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**State/Territory Name: IA**

**State Plan Amendment (SPA) #: 16-0016**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**Financial Management Group**

MAY 17 2017

Charles M. Palmer, Director
Iowa Department of Human Services
1305 East Walnut, 5th Floor
Des Moines, IA 50319-0014

RE: Iowa State Plan Amendment TN: 16-016

Dear Mr. Lynch:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-016. This amendment updates provisions pertaining to intermediate care facility for individuals with intellectual disabilities (ICF-IID) services, including reimbursement for Medicaid's share of assessment fees.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 16-016 is approved effective July 1, 2016. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16 — 016

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ 0.00
b. FFY 2017 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Page 12, 12a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Page 12, 12a

10. SUBJECT OF AMENDMENT

DHS is updating the intermediate care facility for individuals with intellectual disabilities (ICF/ID) add-on for assessment fees effective July 1, 2016.

11. GOVERNOR'S REVIEW *(Check One)*

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 9-29-16

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: MAY 17 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristen Fan

22. TITLE: Director, FMC

23. REMARKS:

**Methods and Standards for Establishing Payment Rates for Nursing Facility Services**

**C. Intermediate Care Facilities for Individuals with an Intellectual Disability (ICFs/ID) (Cont.)**

- A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure which increase costs. (Documentation and verification will be required).
- A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Reimbursement Rate (Payment Rate)

The budgeted reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

After the first six months of operation, the reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

The reimbursement rate for all subsequent cost reports is the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

h. Assessment pursuant to Iowa Code section 249A.21

In lieu of treating the assessment imposed pursuant to Iowa Code section 249A.21 as an allowable cost, a per day assessment amount is added to the reimbursement rate calculated above, not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per day assessment amount will be calculated by dividing the annual assessment paid by a facility by the facility's reported total patient days for the year. The annual assessment will be the calculated by summing the amounts paid quarterly by the facility during the cost report period. The total patient days for the year, will be the census reported on the annual cost report.

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