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State/Territory Name: IA

State Plan Amendment (SPA) #: 19-0003

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

Kansas City Regional Operations Group

June 6, 2019

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

Dear Mr. Randol:

On March 5, 2019, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #19-0003. This SPA is amending the Medicaid State Plan to reflect Iowa's current payment methodology showing when multiple therapy services are received on the same day. The therapy procedure with the highest fee schedule is reimbursed at 100% of the fee schedule and any additional therapy services received the same day will be reimbursed at 90% of the published fee schedule.

SPA #19-0003 was approved June 3, 2019, with an effective date of July 1, 2019, as requested by the state. However, during the review of SPA 19-0003, CMS performed an analysis of the information contained within the submitted SPA pages. This analysis revealed issues that will require corrective action under the companion review process. Under separate cover, CMS will release a companion letter outlining the issues and provide guidance on timeframes for corrections.

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 Sandra Levels at (816) 426-5925.

Sincerely, 6/7/2019

[redacted]

Division of Medicaid Field Operations - North

Signed by: James G. Scott -S

Enclosure

cc: Jennifer Steenblock
Alisa Horn
Jeff Marston

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

Kansas City Regional Operations Group

June 6, 2019

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

Dear Mr. Randol:

This letter is being sent as a companion to our approval of Iowa's State Plan Amendment (SPA) 19-0003. During our review of the SPA, the Centers for Medicare & Medicaid Services (CMS) performed a review of payment methodologies contained within the submitted SPA pages.

Federal Regulations at 42 CFR 430.10 and 447.252, require that the state plan contain a comprehensive description of the rate methodologies. We have included comments below to address the issues identified and this Companion Letter is being issued to document CMS' intent to continue to work with Iowa to resolve our concerns.

During the review process IA attempted to update the identified same page items. However, there was insufficient time to perform public notice during the first clock. Even when the state is memorializing its existing fee schedule it still needs to make public notice and submit a new SPA with the effective date. Similarly, the state needs to make public notice and submit a SPA to change its CPE methodology, removing the proviso that overpayments will be recovered through future interim payment.

Reimbursement Questions/Comments

1. Attachment 4.19-B, Page 9d - The cost settlement process described for Community Mental Health Centers (CMHC) on page 9d specifies in step 1 of the payment methodology that overpayments to the CMHCs will be recovered through an offset of all future claim payments to the provider for a period not to exceed 12 months. This is not consistent with payment at cost which relies on the identification of the current year's allowed cost and a comparison to payment made in the current year for such cost. Comingling the current year's interim payment with adjustments for a prior year's overpayments leads to a misstatement of the current year's settlement amount by underreporting the amount paid in the current year for the current year's cost. The state may continue to pay these providers at cost but must amend its state plan language to remove step 1 of their cost settlement process.

   Step 2 states that the CMHCs will return an amount equal to the overpayment to the US Dept. of Health and Human Services. Actually, the state is responsible for returning the federal share

of any overpayment to CMS, and that the state will return any overpayments to CMS via the CMS-64. Please amend the language for Step 2 to accurately reflect the overpayment process.

2. Dental Services - The state plan should be a comprehensive written statement describing the nature and scope of a state's Medicaid program. The state plan should also contain all the information necessary to determine whether a plan can be approved to serve as a basis for federal financial participation (FFP) in the State Program. Section 10, Dental Services, does not contain fee for service rates or effective date language for reimbursement. Please add to each section of the submission the language outlined below:

   "Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of Dental Services. The agency's fee schedule rate was set as of (insert date here) and is effective for services provided on or after that date. All rates are published (ex. agency website – add website address).

The state has 90 days from the date of this letter to address the issues described above. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

If you have any questions, please contact Karen Hatcher or Sandra Levels at (816) 426-5925.

6/7/2019

Sincerely,

[redacted]

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

Signed by: James G. Scott -S

Enclosure

cc: Jennifer Steenblock, IME
Alisa Horn, IME
Jeff Marston, IME
Sandra Levels, KCROG
Karen Hatcher, KCROG

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: 19-0003

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: July 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

7. FEDERAL BUDGET IMPACT
a. FFY ~~2020~~ 2019 $ ~~(1,356,288)~~ 0 *
b. FFY ~~2021~~ 2020 $ ~~(1,356,288)~~ 0 *

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Page 9d, 10,

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Page 9d, 10,

10. SUBJECT OF AMENDMENT

Request revises the current MPFR reduction percentage of 10% applied to the full Medicaid fee schedule ~~amount to 50% of the practice expense component portion only for "always therapy" services.~~ **

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
[redacted]

13. TYPED NAME: Jerry R. Foxhoven

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 3-5-19

16. RETURN TO

JERRY R FOXHOVEN
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 5, 2019

18. DATE APPROVED: June 3, 2019

PLAN APPROVED - ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: James G. Scott

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

23. REMARKS

* Pen and Ink change per state response dated 5.28.19.
** Pen and Ink change per email dated 5.30.19

FORM CMS-179 (07/92)

Instructions on Back

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 for a period not to exceed 12 months;

2. The Community Mental Health Center will return an amount equal to the overpayment to the US Department of Health and Human Services.

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).

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 or 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%.

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 or after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

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).

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 speech, hearing and language disorder services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

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 every two years beginning in 2014. For services rendered the professional dispensing fee is $10.07.

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.