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State/Territory Name: IA

State Plan Amendment (SPA) #: 19-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

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

Kansas City Regional Operations Group

October 11, 2019

Michael Randol, Medicaid Director
Division of Medical Services
Department of Human Services
Iowa Medicaid Enterprise
611 5th Avenue
Des Moines, IA 50309

Dear Mr. Randol:

On September 30, 2019, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #19-0004. This SPA is an administrative update to address companion issues with the approval of SPA 19-0003 by CMS.

SPA #19-0004 was approved October 10, 2019, with an effective date of September 1, 2019, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Iowa State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher or Laura D'Angelo at (816) 426-5925.

Sincerely,

James G. Scott, Director
Division of Medicaid Field Operations - North

Enclosure

cc:
Jennifer Steenblock
Alisa Horn
Jeff Marston

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: 19-0004

2. STATE: IOWA

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

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

4. PROPOSED EFFECTIVE DATE: September 1, 2019

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.205

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 0.00
b. FFY 2020 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 9c, 9d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B, Page 9c, 9d

10. SUBJECT OF AMENDMENT

This is an administrative update to address companion issues identified with the approval of SPA IA-19-003 by CMS.

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: GERD W. CLABAUGH

14. TITLE: INTERIM DIRECTOR

15. DATE SUBMITTED: 9-30-19

16. RETURN TO

GERD W. CLABAUGH
INTERIM DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 30, 2019

18. DATE APPROVED: October 10, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: James G. Scott

22. TITLE: Director
Division of Medicaid Field Operations - North

23. REMARKS

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 Medicaid cost report, per the Medicaid cost principles 2 CFR, Part 200, 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.

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, at the end of the cost reconciliation, it is determined that the CMHC provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the CMHC provider will receive a lump sum payment upon discovery, but no later than 24-months of the end of the cost reporting period, in the amount of the underpayment.

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).

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of physical therapy services. The agency's fee schedule rate was set as of September 1, 2019 and is effective for services provided on and after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

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).

A payment provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of physical therapy services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on and after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

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).

A payment provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the procedure with the highest fee schedule amount at 100%; payment for each additional unit or procedure is 90%.