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ATTACHMENT 4.19-B
METHODS AND STANDARDS
FOR
ESTABLISHING PAYMENT RATES
FOR
STATE PLAN COVERED SERVICES

A. When services which are reimbursed per a fee schedule, unless otherwise noted below, the same fee schedule applies to all providers -- both public and private -- and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the Iowa Medicaid Agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html. Except for Other Independent Laboratory services, the agency's rates were set as of September 1, 2012, and are effective for services on or after that date. The fee schedule amounts will be updated annually effective July 1 based on the current inflation factor located at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html.

The fee schedule amounts for Other Independent Laboratory services, including code series 81000 are based on 100% of the Medicare Clinical Laboratory Fee Schedule. Effective January 1, 2009, and annually thereafter, the Department shall update the Independent Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

B. The principles and standards established in OMB Circular A-87 are applied, when applicable, in determining rates regardless of the reimbursement methodology or fee schedule described below.

C. Rates paid for individual practitioner services based on the fee schedule or methodology described below shall not exceed the provider's customary charges for the service billed. In order for the Iowa Medicaid Agency to meet the requirements of 42 CFR 447.203(b)(1) providers of individual practitioner services must bill Medicaid the customary charge for the service provided.

D. Providers of services must accept reimbursement based upon the Iowa Medicaid agency fee or methodology without making any additional charge to the recipient.

E. All payments are made to providers. The term "provider" means an individual or an entity furnishing Medicaid services under an agreement with the Iowa Medicaid agency. An entity need not be a facility such as a hospital, ICF/MR, or nursing. Pursuant to 42 CFR 447.15 (g), the term may include facilities or entities who employ or contract with persons who are authorized under the Iowa State Plan to provide covered services. Also an entity may provides, for example, "clinic services (as defined in 42 CFR 440.90)" or "home health services (as defined in 42 CFR 440.70) and other services which are otherwise covered under Iowa Medicaid through its employees or contractors. In the latter case the entity would also be paid for those non-clinic and

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or non-home health services if it had an employment contract or other contract with the licensed health care professional providing those services which meets the requirements of 42 CFR 447.15(g).

F. Below is a description of the methods and standards for establishing rates for all covered services other than waiver services. The numbering is identical to the list of covered services contained in ATTACHMENT 3.1-A and the description of

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The following services will be reduced:

Various services applicable to fees schedule language on page 1 (Physician Services; Podiatrist Services; Optometrist Services; Chiropractor Services; Audiology Services; Hearing Aide Dispenser Services; Psychologist Services; Services of Advanced Registered Nurse Practitioners; Services of Certified Nurse Anesthetists; Certain Pharmacists Services; Services of Advanced Nurse Practitioners Certified in Psychiatric or Mental Health Specialties; Renal Dialysis Clinics; Ambulatory Surgical Centers; Maternal Health Centers; Home Health-Medical Supplies and Equipment; Physical Therapy Services; Occupational Therapy Services; Services for Individuals with Speech, Hearing and Language Disorders; Prosthetic Devices; Eyeglasses; Nurse Midwife Services; Extended Services for Pregnant Women; Ambulatory Prenatal Care for Pregnant Women during a Presumptive Eligibility Period; Nurse Practitioner Services; Transportation Services) – Effective for services rendered on or after September 1, 2011, reimbursement will be 95% of the agency's rates set as of July 1, 2008, excluding IowaCare network providers. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered between December 1, 2009 and December 31, 2009, reimbursement will be made at 95% of Medicare's January 1, 2009 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered on or after January 1, 2010, reimbursement will be 95% of Medicare's January 1, 2010 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Various services applicable to fees schedule language on page 1 (Dental Services; Dentures; Medical and Surgical Services Furnished by a Dentist) – Effective for services rendered on or after December 1, 2009, reimbursement will be 97.5% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

Preventative Exam Codes rendered in connection to services provided by IowaCare network providers – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

EPSDT: Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 5 of Attachment 4.19-B)

Family Planning Services – Agency's rates were set as of July 1, 2008, and are effective for services rendered on or after that date. (Page 1 of Attachment 4.19-B)

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Home Health-Intermittent Nursing Services – Effective for services rendered on or after December 1, 2009, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation. (Page 8 of Attachment 4.19-B)

Effective for services rendered on or after July 1, 2012, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at June 30, 2012, plus two percent; or the base year Medicare per visit limitations plus inflation (Page 8 of Attachment 4.19-B).

Community Mental Health Centers – Effective for services rendered December 1, 2009 through June 30, 2010, reimbursement will be reduced to 97.5% of reconciled cost. (Page 9, of Attachment 4.19-B)

Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 12 of Attachment 4.19-B)

Hospital-Specific Base APC Rates – Effective for services rendered on or after December 1, 2009, all reimbursement rates will be reduced by 5%, excluding IowaCare network providers. (Page 14 of Supplement 2 of Attachment 4.19-B)

Graduate Medical Education and Disproportionate Share Pool – Effective on or after December 1, 2009, the total annual pool amount that is allocated to the Graduate Medical education and disproportionate share pool for direct medical education related to outpatient services is $2,776,336. (Page 22 of Supplement 2 of Attachment 4.19-B)

Physician Services Rendered in Facility Settings – Effective for services rendered on or after September 1, 2011, site of service differentials will be applied to certain professional services rendered by physicians with a facility place of service. The site of service differential will only apply to those CPT/HCPCS codes that Medicare has determined to be eligible for site of service payment differentials under that program. The list of CPT/HCPCS procedures codes affected are posted at the following website: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html.

Effective for services rendered on or after April 25, 2012 and through December 31, 2012, site of service differentials will not be applied to certain professional services rendered by physicians with a facility place of service.

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Physician-Administered Drugs – Effective for services rendered on or after September 1, 2012, reimbursement for HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999, will be reduced by 2%. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:
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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

The basis of payment 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.

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. (Until a center submits a cost report, the Iowa Medicaid Program makes interim payments to the center based on the amounts normally paid under Medicaid's fee schedule.)

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

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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.

Iowa Medicaid makes a supplemental payment to rural health clinics for people enrolled in a Medicaid-contracting MCE when the payment from the MCE is lower than the cost-based amount. Clinics report all income from MCEs for Medicaid-covered services provided to enrollees. The payment to the center for these services is calculated as if the recipient was not an MCE enrollee (base rate plus adjustments times the number of visits) and the underpayment, if any, is paid to the rural health clinic. Such payments are made at least quarterly.

For a new center the Department will use an average of base rates paid to centers within the same geographic area performing the same or similar services as the first year base rate. The geographic area will be considered the current MCE rate setting region as determined by the Department.

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

The basis of payment for federally qualifying 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.

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The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the coming year which reflects payment for 100% of reasonable cost. (Until a center submits a cost report, the Iowa Medicaid Program makes interim payments to the center based on the amounts normally paid under Medicaid's fee schedule.)

Following submission of the Medicare cost report for the current year, the Department adjusts the interim rate for the coming 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 amount supported by the Medicare cost report is paid to the federally qualifying health center. Payment adjustments will be made within 90 days of receipt of the cost report.

Iowa Medicaid makes a supplemental payment to federally qualifying health centers for people enrolled in a Medicaid-contracting HMO when the payment from the HMO is lower than the cost-based amount. Clinics report all income from HMOs for Medicaid-covered services provided to enrollees. The payment to the clinic for these services is calculated as if the recipient was not an HMO enrollee (base rate plus adjustments times the number of visits) and the underpayment, if any, is paid to the center. Such payments are made at least quarterly.

The Department will compute the base rate which would be paid to participating federally qualifying 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.

Iowa Medicaid makes a supplemental payment to federally qualified health centers for people enrolled in a Medicaid-contracting MCE when the payment from the MCE is lower than the cost-based amount. Centers report all income from MCEs for Medicaid-covered services provided to enrollees. The payment to the center for these services is calculated as if the recipient was not an MCE enrollee (base rate plus adjustments times the number of visits) and the underpayment, if any, is paid to the federally qualified health center. Such payments are made at least quarterly.

For a new center the Department will use an average of base rates paid to centers within the same geographic area performing the same or similar services as the first

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year base rate. The geographic area will be considered the current MCE rate setting region as determined by the Department.

3. OTHER INDEPENDENT LABORATORIES SERVICES
Fee Schedule. The fee schedule is based on 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: Fee schedule.

(2) Services of licensed practitioners of the healing arts: Fee schedule.

(3) Home health services – nursing services: Same as home health services under Item 7a.

(4) Home health services –medical supplies and equipment: Fee Schedule

(5) Private duty nursing services: Same basis as home health service payments – nursing services described in Item 7a.

(6) Dental services: Fee Schedule.

(7) Diagnostic services: Fee Schedule

(8) Rehabilitative Services: For services provided on July 1, 2011 and after, 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.

Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

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:

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(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

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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 the 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.

(9) Transportation services: Fee schedule.

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(10) Personal care services: Same basis as home health services – home health aide described in Item 7b.

4c. FAMILY PLANNING SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

4d. TOBACCO CESSATION SERVICES
Fee Schedule. To maximize the effectiveness of tobacco cessation medications, counseling services are available for Medicaid member use in conjunction with cessation medication. Counseling services must be prescribed by a licensed practitioner participating in the Iowa Medicaid Program. Clinicians and other licensed practitioners must bill their usual and customary charges and must use the appropriate CPT codes to bill for counseling services.

5a. PHYSICIANS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

5b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6a. PODIATRISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6b. OPTOMETRISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6c. CHIROPRACTORS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d1. RESERVED

6d2. RESERVED

6d3. AUDIOLOGY SERVICES

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Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d4. HEARING AID DISPENSER SERVICES
Fee schedule. The fee schedule is based on the definitions of medical and surgical supplies given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

6d5A. PSYCHOLOGISTS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d5B. SOCIAL WORKERS' SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The following are exceptions:

When social worker services are provided by a social worker employed by a physician, hospital, home health agency, rural health clinic, federally qualified health center or community mental health center, payment for the service will be made to the provider based upon a fee schedule for physician and community mental health center and the reimbursement defined for hospital, home health agency, rural health clinic and federally qualified health center services.

6d6 BEHAVIORAL SCIENCE PRACTITIONERS
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

6d7 RESERVED

6d8 A. SERVICES OF ADVANCED REGISTERED NURSE PRACTITIONERS
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

6d8 B. SERVICES OF CERTIFIED NURSE ANESTHETISTS
Fee Schedule. Payment for CRNA services is made using the CMS fee schedule (CPT-4) anesthesiology procedure list and associated base units. When the CRNA receives medical direction from the surgeon, reimbursement to the CRNA is 80% of the amount that would be paid to an anesthesiologist (MD or DO). When the CRNA receives medical direction from an anesthesiologist, reimbursement to the CRNA is 60% of what an anesthesiologist would receive for the same procedure.

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6d9. CERTAIN PHARMACISTS SERVICES
Fee Schedule.

6d10. SERVICES OF ADVANCED NURSE PRACTITIONERS CERTIFIED IN PSYCHIATRIC OR MENTAL HEALTH SPECIALTIES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is established as 85% of the physician fee schedule.

7. HOME HEALTH SERVICES
The payment for each home health service is determined retrospectively based on the disciplines (skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), speech therapy and medical social services) in aggregate. Interim payments for home health agencies are made based on the home health agency's cost-to-charge ratios. A tentative cost settlement is performed based on the as-submitted Medicare cost report and a final cost settlement is performed based on the finalized Medicare cost report.

7a. HOME HEALTH SERVICES – SKILLED NURSING SERVICES (INTERMITTENT)
The basis of payment for intermittent skilled nursing services provided by a home health agency is reasonable cost subject, reconciled on a retrospective basis by the State Medicaid Agency, subject to the following:

Payment for intermittent skilled nursing services is made at the lower of: the home health agency's average cost per visit per the submitted Medicare cost report; the agency's Medicaid per visit limit in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation effective November 30, 2009.

The average cost per visit is derived from the Medicare cost report where cost for Medicaid is calculated by multiplying the average cost per visit times the covered Medicaid intermittent skilled nursing visits which are subject to a desk review. The agency's Medicaid per visit limit is based on agency cost at 06/30/2001 subject to periodic adjustment. The base year for the Medicare per visit limit was calendar year 2000 subject to annual home health market basket updates.

7b. HOME HEALTH SERVICES– HOME HEALTH AIDE SERVICES
Same as 7a.

7c. HOME HEALTH SERVICES - MEDICAL SUPPLIES AND EQUIPMENT
Fee schedule.

7d. HOME HEALTH SERVICES - PHYSICAL THERAPY, OCCUPATIONAL THERAPY & SPEECH PATHOLOGY SERVICES
Same as 7a.

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8. RESERVED

9. CLINIC SERVICES

Physician and dental fee schedules, except as follows:

(a). Clinics that are renal dialysis clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(b). Clinics that are ambulatory surgical centers are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(c). Clinics that are maternal health centers are paid for clinic services on a prospective cost-based fee schedule with no retroactive cost settlement, as determined by the Department based on a cost center report submitted by clinics on an annual basis. Services payable to the clinics include: 1) Maternal Health 2) Maternal Oral Health 3) Immunization 4) Laboratory. Cost of services to calculate the cost-based fee schedule rates includes direct cost (personnel and supplies) and overhead indirect cost incurred to support the services. Agency rates were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(d). Clinics that are family planning clinics are paid for clinic services on a fee schedule. Fee schedule amounts were set in accordance with the effective date noted on page 1c of Attachment 4.19-B.

(e). Clinics that are Indian Health Service Facilities are paid for clinic services provided to Native American Indians and Alaska Natives by Indian Health Service 638 facilities at the most current encounter rate established by the Indian Health Service, which is published periodically in the Federal Register. Only one encounter will be payable daily for services provided to any covered recipient.

(f). When a facility provides services, which are otherwise covered under the state plan, in addition to clinic services, payment is based on the methodology as defined for the service that is provided.

(g). Reimbursement methodology for Community Mental Health Centers:

Community Mental Health Centers are reimbursed using a cost based methodology. This methodology will consist of a cost report and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

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Interim Payment

The Department makes interim payments to the Community Mental Health Center based upon 105% of the greater of the statewide fee schedule for Community Mental Health Centers effective July 1, 2006 or the average Medicaid managed care contracted fee amounts for Community Mental Health Centers effective July 1, 2006.

After cost reports are received, the Department will examine the cost data for Community Mental Health Center services to determine if an interim rate change is justified.

Determination of Medicaid-allowable direct and indirect costs

To determine the Medicaid-allowable direct and indirect costs of providing Community Mental Health Center services, the following steps are performed:

1. Direct costs for Community Mental Health Center services include unallocated payroll costs and other unallocated costs than can be directly assigned to Community Mental Health Center services. Direct payroll costs include total compensation of direct services personnel.

   Other direct costs include costs directly related to the approved Community Mental Health Center personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment.

   These direct costs are accumulated on the annual cost report, resulting in total direct costs.

2. General and Administrative indirect costs are determined based on the percentage of directly assigned Community Mental Health Center direct cost to Total cost before general and administrative overhead.

3. Net direct cost and general and administrative indirect costs are combined.

4. The combined costs from Item 3 are divided by total Community Mental Health Center units of service provided for all patients to calculate a cost per unit.

5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the total Medicaid units of service that were paid from the claims data.

Annual Cost Report Process

Community Mental Health Centers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after their fiscal year for free-standing clinics and 120 days for hospital-based clinics. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Community Mental Health Center.

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The primary purposes of the Medicaid cost report are to:

1. Document the provider's total Medicaid-allowable costs of delivering Medicaid coverable services.
2. Reconcile annual interim payments to its total Medicaid allowable-costs.

All filed annual Medicaid cost reports are subject to a desk review by the Department or its designee. Community Mental Health Centers must eliminate unallowable expenses from the cost report. If they are not removed the Department or its designee will make the appropriate adjustments to the Community Mental Health Center's Medicaid cost report.

Cost Reconciliation Process

The cost reconciliation must be completed by the Department or its designee within twenty-four (24) months of the end of the cost reporting period covered by the annual Medicaid cost report. The total Medicaid-allowable costs are compared to interim payments received by the Community Mental Health Center for services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

Cost Settlement Process

EXAMPLE: For services delivered for the period January 1, 2010, through December 31, 2010, the annual Medicaid cost report is due on or before March 31, 2011, for free-standing clinics or May 31, 2011, for hospital-based clinics, with the cost reconciliation process completed no later than December 31, 2012.

If a Community Mental Health Center's payments for Medicaid-covered services exceed the actual Medicaid costs for services, the Department will recoup the overpayment using one of these two methods:

1. Offset all future claims payments from the Community Mental Health Center until the amount of the overpayment is recovered;
2. The Community Mental Health Center will return an amount equal to the overpayment to the Department of Human Services.

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If a Community Mental Health Center's actual Medicaid costs exceed the payments for Medicaid-covered services the Department will pay the difference to the Community Mental Health Center.

The Department shall issue a notice of settlement that denotes the amount due to or from the Community Mental Health Center.

10. DENTAL SERVICES
Fee Schedule. The definitions of dental and surgical procedures are based on the definitions of dental and surgical procedures given in the Current Dental Terminology (CDT).

11a. PHYSICAL THERAPY SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

11b. OCCUPATIONAL THERAPY SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT).

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11c. SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent addition of Physician's Current Procedural Terminology (CPT).

12a. PRESCRIBED DRUGS

The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500-520 as amended.

a. Reimbursement for covered prescription and nonprescription drugs shall be the lowest of the following as of the date of dispensing:

(1) "Estimated acquisition cost (EAC)," defined as the average Actual Acquisition Cost (AAC), as determined from surveys of Iowa Medicaid enrolled pharmacies, plus the professional dispensing fee. If no AAC is available, the EAC will be defined as the Wholesale Acquisition Cost (WAC), as published by Medi-Span.

(2) "Federal upper limit (FUL)," defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Service as described in 42 CFR 447.514, plus the professional dispensing fee.

(3) Submitted charge, representing the provider's usual and customary charge for the drug.

b. Professional Dispensing Fee: The professional dispensing fee is based on the cost of dispensing survey which must be completed by all medical assistance program participating pharmacies. This fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. For services rendered on or after February 1, 2013, the professional dispensing fee is $10.02.

c. Subject to prior authorization requirements, if a physician certifies in the physician's handwriting that, in the physician's medical judgment, a specific brand is medically necessary for a particular recipient, the FUL does not apply and the payment equals the lesser of EAC or submitted charges. If a physician does not so certify, the payment for the product will be the lower of FUL, EAC, or submitted charges.

State/Territory: IOWA

d. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by a pharmacist.

e. Pharmacies and providers that are enrolled in the Iowa Medicaid program are required to make available and submit to the department or its designee, drug acquisition cost invoice information, product availability information, or other information deemed necessary by the department for the determination of reimbursement rates and the efficient operation of the pharmacy benefit.

f. No payment shall be made for sales tax.

g. All hospitals which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Hospitals receive reimbursement for the administration of vaccines to Medicaid recipients through the DRG reimbursement for inpatients and APG reimbursement for outpatients.

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State/Territory: IOWA

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

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

12c. PROSTHETIC DEVICES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

12d. EYEGLASSES

Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Healthcare Common Procedure Coding System (HCPCS).

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES

For services provided on July 1, 2011 and after, 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.

State/Territory: IOWA

13d. REHABILITATIVE SERVICES (Cont.)

87 shall be used to determine the actual cost of services rendered to Medicaid recipients.

ACT Services. The state-wide fee amount is a daily rate of $36.16 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 and the fee schedule and any annual/periodic adjustments to the fee schedule are published at 441 Iowa Administrative Code Chapter 79. The agency's rates will be set as of 7-1-2007, and are effective for services on or after that date.

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State/Territory: IOWA

Except as otherwise noted in the plan, payment for rehabilitation services is based on state-developed provider-specific fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of 7/1/2011 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

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:

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.
(2) Basis for service—general rule. General requirements for all services are listed herein. The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:
1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.

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11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

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 the State Medicaid agency, for those services actually provided under the treatment plan recommended. Reasonable and necessary costs shall not exceed 110 percent of the statewide average allowable costs 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.

14a. SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – INPATIENT HOSPITAL SERVICES

See Attachment 4.19-A of the State Plan.

14b. SERVICES FOR INDIVIDUAL AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES – NURSING FACILITY SERVICES

See Attachment 4.19-D of the State Plan.

15a. ICF/MR SERVICES – NOT PUBLIC

See Attachment 4.19-D of the State Plan.

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15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

15b. ICF/MR SERVICES – PUBLIC

See Attachment 4.19-D of the State Plan.

16. INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 21 YEAR OF AGE

See Attachment 4.19-A of the State Plan.

17. NURSE-MIDWIFE SERVICES

When nurse midwife services are provided in a birthing center by a nurse-midwife employed by the center, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse mid-wives in birth centers, provided the nurse mid-wife is required to turn over his or her fees to the center as a condition of employment.

When nurse midwife services are provided in a birthing center by a nurse mid-wife with whom the nurse-midwife has a contract under which the facility submits the claim, payment for the service will be made to the birth center only, at the published fee schedule for services provided by nurse midwives in birthing centers.

All other payments for the services of an nurse-midwife enrolled in the Iowa Medicaid program shall be paid on the basis of the fee schedule for services provided nurse mid-wives and no separate payment shall be made to any other facility or provider in connection with the birth, other than a hospital, or ambulatory surgical center. The nurse-midwife fee schedule is based on 85% of the physician fee schedule.

18. HOSPICE SERVICES

Iowa Medicaid reimburses for hospice services in accordance with the requirements of Section 4306 of the State Medicaid Manual (Hospice Reimbursement).

Pursuant to Section 4307 of the State Medicaid Manual (Payment for Physician Services Under Hospice), when the Iowa Medicaid agency has been notified of the name of the physician who has been designated as the attending physician and is not a hospice employee, the Iowa Medicaid Agency will reimburse the attending physician in accordance with the physician fee schedule described in Item 5a.

19a. CASE MANAGEMENT SERVICES

For target group 1 (Adults with chronic mental illness, and severely emotionally disturbed children receiving services through the HCBS Children's Mental Health waiver); and target group 2 (Persons with a developmental disability, including mental retardation):

For the period of December 3, 2009, through June 30, 2010, case management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed using a monthly unit established on the basis of the provider's reasonable and necessary costs in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." A prospective cost-based interim rate will be set based on the finalized FYE June 30, 2009 financial and statistical cost report. An inflation factor of 4.8% will be applied from midpoint of the cost report period to midpoint of the rate period (January 1, 2009 through March 15, 2010), then reduced by 2.5% resulting in an inflation factor of 2.3%. If the provider's cost does not support the payments made during December 1, 2009, – June 30, 2010, the provider will be required to return the difference between actual cost and the prospective cost-based rate. If actual cost exceeds the prospective cost-based rate the amount paid to the provider shall be actual cost less 2.5% not to go lower than the prospective cost-based rate. Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. The indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

Revised Submission 5.2.11

State/Territory: IOWA

For the period July 1, 2010, and thereafter, reimbursement rates for case management providers will be established on the basis of a 15 minutes unit in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." Case Management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency.

Interim Payment

The Department will make interim payments to Case Management providers based upon a projected cost report. Providers are required to submit a CMS-approved, Medicaid projected cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment.

Annual Cost Report Process

Case Management providers are required to submit a CMS-approved, Medicaid cost report to the Department 90 days after each fiscal year end. A 30-day extension of the Medicaid cost report due date may be granted upon request by the Case Management.

The Medicaid cost report data includes direct costs, programmatic indirect costs, and general and administrative costs. Direct costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel and other direct costs related to the delivery of Case Management services. Programmatic indirect costs include salaries, benefits and other costs that are indirectly related to the delivery of Case Management services. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the Case Management service, constitute costs that support the operations of the Case Management agency. These general and administrative overhead costs are included in accordance with OMB Circular A-87. Case Management providers must eliminate unallowable expenses from the cost report. If they are not removed Iowa Medicaid will make the appropriate adjustments to the Case Management's Medicaid cost report.

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Cost Reconciliation Process
The cost reconciliation must be completed within twenty-four (24) months of the end of the cost report period covered by the annual Medicaid cost report. The total Medicaid allowable costs per unit are compared to the interim projected rate paid for services delivered during the reporting period. Retroactive claim adjustments are made based on the final rates determined using the final actual financial reports.

Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. 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 indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

Target Group 3
For target group 3 (Children from birth to age three who meet the "developmental delay" eligibility categories set forth in the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA)):

Case management services are reimbursed according to a fee schedule, established September 1, 2002 and updated July 1, 2005 for services rendered on or after that date, based on 15-minute units of service. The number of 15-minute units billed cannot exceed 24 per day per case manager.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management for target group 3 and the fee schedule and any annual periodic adjustments to the fee schedule are published on the agency's website at: www.ime.state.ia.us/Reports_Publications/FeeSchedule.html .

19b RESERVED

20. EXTENDED SERVICES FOR PREGNANT WOMEN
Fee Schedule.

State/Territory: IOWA

21. AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN DURING A PRESUMPTIVE ELIGIBILITY PERIOD
Fee Schedule.

22. RESERVED

23. NURSE PRACTITIONER SERVICES
Fee Schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). The fee schedule is based on 85% of the physician fee schedule.

24a. TRANSPORTATION SERVICES
Fee Schedule. If transportation is by car, the maximum payment that may be made is the actual charge made by the provider for transportation to and from the source of medical care, based on a fee schedule.

24b. RESERVED

24c. RESERVED

24d. SKILLED NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS OF AGE
See Attachment 4.19-D of the State Plan.

24e. RESERVED

24f. RESERVED

25g. RESERVED

26. RESERVED

27. RESERVED

28. RESERVED

Revised Submission 6.27.13

State/Territory: IOWA

29. FREE-STANDING BIRTH CENTER SERVICES

Reimbursed based on a fee schedule as follows:

(a) Payment for covered services provided by a participating free-standing birth center is limited to the lesser of the charges billed or the allowable rates per fee schedule.

(b) The fee schedule established is based upon: (1) review of Medicaid fees paid by other states; (2) Medicaid fees for similar services; (3) Medicare fees; and/or (4) some combination or percentage thereof.

Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2009, and is effective for services provided on or after that date. All rates are published at:
http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html

29. **Payment Adjustment for Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(B)

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable conditions identifies below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

Medical claims must be billed with the surgical procedure code and modifier which indicates the type of serious adverse event for wrong body part, wrong patient, or wrong surgery, and at least one (1) of the diagnosis codes indicating wrong body part, wrong patient, or wrong surgery must be present as one of the first four (4) diagnoses codes on the claim.

Methods And Standards For Establishing Payment Rates For Other Types Of Care

Supplemental Payments for Physician Services at Qualifying Hospitals
Beginning July 1, 2003, and ending June 30, 2005, the State shall make supplemental payments for physician services provided to Medicaid recipients by participating physicians at qualifying hospitals. These supplemental payments shall be equal to the difference between the average commercial payment rate and the amount otherwise paid pursuant to the fee schedule for physicians' services under Attachment 4.19-B.

The average commercial rate is equal to a qualifying hospital's average aggregate commercial collection percentage times billed charges from the Medicaid claim. Each qualifying hospital will submit data, by physician specialty, to the department that includes the amount of charges and payments for each contracted, non-contractual and self-pay commercial plan. A collection percentage will be calculated for each commercial plan by dividing payments by charges. The average aggregate commercial collection percentage is the average of all commercial plans.

For this purpose, "participating physician" means a physician who is employed by a qualifying hospital or who has assigned Iowa Medicaid payments to a qualifying hospital or to an organized health care delivery system (as defined in 42 CFR sec. 447.10(b)) affiliated with a qualifying hospital so that payment can be made to the hospital or the organized health care delivery system in conformance with 42 CFR 447.10(g). "Qualifying hospital" means a hospital that is Iowa state-owned and has more than 500 beds. Supplemental payments shall be directly remitted to the qualifying hospital or the organized health care delivery system to which participating physicians have assigned Iowa Medicaid payments and shall be paid no less than annually and no more frequently than quarterly.

Revised Submission 5.2.11

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☑ HCBS Case Management

For the period July 1, 2010, and thereafter, reimbursement rates for case management providers will be established on the basis of a 15-minute unit in accordance with the Office of Management and Budget Circular A-87, "Cost Principles for State and Local Governments." Case Management services will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency. Providers are required to submit a cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment. A cost report showing actual costs is submitted ninety days after each fiscal year end. 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. Because case management is the only service provided by case management providers, enrolled providers are not required to complete CMS approved time studies. 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 indirect cost rate for each provider is reviewed and monitored annually by the State Medicaid Agency.

☐ HCBS Homemaker

- ☐ HCBS Basic Homemaker
- ☐ HCBS Chore Services

☐ HCBS Home Health Aide

☐ HCBS Personal Care

- ☐ HCBS Personal Care I
- ☐ HCBS Personal Care II
- ☐ HCBS Attendant Services
- ☐ HCBS Adult Companion
- ☐ HCBS Personal Emergency Response Systems

	☐	HCBS Assistive Technology
☐	HCBS Adult Day Health	

☑	Habilitation	
	☑	HCBS Home-Based Habilitation
		Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. 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 (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
	☑	HCBS Day Habilitation
		Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. 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 (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
	☐	HCBS Behavioral Habilitation
	☐	HCBS Educational Services
	☑	HCBS Prevocational Habilitation
		Reimbursement is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. 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 (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
	☑	HCBS Supported Employment Habilitation

		Reimbursement for Supported Employment activities to obtain a job – job development, and supported employment activities to obtain a job – employer development is based on a fee schedule developed by the state Medicaid agency with advice and consultation from the appropriate professional group and reflects the amount of resources involved in service provision. Reimbursement for all other Supported Employment activities is on a retrospective cost-related basis. Providers are reimbursed on the basis of a rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. 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 (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients. The initial rate for a new provider is based on projected costs of operation calculated based on submission of financial and statistical reports by the provider.
☐	Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one)*:

⊙	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be [ ] days (not to exceed 60 days).

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Effective: 7-1-12 Approved: 6-7-12

Attachment 4.19-B

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Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Health Home Provider

Description

Overview of Payment Structure:
Iowa has developed the following payment structure for designated Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Iowa. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Patient Management Per Member Per Month Payment
This reimbursement model is designed to only fund Health Home services that are not covered by any of the currently available Medicaid funding mechanisms. Health Home Services, as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes. Iowa Medicaid Enterprise recognizes that health home transformation requires financial support to clinic leadership and administrative functions so that members receive services in a data driven, population focused, and person centered environment. The criteria required to receive a monthly PMPM payment is:
A. The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR).
B. The member has full Medicaid benefits at the time the PMPM payment is made.
C. The member has agreed and enrolled with the designated health home provider.
D. The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
E. The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring

for treatment gaps defined as Health Home Services in this State Plan, or a covered service defined in this state plan was provided that was documented in the member's EHR.
a. The health home will attest, by a monthly claim submission, that the minimum service requirement is met. The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of claim submission.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Tier Minutes Per Month Sum of Chronic Conditions
Tier 1 15 1-3
Tier 2 30 4-6
Tier 3 60 7-9
Tier 4 90 10 or more

Additional Tiering Information
Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

Reimbursement for Evaluation and Management (E/M) procedure code 99215 as of January 2012 was used as the base value for determining one hour of physician work. The count of major conditions serves as a proxy for the time (expressed in minutes in above table) and work required to coordinate patient care. PMPM time units of care coordination were determined for each tier utilizing best practice criteria for care coordination. The work of care coordination is divided between the physician and other members of the care coordination team; therefore, the following distribution of work in an optimally-functioning practice is as follows:
20% Physician
30% Care Coordinator
20% Health Coach
30% Office/Clerical

The fee-for-service rate for one hour of care coordination was calculated after discounting for the above work distribution over time (Care Coordinator and Health Coach are at 65% of the physician rate and office/clerical are at 30%).

The agencies rates were set as of July 1, 2012 and are effective for services on or after that date. All rates are published on the agency website: www.ime.state.ia.us/Reports_Publications/FeeSchedule.html . The State fully intends to evaluate set rates annually to ensure they are reasonable and appropriate for the services they purchase.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Quality/Outcome Measurement Incentive Calculation
All Health Home Providers will report annually Quality/Outcome Measurements to the State and are eligible to receive incentive payments for achieving quality/performance benchmarks. No monetary value will be tied to performance measures in the first measurement year, (7/1/2012 – 6/30/2013). Beginning July 1, 2013, performance payments will be paid lump sum annually based on achieving quality/performance benchmarks. The quality/outcome measures are separated into five categories: 1) Preventive Measures; 2) Diabetes Measures; 3) Hypertension Measure; and 4) Mental Health Measure; and 5) Total Cost of Care. Each category is weighted based on importance and attainability of the measures. Payment will be made by September 30, following the end of the perforamnce year.

The quality/outcome measurement incentive payment is equal to a percentage of the PMPM payments that are made to each participating health home. The maximum amount of incentive payment that a health home can attained is twenty (20) percent of the total PMPM payments made to that participating Health Home. The total PMPM payments is the sum of all Patient Management Payments make to the participating Health Home for patients attributed to the provider during the performance year.

The quality/outcome measurement incentive payment is contingent on a participating Health Home provider's performance on the quality/outcome measures specified for the categories below. Each category is worth a percentage of the maximum incentive payment amount. Within each category, the specified minimum performance must be achieved for each measure in order to receive the category's percent value; if performance is not achieved, on any of the required measures, the category's value is zero (0). The weight for each category achieved is then applied as a percentage of the maximum incentive payment amount.

The State will inform Health Home providers prior to the start of each performance year the target performance (also known as the minimum performance or benchmark) for each measure. The Health Home Provider must achieve the target performance for each measure in the category to achieve the bonus for that category.

Formula:
20% of Patient Management Payments for Measurement Year = Maximum Incentive Payment (MIP)
Category 1 Assigned Value = 35% of MIP
Category 2 Assigned Value = 30% of MIP
Category 3 Assigned Value = 20% of MIP
Category 4 Assigned Value = 15% of MIP

Category: Preventive Measures (best two out of three measures count for the practice)
Assigned Value of bonus = 35% Source = Health Information Network

Children turning 2 years old in reporting year who receive 4 DtaP, 3 IPV, 1 MMR, 4 HIB, 3 HEP-B, 1 VZV and 4 pneumococcal conjugate vaccines on or before their second birthday.

Flu shots for adults ages > 6 months
Document BMI and appropriate follow-up planning when needed.

Category: Disease Option 1 (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus = 30% Source = Health Information Network

Diabetes Management:
- Dilated eye exam (annual by optometrist or ophthalmologist)
- Micro albumin (annual)
- Foot exam (annual)
- Proportion with HgA1c less than 8
- Proportion with LDL less than 100

Asthma Management
- Asthma Patients with Asthma-related Emergency Room Visit
- Use of appropriate medications for people with asthma
- Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen

Category: Disease Option2 (Health Home picks the measure that most aligns with the practice population)
Assigned value of bonus = 20% Source = Health Information Network

Proportion with blood pressure less than 140 systolic and less than 90 diastolic; blood pressure check each visit.

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Effective: 7-1-12 Approved: 6-7-12

Systemic Antimicrobials

Category: Mental Health Measure (Health Home picks the measure that most aligns with the practice population)
Assigned Value of Bonus 15% Source = Health Information Network

Percentage of discharges for members 6 years of age and older who were hospitalized for treatment selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
Clinical Depression Screening

Category: Total Cost of Care
Assigned Value of Bonus = 0% Source = Health Information Network

Total cost of care per member/per year Reporting Only The state envisions this measures being tied to monetary bonus in the future, once the baseline has been established. This measure will begin for reporting purposes only to introduce the calculation to health home providers.

Health Home providers are measured during the twelve month reporting period using the measures described above for only those Health Home patients that were enrolled at start of the reporting period and that received at least two months of patient management payments during the reporting period.

☐ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

none

Description

none

☐ Tiered?

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

X The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

X The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

X The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

X The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99339, 99340, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99403, 99404, 99406, 99411, 99412, 99429

(Primary Care Services Affected by this Payment Methodology – continued)

X The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460 (Effective 01.01.11) , 90461 (Effective 01.01.11), 99224 (01.01.11), 99225 (01.01.11), 99226 (01.01.11), 99441 (10.01.10), 99442 (10.01.10), 99443 (10.01.10), 99444 (10.01.10), 99499 (10.01.10)

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☐ State regional maximum administration fee set by the Vaccines for Children program

X Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.

X A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $5.30.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: _____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at www.ime.state.ia.us

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at www.ime.state.ia.us

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