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State/Territory Name: IA

State Plan Amendment (SPA) #: 16-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

August 1, 2016

Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut Street, 5th Floor
Des Moines, IA 50319-0114

Dear Mr. Palmer:

On May 5, 2016, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #16-0022, requesting approval for adding language to reflect Iowa's managed care transition with an April 1, 2016, effective date.

This SPA 16-0022 was approved on July 22, 2016, with an effective date of April 1, 2016, as requested by the state. Enclosed is a copy of the CMS-179 form, as well as, the approved pages for incorporation into the Iowa State plan.

If you have any questions regarding this amendment, please contact Kevin Slaven at (816) 426-5925 or Kevin.Slaven@cms.hhs.gov.

Sincerely, 8/1/2016

Megan K. Buck
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: Megan K. Buck -A

Enclosures

cc:
Mikki Stier
Jennifer Steenblock
Martin Swartz
Jeff Marston
Alisa Horn

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: 16-022

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: April 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
b. FFY 2017 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, page 2, 3, 4, 5, 12, 12a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, page 2, 3, 4, 5, 12, 12a

10. SUBJECT OF AMENDMENT
This modifies language for managed care transition that occurred on 4/1/16. Changes are budget-neutral as there is no change in funding amounts.

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: 5-5-16

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: May 5, 2016

18. DATE APPROVED: July 22, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: Megan K Buck

22. TITLE: Acting Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS

limits on amount, duration and scope contained in SUPPLEMENT 2 TO ATTACHMENT 3.1-A.

1. INPATIENT HOSPITAL SERVICES
See Attachment 4.19 - A of the State Plan

2a. OUTPATIENT HOSPITAL SERVICES
See Supplement 2 to Attachment 4.19-B of the State Plan

2b. RURAL HEALTH CLINICS SERVICES

_X_ The payment methodology for rural health clinics will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

___ The payment methodology for rural health clinics will conform to the BIPA 2000 requirements Prospective Payment System.

_X_ The payment methodology for rural health clinics will conform to BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:
1) is agreed to by the State and the clinic: and
2) results in payment to the clinic of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement
The APM reimbursement methodology for rural health clinics is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement
The Department uses the clinic's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost. Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the rural health clinic. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate, which would be paid to participating rural health clinics under the prospective payment system considering any change in the scope of service applying all appropriate Medicare Economic Index increases. The Department will compute the center's FY 1999 and FY 2000 per visit rate for each clinic and will use an average of the two as the initial PPS base rate. This rate will be used to calculate the total

payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each clinic an encounter rate that is at least equal to the PPS rate specific to each clinic. The clinic must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Clinics

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

X The payment methodology for federally qualifying health centers will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

___ The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for federally qualifying health centers will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the center; and
2) results in payment to the center of an amount which is at least equal to the PPS payment rate

Alternative Payment Methodology (APM) Reimbursement

The APM reimbursement methodology for federally qualified health centers is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

Interim Payment Rate and Annual Settlement

The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost.

Following submission of the cost report for the current year, the Department adjusts the interim rate for the subsequent year.

Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the federally qualified health center. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate which would be paid to participating federally qualified health centers under the prospective payment system, considering any change in the scope of service and applying all appropriate Medicare Economic Index increases. This rate will be used to calculate the total payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Managed Care Supplemental Wrap Payments

For Medicaid members enrolled with a managed care contractor, and effective April 1, 2016, the State requires that each managed care contractor will pay each center an encounter rate that is at least equal to the PPS rate specific to each clinic. The center must specifically agree to receive the full payment rate from the managed care contractor. The State shall supplement the reimbursement made by the managed care organization that equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it had been made in accordance with the above PPS or APM methodology. This process will apply to centers reimbursed under the APM rate methodology.

Prospective Payment System (PPS) Reimbursement for New Centers

Newly qualified clinics will have initial rates based on an average of rates paid to clinics within the same geographic area performing the same or similar services as the first year base rate.

3. OTHER INDEPENDENT LABORATORIES SERVICES
Fee Schedule. The fee schedule is 95.00% of the Medicare Clinical Laboratory Fee Schedule.

4a. NURSING FACILITY SERVICES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES)
See Attachment 4.19-D of the State Plan.

4b. EARLY PERIODIC DIAGNOSTIC AND SCREENING SERVICES

(1) Outpatient Hospital Services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(2) Services of licensed practitioners of the healing arts: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(3) Private duty nursing services: For services on or after, July 1, 2013, payment for private duty nursing services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per hour. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.

(4) Home health services –medical supplies and equipment: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(5) Personal care services: For services on or after, July 1, 2013, payment for personal care services will be based on the provider's reasonable and necessary costs as determined by the State Medicaid agency, not to exceed 133 percent of the statewide average allowable costs per 15 minutes. An interim provider-specific fee schedule based on the State Medicaid agency's estimate of reasonable and necessary costs for services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports.

(6) Dental services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(7) Diagnostic services: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(7a) Preventive Services: Fee Schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of July 1, 2014, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

(8) Rehabilitative Services: For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using finalized cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov. Providers of rehabilitative services shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program containing the following components:

Pharmacies and providers will submit information to the department or its designee within 30 days following a request for such information unless the department or its designee grants an extension upon written request of the pharmacy or provider. Pharmacies and providers are required to produce and submit information in the manner and format requested by the department or its designee, as requested, at no cost to the department or its designee.

12b. DENTURES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12c. PROSTHETIC DEVICES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

12d. EYEGLASSES

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of preventive services. The agency's fee schedule rate was set as of April 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES

For services provided from July 1, 2011, to March 31, 2016, rehabilitative services will be reimbursed according to the Medicaid Managed Care provider specific fee schedule. The provider specific fee schedule was established using cost based rates in effect on February 28, 2011 in accordance with the reimbursement methodology in effect prior to July 1, 2011, described below.

Beginning April 1, 2016, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of July 1, 2015, and is effective for services provided on or after that date. All rates are published on the Department of Human Services website: www.dhs.iowa.gov.

13d. REHABILITATIVE SERVICES (Cont.)

For services provided prior to July 1, 2011, rehabilitative treatment services are reimbursed on the basis of the provider's reasonable and necessary costs plus 1%, calculated retrospectively, as determined by State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary cost shall not exceed 110 percent of the statewide average allowable cost for the service.

No payment is made for services other than those included in the treatment plan.

An interim rate based on the State Medicaid agency's estimate of actual reasonable and necessary costs for the services provided will be paid based on financial forms approved by the department, with suitable retroactive adjustments based on final financial reports. The method of cost apportionment specified in OMB Circular A-87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

The retroactive adjustment is performed each year at the end of the agency's fiscal year based on submission of the agency's cost report. Based on this report the department adjusts the interim rate for the following months until submission of the next cost report.

ACT Services. The state-wide fee amount is a daily rate of $51.08 per client.

The fee is paid to the ACT team according to the number of days that the client has received ACT services.

The state-wide fee amount was established by Magellan based on a review of site budgets that included expenses for salaries, administrative costs, and other allowable costs as well as service costs. The reasonableness of cost was evaluated related to client to staff ratio. A ratio of 7 clients to 1 staff was used in the determination of the rate.

Each ACT team receiving payment under provisions of services as defined in Section 3.1A will be required to sign a contract enrolling in the Medicaid program and to file a report with the Medicaid agency annually.

This annual reporting would include at a minimum:

- Data, by practitioner, on the utilization by Medicaid beneficiaries of all the services included in the unit rate and;
- Cost information by practitioner type and by type of service actually delivered within the service unit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ACT services. The agency's fee schedule rate was set as of April 1, 2016 and is effective for services provided on or after that date. All rates are published at https://secureapp.dhs.state.ia.us/MedicaidFeeSched/