STATE OF IOWA
IOWA DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL SERVICES

Instructions for the Nursing Facility Quality Assurance Assessment Fee Calculation Worksheet

All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

a. Nursing facilities operated by the state.
b. Non-state government-owned or government-operated nursing facilities.
c. Distinct-part skilled nursing units and swing-bed units operated by a hospital

Provider Name and Identification Data

NPI Number: Report the facility's National Provider ID, taxonomy and nine-digit zip code. It is very important that all of these numbers correspond to those on file with the IME Provider Services Unit so that your facility can be correctly indentified and the fee be attributed to your facility.

Type of Control: Indicate whether the facility is proprietary for-profit, voluntary non-profit, or government owned. If the facility is government-owned, no quality assurance assessment fee is due.

CCRC Registered: If the facility is registered as a Continuing Care Retirement community (CCRC) by the Iowa Insurance Division, then the question should be answered 'Yes.'

If the facility has changed its status as a Continuing Care Retirement community (CCRC) with the Iowa Insurance Division since the last quarterly Nursing Facility Quality Assurance Assessment Calculation Worksheet was filed, please answer 'Yes' and indicate the date the facility became a CCRC or terminated its designation.

Statistical Data

Beds at Beginning of Period: Report the number of authorized licensed beds at the beginning of the quarter for which this form is being completed.
Beds at End of Period: Report the number of authorized licensed beds at the end of the quarter for which this form is being completed.

NOTE: If there was a change in the number of beds, please submit documentation with the completed form to the address identified on the form.

A. *Total Medicaid Days:* Report the number of days that a bed was occupied in the facility for which Medicaid was the primary payor during the quarter. Exclude leave days.

B. *Total Medicare Days:* Report the number of days that a bed was occupied in the facility for which Medicare Part A or Part C was the payor during the quarter. This includes any day where Medicare was the primary payor and there was a secondary payor for the same day (crossover), regardless if the secondary payor was Medicaid, private insurance or any other payor. Exclude leave days.

C. *Hospice Days:* Report the number of days that a bed was occupied in the facility for which a resident was receiving Hospice benefits during the quarter.

D. *Total Other Days for Reporting Period:* Report the number of days that a bed was occupied in the facility for a payor type other than Medicaid, Medicare Part A or Medicare Part C, or Hospice for the quarter. Exclude leave days.

E. *Total Leave Days:* Report the number of days any resident was absent, regardless of reason, and regardless of if the bed-hold was paid for.

Calculation of Quality Assurance Assessment Fee Amount

F. Patient days: Report the number of days from above from the Total Medicaid Day and Total Other Days (sum of A and D from above)

NOTE: This field will automatically calculate based on information provided in the Statistical Data section

G. Quality assurance assessment fee per bed day: The assessment fee is $5.26 per patient day except if a nursing facility:

a. Has 50 or fewer licensed beds
b. Designated as a Continuing Care Retirement Centers (CCRC)
c. Has annual Iowa Medicaid patient days of 26,500 or more

If a facility meets any of the criteria in a, b, or c the assessment fee is $1.00 per bed day.

H. Total quality assurance assessment fee owed to Iowa Medicaid: The quality assurance assessment fee owed is the product of bed days from F and the quality assurance assessment fee per bed day from G.

NOTE: This field will automatically calculate based on information provided in F and G above.

This form and a check for the total quality assurance assessment owed are due no later than 30 days after quarter end.

Completed forms should be submitted to the following address:

Iowa Medicaid Enterprise
PO Box 310280
Des Moines, IA 50331-0280

An electronic copy of the **form only** should be submitted to costaudit@dhs.state.ia.us

If a package is sent requiring a signature (i.e., certified mail or overnight), send to:

Iowa Medicaid Enterprise
Attn: Lockbox Services – 310280
666 Walnut Street, Suite 700
Des Moines, IA 50309

Facilities whose form is received after 30 days from the end of the quarter will be required to pay a penalty in the amount of 1.5% of the quality assurance assessment owed for each month or portion of a month the payment is overdue.

This form can be found on the IME website at http://www.ime.state.ia.us/Providers/Forms.html

Questions concerning this form should be addressed to Provider Cost Audit at 1-866-863-8610, or (515) 256-4610, or to costaudit@dhs.state.ia.us

Certification Statement

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The certification statement submitted must contain **original signatures**.