 2009 through June 30, 2010, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to July 1, 2008, less three percent.

Effective July 1, 2010, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to July 1, 2008.

b. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

c. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the non-state-owned nursing facility rate components.

The per diem normalized direct care cost for each non-state-owned facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated using the latest completed financial and statistical report with a fiscal year end of the preceding December 31 or earlier. For rates effective December 1, 2009 through June 30, 2010, inflation is applied from the midpoint of the cost report period to July 1, 2008, less three percent, using the SNF total market basket index. For rates effective July 1, 2010, and thereafter, inflation is applied from the midpoint of the cost report period to July 1, 2008, using the SNF total market basket index.

d. Excess Payment Allowance Calculation

Two classes of non-state-operated providers are recognized for computing the excess payment allowance calculation.

- Facilities that are located in a metropolitan statistical area (MSA) as defined by CMS.
- Facilities that are not located in an MSA.

For non-state-operated facilities not located in an MSA, the excess payment allowance is calculated as follows:

(1) For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):

- The direct care non-state-operated patient-day-weighted median times 95 percent times the provider's Medicaid average case-mix index, minus
- A provider's normalized allowable per patient day direct care costs times the provider's Medicaid average case-mix index.

In no case shall the excess payment allowance exceed ten percent times the non-state-operated direct care patient-day-weighted median.

State/Territory: IOWA

ii. Measurement Period – The measurement period shall be the period of the latest form 470-0030, *Financial and Statistical Report*, with a fiscal year end on or before December 31 of the state fiscal year payment period.

iii. Value – 3 points if administrative costs percentage is less than the mean less ½ standard deviation; 4 points if administrative costs percentage is less than the mean less 1 standard deviation.

iv. Source – The IME Provider Cost Audit and Rate Setting Unit staff shall calculate whether the nursing facility has met this measure from form 470-0030, *Financial and Statistical Report.*

B. The number of points awarded shall not be determined beginning July 1, 2009. When funding becomes available, the number of points awarded shall be determined annually. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period (state fiscal year). Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period (state fiscal year) as follows, subject to paragraph C:

0 – 50 points	No additional reimbursement
51 – 60 points	Zero (0) percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (D)
61 – 70 points	Zero (0) percent of the direct care plus non-direct care cost component patient-day-weighted medians subject to reduction as provided in subparagraph (D)
71 – 80 points	Zero (0) percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (D)
81 – 90 points	Zero (0) percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (D)
91 – 100 points	Zero (0) percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (D)

C. A nursing facility shall not be eligible for any additional reimbursement under this rule if during the payment period (state fiscal year) the nursing facility receives a deficiency resulting in actual harm or immediate jeopardy, pursuant to the federal certification guidelines at an H level scope and severity or higher, regardless of the amount of fines assessed.

10. A copy of the facility's allocation methodology used to allocate allowable costs between nursing facility services and non-nursing facility services.

E. Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced component limit is requested, including a list of goals for the project and a timeline of the project that spans the life of the project.
2. Documentation that the facility meets the qualifications in paragraph B.
3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

F. Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for nursing facility services for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual nursing facility total patient days.

1. Nursing facility total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.
2. The annual estimated property costs for nursing facility services is calculated as the total annual estimated property costs less estimated annual property costs for non-nursing facility services.
3. The total annual estimated property costs for the project is calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.
4. A reconciliation between the estimated amounts and actual amounts shall be completed as described in paragraph I.

G. Effective date of capital cost per diem instant relief add-on. A capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit.

H. Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biannual rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biannual rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

I. Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid Enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.
2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit. The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

J. Effective date of enhanced non-direct care rate component limit. An enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

State/Territory: IOWA

Additional reimbursement for non-state-owned facilities, based on the nursing facility pay for performance program, is not available beginning July 1, 2009, as provided in this paragraph. The program provides a pay for performance payment based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks. The pay for performance benchmarks include characteristics in four domains: 1. Quality of Life; 2. Quality of Care; 3. Access; 4. Efficiency. These characteristics are objective, measurable, and, when considered in combination with each other, deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

Additional reimbursement for the nursing facility-pay-for performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or amount of additional reimbursement based on the nursing facility pay-for-performance program.

The additional reimbursement for nursing facility pay-for-performance shall be withheld from the weekly payment remittances and be paid out to qualifying nursing facilities at the end of the state fiscal year. The additional reimbursement for nursing facility pay-for-performance shall be calculated at the end of the state fiscal year but shall have a retroactive effective date of the first day of the state fiscal year. For example, for state fiscal year 2010, the additional reimbursement for nursing facility pay-for-performance shall be calculated at the end of June 30, 2010, based on points awarded on July 1, 2009, with a retroactive effective date of July 1, 2009.

For the purposes of the nursing facility pay-for-performance program, direct care worker is defined to include registered nurse (RN), licensed practical nurse (LPN), certified nurse aide (CNA), rehab nursing and other contracted nursing services. This does not include the director of nursing (DON) or Minimum Data Set (MDS) coordinator.

A. To qualify for additional Medicaid reimbursement for the nursing facility-pay-for performance program, a facility must achieve a minimum score of 51 points. The maximum available points are 100. The Iowa Medicaid enterprise shall award points based on the measures achieved in each of the four domains, as described in subparagraphs (1) through (4).

OS Notification

State/Title/Plan Number: Iowa 09-020

Type of Action: SPA Approval

Required Date for State Notification: August 25, 2010

Fiscal Impact:

FY 2010	$ -20,685,858
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: This SPA implements staggered rate reductions between 5% and 2.5% for IH, NF, and Reserve Bed Day rates for the period December 1, 2009 through June 30, 2010. The rate cuts were as a result of across the board rate cuts made by the Governor. The rate cut period is over and the State has not lost any providers related to these cuts. We asked the access questions and the State responded satisfactorily that:

1. The proposed rate cuts were planned to impact the most vulnerable providers the least.
2. The provider community had not offered any opposition.
3. The State followed its public process that allowed providers to provide input during a Medical Assistance Advisory Council meeting, as well as the Departments rules meeting.
4. The legislature retroactively changed the budget to mitigate some of the decreases.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS Contact: Tim Weidler (816) 426-6429, NIRT