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State/Territory Name: IA

State Plan Amendment (SPA) #: 25-0026

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

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

Financial Management Group

December 11, 2025

Mr. Lee Grossman, Medicaid Director
Iowa Medicaid Enterprise
1305 E. Walnut Street
Des Moines, IA 50319

RE: TN 25-0026

Dear Mr. Grossman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Iowa state plan amendment (SPA) to Attachment 4.19-D IA 25-0026, which was submitted to CMS on September 25, 2025. This SPA updates the nursing facility (NF) per diem rates utilizing 2024 cost report data under the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Fred Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

Rory Howe
Director

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: 25-0026

2. STATE: IA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. §447.200

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 56,855
b. FFY 2026 $ 225,444

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D
Page 1, 2, 2a, 4, 5a, 5b, and 5d

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D
Page 1, 2, 2a, 4, 5a, 5b, and 5d

9. SUBJECT OF AMENDMENT
This amendment will provide guidance for nursing facility rate rebasing which occurs every second year beginning July 1, 2001, to reflect more current cost information on a biannual basis with an effective date of July 1 of each odd-numbered year. The inflation factor of the rate calculation will be adjusted to ensure that the amounts estimated using the 2024 cost information will not exceed the appropriation.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Rebecca Curtiss

13. TITLE
Medicaid Deputy Director of Operations

14. DATE SUBMITTED
9/25/2025

15. RETURN TO
Iowa Department of Health and Human Services
Iowa Medicaid
321 E 12th Street
Des Moines, IA 50319

FOR CMS USE ONLY

16. DATE RECEIVED
9/25/2025

17. DATE APPROVED
December 11, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Medicare-Certified Hospital-Based Facilities That Provide Only Skilled-Level Care

1. Introduction

Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care receive Medicaid reimbursement based on a modified price- based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data and adjusted semi-annually to account for changes in the Medicaid day- weighted case-mix index.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price- based rate.

   In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

b. Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be:

   - 33.33 percent of the facility's Medicaid rate effective June 30, 200 I, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
   - 66.67 percent of the July 1, 2002, modified price-based rate.

   In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following l2 months.

c. Payment rates for services rendered from July l, 2003, and thereafter will be 100 percent of the modified price-based 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 July 1, 2025, 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 September 1, 2022 less an additional 0.17%.

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 day-weighted case-mix index for the cost report period, carried to four decimal places.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/0l/2001- 12/31/200 I financial reporting period would use the facility-wide day-weighted 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 Medicaid 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 Medicaid cost report with a fiscal year end of the preceding December 31 or earlier. Effective July 1, 2025, 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 September 1, 2022 less an additional 0.17%.

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 day-weighted case-mix index, minus
   - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted case-mix index.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Other Non-State-Owned Nursing Facilities

The methodology in this section applies to all nursing facilities that are not state-owned, including facilities for people with mental illness who are aged 65 or over, except for:

- Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care (see Section A)
- Facilities serving special populations (see Section D)

1. Introduction

Non-state-owned nursing facilities receive Medicaid reimbursement based on a modified price-based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted semi-annually to account for changes in the Medicaid day-weighted case-mix index.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 200I, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price- based rate.

   In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

b. Payment rates for services rendered from July **1,** 2002, through June 30, 2003, shall be:
   - 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
   - 66.67 percent of the July 1, 2002, modified price-based rate.

   In no case shall the July l, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following 12 months.

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 July 1 2025, 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 September 1, 2022 less an additional 0.17%.

c. 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 day-weighted case-mix index for the cost report period, 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 day-weighted case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

d. 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. Effective July 1, 2025, 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 September 1, 2022 less an additional 0.17%.

e. 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 day-weighted case- mix index, minus
   - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted 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.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

a. Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted semi-annually to account for changes in the provider's Medicaid day-weighted case-mix index, plus a potential excess payment allowance and a capital cost per diem instant relief add-on for qualifying nursing facilities as described in Supplement 4 to Attachment 4.19-D, not to exceed an overall rate component limit.

The direct care and non-direct care rate components are calculated as follows:

- The direct care component is equal to the provider's normalized allowable per patient day costs times the provider's Medicaid day-weighted case-mix index plus the allowed excess payment allowance.

  For facilities located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day- weighted median times 120 percent times the wage index factor times the provider's Medicaid day-weighted case-mix index.

  For facilities not located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid day-weighted case-mix index.

- The non-direct care component is equal to the provider's allowable per patient day costs plus the allowed excess payment allowance and the capital cost per diem instant relief add-on for qualifying nursing facilities. The component limit is the non-direct care non-state-owned nursing facility patient-day-weighted median times 110 percent or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit as described in Supplement 4 to Attachment 4.19-D.