Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

February 6, 2009

Michael Marshall
Secretary of Senate
State Capitol
LOCAL

Mark Brandsgard
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Mr. Brandsgard:

Enclosed please find copies of reports to the General Assembly relative to the Department of Human Services Growth Mechanism For Child Welfare Services. This report was prepared pursuant to directive contained in SF2425/40/12.

> "The department shall develop options for providing a growth mechanism for reimbursement of the child and family services traditionally funded under this appropriation. The growth mechanism options may provide for a tie to allowable growth for school aid, an inflationary adjustment reflective of the cost increases for the services, or other reasonable proxy for the cost increases affecting such service providers."

The Department of Human Services worked with a committee that included child welfare providers that provide in-home services, out-of-home services, and the Coalition for Family and Children's Services in Iowa to review the options and discuss the contents of the report. In the report the options that appeared most viable are presented. These options are provided for the review of the legislature.

Please let me know if you have any questions.

Sincerely

Molly Kottmeyer

Molly Kottmeyer
Legislative Liaison

MK/mw
Enclosure

cc: Governor Chet Culver
Legislative Service Agency
Kris Bell, Senate Majority Caucus
Peter Matthes, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

February 6, 2009

The Honorable Chester J. Culver
Governor
State Capitol
LOCAL

Dear Governor Culver:

Enclosed please find copies of reports to the General Assembly relative to the Department of Human Services Growth Mechanism For Child Welfare Services. This report was prepared pursuant to directive contained in SF2425/40/12.

> "The department shall develop options for providing a growth mechanism for reimbursement of the child and family services traditionally funded under this appropriation. The growth mechanism options may provide for a tie to allowable growth for school aid, an inflationary adjustment reflective of the cost increases for the services, or other reasonable proxy for the cost increases affecting such service providers."

The Department of Human Services worked with a committee that included child welfare providers that provide in-home services, out-of-home services, and the Coalition for Family and Children's Services in Iowa to review the options and discuss the contents of the report. In the report the options that appeared most viable are presented. These options are provided for the review of the legislature.

Please let me know if you have any questions.

Sincerely

Molly Kottmeyer

Molly Kottmeyer
Legislative Liaison

MK/mw
Enclosure

cc: Michael Marshall, Secretary Iowa Senate
Mark Brandsgard, Chief Clerk of the House

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Child Welfare Provider Growth Options Committee

Final Report – February 6, 2009

This report summarizes the work undertaken and results produced, by the Iowa Department of Human Services (DHS) in consultation with the Child Welfare Provider Growth Options Committee. The committee's purpose, membership, work process and options considered are outlined below.

Committee Purpose

The Iowa Department of Human Services (DHS) formed the Child Welfare Providers Growth Options Committee to gather input from providers, to respond to SF 2425, which required that:

"The department shall develop options for providing a growth mechanism for reimbursement of the child and family services traditionally funded under this appropriation. The growth mechanism options may provide for a tie to allowable growth for school aid, an inflationary adjustment reflective of the cost increases for the services, or other reasonable proxy for the cost increases affecting such service providers."

The purpose of the Provider Growth Options Committee is to report options for reimbursement that improve the quality and availability of provider services designed to achieve positive outcomes for children and families.

The importance of this study is that it directly addresses the need to achieve good outcomes for children, as measured by the federal Child and Family Service Review. To obtain these good results for children, private agency staff need to be both trained and experienced. The continuity of these competent professional relationships is essential to progress in treatment. Staff turnover has been an increasing problem in private agencies, which negatively impacts their ability to achieve positive outcomes for children.

Salary and benefit data trends over the past several years reveal that the private agency youth workers and social workers earn 65 - 70% of the salaries of their public-agency counterparts. Other supporting data shows

- Preliminary data shows that starting salaries for private agency care manager staff average $10,000 below starting salaries for public agency child welfare caseworker staff. (data DHS drawn from the Safety Plan/Family Safety Risk Permanency proposals)

From December 1998 to December 2007 the Consumer Price Index – Urban adjusted rate has outpaced the across the board rate increases for providers by 12.16%.

Among direct service staff in private FSRP agencies, voluntary turnover rates currently range from just under 20% to 47%. Turnover among supervisors is more variable, from lower than five percent in one agency to a high of 33% in another. Among the reasons that staff offer for leaving these

private agencies are: demanding work hours and work schedules; poor opportunities for advancement; and low salary and benefits.

- A 2005 study in Milwaukee Wisconsin, found that 74.5% of children that had only one worker achieved permanency within a 21 month period, compared to 17.5% that had 2 workers and only 5.2% for children that had 3 workers.

The Committee's work recognizes that this gap will continue to widen unless ongoing mechanisms to assure better retention of trained qualified and experienced staff are established. Also, the committee recognizes that there is currently no uniform way of collecting the actual costs involved in order to determine an equitable reimbursement system that will also favorably impact the federal Child Family Service Review targets that are charged to the Iowa Department of Human Services.

The committee's review covered all child welfare providers in the areas of: Group Care, Emergency Services/Shelter Care, Community Care, Family Safety Risk & Permanency, and Safety Plan.

Committee Membership

The committee was convened by the DHS, under the leadership of Mary Nelson, Administrator of the Division of Child and Family Services (CFS), additional committee participants included:

Iowa Department of Human Services
Jan Clausen, Administrator of the Division of Fiscal Management
Vern Armstrong, Administrator of Division of Field Operations Support
Evan Klenk, Manager of North Central Iowa Service Area
Margaret Wright, Chief for Bureau of Child Welfare, CFS Division

Child Welfare Providers
Mike Buck, Chief Financial Officer, Lutheran Services in Iowa
Anne Gruenewald, Chief Operations Officer, Four Oaks of Iowa, and Chief Executive Officer of Iowa KidsNet
Ann Harrmann, Associate Director, Coalition for Family and Children's Services in Iowa
Kathy Melby, Chief Financial Officer, Youth Homes of Mid-America

Committee Work Process

The work of this committee took place from September through November 2008, with the objective of providing a report to the Iowa Legislature. The group researched and considered several sources of information and different cost methodologies, including:

1) Current categories of cost documentation: independent audits, financial and statistical (cost) reports, and IRS tax documents (990) to determine increase in reimbursements
2) Allowable growth for school aid formula
3) Mental Health growth formula
4) Medicaid rebasing and cost adjustments, and other combinations of formulas
5) Past provider cost increase trends
6) Inflationary and COLA (Cost Of Living Adjustment) cost increase methodologies, including consumer price indices (CPI-U) and USDA cost of raising a child
7) Collective bargaining increases such as ATB (across the board)
8) Approaches used in other states

Committee deliberations about this information recognized that consideration should be given to avoid methodologies that would be too costly or time consuming to administer, that use data older than 18 to 24 months, or that are too difficult to compare and/or apply across provider agencies. The committee elected to consider the two most important issues in this report:

- Options to review the adequacy of current rates in terms of addressing provider costs and supporting positive outcomes
- Options to review provider rates from year to year to reflect changes in costs

Options Considered by the Committee

The committee discussed that options A and B could stand-alone or could also be considered in combination. For example one or more of the items from A could be used with one of the items from B for establishing a growth mechanism for child welfare providers.

Option A – Evaluate the Costs to Achieve Desired Outcomes

Using an independent firm to research markets, perform analyses, and provide recommendations:

- **Evaluate the Adequacy of the Current Rate Structure in Addressing Operating Costs and Relevant Market Data.**
  This would vary by type of provider (service only, residential, etc.), include current wages including benefits; competing employers may mean other employment sectors not just human services. Also includes cost of office space, equipment; and other related operating costs to deliver services. This could be done every 5 years.
- **Project Trend of Child Welfare Services.**
  Anticipate increase, decrease, or status of population using various services in-home Family Safety Risk & Permanency, Safety Services, out-of-home care foster care, kinship care, congregate care, shelter, etc.
- **Determine the Cost Based on Desired Outcomes.** Costs can include caseloads (ratio of staff to consumer), supervisor supports, equipment needs, training, mileage and travel time, how do we evaluate/audit outcomes, how are payment adjustments made if targets/requirements not met.

- Items to consider for the above option
  - Analysis of costs based on performance targets
  - Independent, reliable source providing inputs
  - Would look at trend analysis and results based practices
  - Labor intensive to do the analysis and can be costly to acquire consultants for an initial review and recommendation.
  - May be hard to determine if costs are correct
  - Trend analysis challenges for 5-year period (e.g. gas ranging from $4 to $1.50)

Option B – Mechanisms for Cost Growth

All of the following could be used for a legislative "built-in" for upcoming fiscal years. See the attached report with some of the mechanisms for cost growth applied over a 10-year period.

- **Use Appropriate Indices for Growth Mechanism**

  The Consumer Price Index - Urban, or similar economic index that can assure consistent and sustainable market growth. This would be a reliable, valid and applicable instrument.
  Items to consider:
  - This method is probably the most recognized, easiest to understand, reliable and consistent method.
  - No one particular CPI relates 100% to the various child welfare providers.
  - Doesn't address underlying issue of reaching a competitive rate to acquire, retain and develop staff.

- **Flat Percentage Rate Annually**

  Historically a flat percentage rate of 1-3% was determined by the legislature each session. Going forward this could be a fixed rate built-in each year.

  Items to consider:
  - Unless fixed rate is based on costs of acquiring and retaining qualified staff and the supports for them, the issue of adequate funding (too little or too much) could come into play.

- **Use School Aid Allowable Growth percentage**

  This method has already been passed by legislators and is a proxy to determine an increase in salaries and costs for child welfare providers serving a similar youth population.

  Items to consider:
  - Working with a formula that has been approved and in use.
  - No need to pay for additional surveying and analysis.
  - Instrument was not built with child welfare providers in mind.

Note: Even with a growth mechanism, the gap in starting salaries between the Department of Human Services and child welfare providers will continue to widen in the more than decades old lag in rates is not addressed. This would indicate elements of Option A and Option B would be utilized in a growth mechanism solution.

Appendices

- CPI-U Examples
- "Safety Plan & Family Safety Risk & Permanency (FSRP) Services" report from Myers & Stauffer
- "Iowa Medicaid - Basis of Reimbursement Medicaid" Chart from Myers and Staufer
- "Market Basket Definitions and General Information" from DHS Fiscal
- "Human Service Benefits and Provider Rate Calculations" from DHS Fiscal

The Consumer Price Index for all Urban Consumers is a measure of the average change in prices over time of goods and services purchased by households.
The CPIs are based on prices of food, clothing, shelter, and fuels, transportation fares, charges for doctors' and dentists', drugs and other goods and services that people buy for day-to-day living. All taxes directly associated with the purchase and use of items are included.
The CPI-U is considered final when released.

	CPI-U		ATB
Dec-98	1.60%	7/1/1999	0
Dec-99	2.70%	7/1/2000	5.00%
Dec-00	3.40%	7/1/2001	0
Dec-01	1.30%	7/1/2002	0
Dec-02	2.40%	7/1/2003	0
Dec-03	1.90%	7/1/2004	0
Dec-04	3.30%	7/1/2005	3.00%
Dec-05	3.40%	7/1/2006	3.00%
Dec-06	2.50%	7/1/2007	3.00%
Dec-07	4.10%	7/1/2008	1.00%
Dec-08		7/1/2009	
Dec-09		7/1/2010	

If we looked at the base difference between a sample rate increased by the CPI-U, compounded each year and the legislated ATB rate increases compounded as given, the difference is 14.09% over the 10-year period.

Starting Rate Example		CPI-U*	CPI-U Adjusted Rate		Legislated ATB	Actual Rate (1/1/98 negotiated)	Rate Difference
$100.00	Dec-98	1.60%	$101.60	7/1/1999	0	$100.00	($1.60)
$101.60	Dec-99	2.70%	$104.34	7/1/2000	5.00%	$105.00	$0.66
$104.34	Dec-00	3.40%	$107.89	7/1/2001	0	$105.00	($2.89)
$107.89	Dec-01	1.30%	$109.29	7/1/2002	0	$105.00	($4.29)
$109.29	Dec-02	2.40%	$111.92	7/1/2003	0	$105.00	($6.92)
$111.92	Dec-03	1.90%	$114.04	7/1/2004	0	$105.00	($9.04)
$114.04	Dec-04	3.30%	$117.81	7/1/2005	3.00%	$108.15	($9.66)
$117.81	Dec-05	3.40%	$121.81	7/1/2006	3.00%	$111.39	($10.42)
$121.81	Dec-06	2.50%	$124.86	7/1/2007	3.00%	$114.74	($10.12)
$124.86	Dec-07	4.10%	$129.98	7/1/2008	1.00%	$115.88	($14.09)
$129.98	Dec-08		$129.98	7/1/2009		$115.88	($14.09)
$129.98	Dec-09		$129.98	7/1/2010		$115.88	($14.09)

* Assumes a utilization factor of 100%

Under the RTSS cost reporting system, calculation of rates were as follows (see 441-185.106):

Aggregate, reasonable and necessary costs (185.105)
Less non fee-for-service revenues, and certain contributions for services provided to individuals
Divided by effective utilization (185.106(2)"a")*
Multiplied by the inflation factor (CPI-U, December 31 in preceding calender year)

* Effective utilization = 80% or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program, except for group care, which shall be as follows.
Effective utilization of residential = 90% or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program for the maintenance portion of the per diem
Effective utilization of residential = 85% or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program for the service portion of the per diem
When a provider fails to achieve a utilization rate of 70%, the subsequent rate shall be calculated on the basis of 100% of licensed or staffed capacity, whichever is less.

In each example below -- assumes the cost report justifies 100% of the rate as aggregate, reasonable and necessary costs each year:

Starting rate example	Effective Utilization		CPI-U	Adjusted rate	Difference
$100.00	80%	Dec-98	1.60%	$102.00	($2.00)
$102.00	80%	Dec-99	2.70%	$105.44	($0.44)
$105.44	80%	Dec-00	3.40%	$109.92	($4.92)
$109.92	80%	Dec-01	1.30%	$111.71	($6.71)
$111.71	80%	Dec-02	2.40%	$115.06	($10.06)
$115.06	80%	Dec-03	1.90%	$117.79	($12.79)
$117.79	80%	Dec-04	3.30%	$122.65	($14.50)
$122.65	80%	Dec-05	3.40%	$127.87	($16.47)
$127.87	80%	Dec-06	2.50%	$131.86	($17.13)
$131.86	80%	Dec-07	4.10%	$138.62	($22.74)
		Dec-08			
		Dec-09			

Starting rate example	Effective Utilization		CPI-U	Adjusted rate	Difference
$100.00	85%	Dec-98	1.60%	$101.88	($1.88)
$101.88	85%	Dec-99	2.70%	$105.12	($0.12)
$105.12	85%	Dec-00	3.40%	$109.32	($4.32)
$109.32	85%	Dec-01	1.30%	$111.00	($6.00)
$111.00	85%	Dec-02	2.40%	$114.13	($9.13)
$114.13	85%	Dec-03	1.90%	$116.68	($11.68)
$116.68	85%	Dec-04	3.30%	$121.21	($13.06)
$121.21	85%	Dec-05	3.40%	$126.06	($14.66)
$126.06	85%	Dec-06	2.50%	$129.77	($15.03)
$129.77	85%	Dec-07	4.10%	$136.03	($20.14)
		Dec-08			
		Dec-09			

Starting rate example	Effective Utilization		CPI-U	Adjusted rate	Difference
$100.00	90%	Dec-98	1.60%	$101.78	($1.78)
$101.78	90%	Dec-99	2.70%	$104.83	$0.17
$104.83	90%	Dec-00	3.40%	$108.79	($3.79)
$108.79	90%	Dec-01	1.30%	$110.36	($5.36)
$110.36	90%	Dec-02	2.40%	$113.31	($8.31)
$113.31	90%	Dec-03	1.90%	$115.70	($10.70)
$115.70	90%	Dec-04	3.30%	$119.94	($11.79)
$119.94	90%	Dec-05	3.40%	$124.47	($13.08)
$124.47	90%	Dec-06	2.50%	$127.93	($13.19)
$127.93	90%	Dec-07	4.10%	$133.76	($17.87)
		Dec-08			
		Dec-09			

Starting rate example	Effective Utilization		CPI-U	Adjusted rate	Difference
$100.00	100%	Dec-98	1.60%	$101.60	($1.60)
$101.60	100%	Dec-99	2.70%	$104.34	$0.66
$104.34	100%	Dec-00	3.40%	$107.89	($2.89)
$107.89	100%	Dec-01	1.30%	$109.29	($4.29)
$109.29	100%	Dec-02	2.40%	$111.92	($6.92)
$111.92	100%	Dec-03	1.90%	$114.04	($9.04)
$114.04	100%	Dec-04	3.30%	$117.81	($9.66)
$117.81	100%	Dec-05	3.40%	$121.81	($10.42)
$121.81	100%	Dec-06	2.50%	$124.86	($10.12)
$124.86	100%	Dec-07	4.10%	$129.98	($14.09)
		Dec-08			
		Dec-09			

The Consumer Price Index for all Urban Consumers is a measure of the average change in prices over time of goods and services purchased by households.
The CPIs are based on prices of food, clothing, shelter, and fuels, transportation fares, charges for doctors' and dentists', drugs and other goods and services that people buy for day-to-day living. All taxes directly associated with the purchase and use of items are included.
The CPI-U is considered final when released.

	CPI-U		ATB
Dec-98	1.60%	7/1/1999	0
Dec-99	2.70%	7/1/2000	5.00%
Dec-00	3.40%	7/1/2001	0
Dec-01	1.30%	7/1/2002	0
Dec-02	2.40%	7/1/2003	0
Dec-03	1.90%	7/1/2004	0
Dec-04	3.30%	7/1/2005	3.00%
Dec-05	3.40%	7/1/2006	3.00%
Dec-06	2.50%	7/1/2007	3.00%
Dec-07	4.10%	7/1/2008	1.00%
Dec-08		7/1/2009	
Dec-09		7/1/2010	

If we looked at the base difference between a sample rate increased by the CPI-U, compounded each year and the legislated ATB rate increases compounded as given, the difference is 14.09% over the 10-year period.

Starting Rate Example		CPI-U*	CPI-U Adjusted Rate		Legislated ATB	Actual Rate (1/1/98 negotiated)	Rate Difference
$100.00	Dec-98	1.60%	$101.60	7/1/1999	0	$100.00	($1.60)
$101.60	Dec-99	2.70%	$104.34	7/1/2000	5.00%	$105.00	$0.66
$104.34	Dec-00	3.40%	$107.89	7/1/2001	0	$105.00	($2.89)
$107.89	Dec-01	1.30%	$109.29	7/1/2002	0	$105.00	($4.29)
$109.29	Dec-02	2.40%	$111.92	7/1/2003	0	$105.00	($6.92)
$111.92	Dec-03	1.90%	$114.04	7/1/2004	0	$105.00	($9.04)
$114.04	Dec-04	3.30%	$117.81	7/1/2005	3.00%	$108.15	($9.66)
$117.81	Dec-05	3.40%	$121.81	7/1/2006	3.00%	$111.39	($10.42)
$121.81	Dec-06	2.50%	$124.86	7/1/2007	3.00%	$114.74	($10.12)
$124.86	Dec-07	4.10%	$129.98	7/1/2008	1.00%	$115.88	($14.09)
$129.98	Dec-08		$129.98	7/1/2009		$115.88	($14.09)
$129.98	Dec-09		$129.98	7/1/2010		$115.88	($14.09)

* Assumes a utilization factor of 100%

Safety Plan Services and Family Safety, Risk, and Permanency (FSRP) Services

Evaluating the Adequacy of the Current Rate Structure

1. Perform an analysis of actual cost to current rates and relevant market data
   - Barrier – cost and statistical information is currently not reported
   - Solution – implement a cost data collection tool to obtain necessary data
     - Develop a new cost data collection tool to be used by providers to report the cost of FSRP services. A data collection tool should take into consideration the following criteria:
       - Account for all costs, regardless of funding source, incurred by providers, and line item expense.
       - Identify costs so that each of the service programs can be adequately reviewed.
       - Itemize expenditures so that non-allowable costs are easily excluded.
       - Use the Office of Management and Budget (OMB) Circular A-87, Attachment B to identify allowable cost.
       - Be in electronic format for ease of reporting and analysis.
     - Utilize the current Remedial Services cost report by including the costs for these services in a separate column instead of reporting in "Other Programs".

2. Perform an analysis of current rates to relevant market data
   - Collect general wage level data
   - Cost differences driven by metropolitan vs. rural service provisions
   - Unemployment level
   - Type and costs of benefits provided by competing employers
   - Gasoline costs
   - Insurance costs
   - Credentialing requirements

Determining What the Service Should Cost Based on Desired Outcomes

1. Develop list of desired outcomes
2. Develop cost model taking into consideration the desired outcomes
   - Identify cost components of the model
   - Cost out each component using staff level requirements and relevant market data

Rate Methodology Options

1. Statewide fee schedule
2. Provider specific cost-based rate
   - Rebasing options
     - Annual rebase of provider cost data
     - Base year provider cost data with growth factor applied during non-rebase years
     - Annual rebase of provider cost data with increase in actual cost limited by a growth factor
   - Cost containment options
     - None – rate is 100% of cost
     - Rate cap – various ways to develop rate cap such as using actual cost or cap developed using cost model
3. Cost Model Rate

Mechanisms for Recognizing Cost Growth

1. Recognize actual cost growth
2. Recognized price index such as the Consumer Price Index published by the Bureau of Labor and Statistics

IOWA MEDICAID – BASIS OF REIMBURSEMENT

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Inpatient				
Inpatient Hospital (General Hospital)	Prospective reimbursement system for inpatient hospital services based on diagnosis-related groups (DRGs), physical rehabilitation and psychiatric units are paid on a per diem basis.	Inpatient rates effective 07/01/08 range from $3,517.53 to $4,776.41 with an average statewide rate of $3,808.41.	Rebase and recalibration of rates and weights will occur in SFY 2009. During the 2005 rebase it was noted that a higher than expected percentage of payments were being paid through outlier payments. Alternative methodologies will be recommended during the evaluation of MS-DRG in SFY 2010. Recommend basing DRG weights on costs vs. charges. More frequent updates to weights.	CMS implemented an expanded set of DRGs (MS-DRGs) to pay inpatient hospitals based on severity of patients. The DRG reform bases DRG weights on costs, rather than charges. Proposed cost limits on government units if implemented by CMS should have no impact on Medicaid. Proposed GME rule carving out all federal matching funds on Medicaid payments to teaching hospitals for direct medical education could have a significant impact on overall State budget since Medicaid funding to UIHC would be reduced by approximately $6.5M.
Critical Access Hospital	Cost-based w/ cost settlement (in-state and out-of-state). Inpatient interim payments are based on DRG methodology. Swing bed payments are based on a per-diem rate.	CAH inpatient base rates range from $2,401.13 to $15,501.80 with an average rate of $5,852.80. Swing bed base rates range from $126.83 to $2,816.07 with an average rate of $1,085.48.	No recommended policy changes.	
Psychiatric Medical Institution for Children (PMIC)	Cost-based per diem rate to a maximum established by the Iowa Legislature.	In-State PMIC rates as of 7/1/08 range from $152.88 to $167.19 with $167.19 being the capped rate effective 07/01/08Out-of-state PMIC rates range from $186.13 to $710.00 with an average rate of $381.56. Any provider with a rate over the legislative cap has an exception to policy.	No recommended policy changes.	

IOWA MEDICAID – BASIS OF REIMBURSEMENT

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Acute Care Psychiatric Hospital (State Mental Health Institution)	Cost-based w/ cost settlement. Interim payment is based on a per diem rate.	Clarinda = $627.26; Mt. Pleasant = $654.51; Independence = $628.11 Cherokee = $638.86	Continue to pay 100% of cost. No recommended policy changes.	
Rehabilitation Hospital	Per diem rate		No recommended policy changes.	
Outpatient				
Outpatient Hospital (General Hospital; Both in-state and out-of-state)	Prospective reimbursement system for outpatient hospital services based on Ambulatory Payment Classification (APC).	APC was implemented on 10/01/08. Outpatient hospital APC rates effective 10/01/08 range from $47.60 to $80.13 with an average statewide rate of $62.86.	Rebase of APC base rates will be effective 1/1/09 and every three years thereafter. APC weights will be updated 1/1/09 and annually thereafter based on Medicare weights.	Proposed cost limits on government units if implemented by CMS should have not impact on Medicaid. CMS is proposing additional outpatient payments related to the reporting of quality measures.
Critical Access Hospital	Cost-based w/ cost settlement (in-state and out-of-state). Outpatient interim payments are based on a percentage of charge methodology.	Outpatient cost-to-charge ratios range from .36 to 1.21 with a statewide average of 0.61.		
Laboratory Only	Fee schedule			
Non-inpatient Programs (NIPS)	Fee schedule			
Nursing Facilities				
Skilled Nursing Facility (SNF)	Modified price-based case-mix adjusted per diem For reimbursement purposes a SNF is a hospital-based nursing facility that is Medicare-certified and provides only skilled level of care and swing-bed hospitals unless stated otherwise	Modified price-based case-mix adjusted per diem is updated on a calendar quarter basis to adjust rate for most current acuity. Per diem medians and rates are update every two years with more current cost data. The next rebase will occur on 7/1/09. 10 facilities are classified as SNF. 7-1-08 Average Rate $468.31 7-1-08 Min Rate $399.26 7-1-08 Max Rate $544.84	Rebase was effective 7/1/07. Per IAC rules, there would be no changes/funding required in SFY 2009. The rate system is set up as a two-year cycle with only quarterly acuity adjustments during the two-year cycle. The rebase effective 7/1/07 was not fully funded. SF 2425 appropriated additional funding to fully fund the rebase plus an additional 1%.	Proposed cost limits on government units if implemented by CMS should have not impact on Medicaid. Medicare implemented an expanded version of the 44 RUG group effective January 1, 2006. The new 53 Grouper includes 9 new RUG classifications. These new classifications are a result of combining Extensive Services classifications with Rehabilitative classifications.

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
		Direct Care Component is capped at 120% of the case-mix adjusted median or $112.21 effective 7/1/08. Non-Direct Care Component is capped at 110% of the median or $268.60 effective 7/1/08.		
Specialty Skilled Nursing Facility (Specialty SNF)	Cost-based per diem without case-mix factor; with no cap for State-owned facilities or facilities certified before July 1, 1993	The current rate for: Iowa Veterans Home: 09/01/08 = $285.91 Childserve Habilitation Center: 07/01/07 = $513.66 On with Life at Glenwood: 08/01/07 = $299.54 On with Life at Ankeny: 09/01/07 = $647.61	No recommended policy changes.	
Nursing Facility (NF)	Modified price-based case-mix adjusted per diem	Modified price-based case-mix adjusted per diem is updated on a calendar quarter basis to adjust rate for most current acuity. Per diem medians and rates are updated every two years with more current cost data. Additional payment for Accountability Measures is paid at the end of the fiscal year. 425 facilities are classified as NF. 7-1-08 Average Rate $120.83 7-1-08 Min Rate $85.85 7-1-08 Max Rate $179.36 Direct Care Component is capped at 120% of the case-mix adjusted median or $55.38 effective 7/1/08.	Rebase was effective 7/1/07. Per IAC rules, there would be no changes/funding required in SFY 2009. The rate system is set up as a two-year cycle with only quarterly acuity adjustments during the two-year cycle. The rebase effective 7/1/07 was not fully funded. SF 2425 appropriated additional funding to fully fund the rebase plus an additional 1%. SF 2425 also reduced the amount of the accountability measure by 20% and holds all payments until the end of the fiscal year. In addition, the	Proposed cost limits on government units if implemented by CMS should have not impact on Medicaid. Medicare implemented an expanded version of the 44 RUG group effective January 1, 2006. The new 53 Grouper includes 9 new RUG classifications. These new classifications are a result of combining Extensive Services classifications with Rehabilitative classifications.

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
		Non-Direct Care Component is capped at 110% of the median or $69.49 effective 7/1/08.	accountability measure will be evaluated at the end of the year for each facility based on certification findings, allowing for further reductions up to a forfeiture of the add-on if G or H level deficiencies are found. Any accountability measure add-on will be done as a retroactive adjustment from the period 7-1-08 through 6-30-09 after the end of the SFY. Legislation was passed to create a work group to discuss changes to the Accountability Measure add-on system.	
Nursing Facility for the Mentally Ill (NF-MI) and Specialty Nursing Facility for the Mentally Ill (Specialty NF-MI)	Cost-based per diem without case-mix factor; with no cap for State-owned facilities or facilities certified before July 1, 1993	Davis Acres receives a modified price-based case-mix adjusted rate currently at 07/01/08 of $140.20. They also receive a NFMI rate effective 7/01/08 of $217.12 that can be used when the individual counties pay the difference between the two rates. Clarinda Mental Health Institute has a rate effective 9/1/07 of $422.69	No recommended policy changes.	
ICF/MR	Per diem rate, capped at 80th percentile, except for State Resource Centers (Woodward and Glenwood)	Providers are reimbursed at their per diem rate capped at the 80th percentile plus an add-on for a per diem amount of a 5.5% assessment of their total revenue (assessment add-on is not subject to the 80th percentile limit): 80th Percentile Cap in effect at 7-1-08 prior to assessment add-on is $307.59	HF 841 requires development of an acuity-based per diem reimbursement methodology.	

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
		After assessment add-on rate data: Average Rate $309.95 Min Rate $210.56 Max Rate $326.04 Woodward Current Rate - $665.68 Glenwood Current Rate - $689.46		
Other Institutional Reimbursements				
Home Health Agency	Currently cost-based, not to exceed established maximums, with cost settlement. Interim payment is based on a percent of charges.	Home Health rates range as follows: Skilled Nrsg $32.1 - $232.65 Aide - $19.46 - $99.15 PT - $30.15 - $332.17 OT - $30.15 - $332.17 ST - $9.72 – $413.4 MSW - $68.90 - $564.40	Implementing fee schedule	
Family Planning Clinic	Fee schedule			
Rural Health Clinic (RHC)	Cost-based w/cost settlement Interim payment is based on an "all-inclusive" visit rate. HMO wraparound payments can be made based on HMO utilization and payment information submitted by the provider. Wraparound payments are subject to cost-settlement.	RHCs are settled using the greater of cost per visit or BIPA rate. RHC rates have an average cost per visit of $117.00.	No recommended policy changes.	
Federally Qualified Health Center (FQHC)	Cost-based w/cost settlement Interim payment is based on an "all-inclusive" visit rate. HMO wraparound payments can be made based on HMO utilization and payment information submitted by the provider. Wraparound payments	FQHCs are settled using the greater of cost per visit or BIPA rate. FQHC rates have an average cost per visit of $146.51.	No recommended policy changes.	

INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
	are subject to cost-settlement.			
Partial Hospitalization	APC or fee schedule		Iowa Medicaid implemented an APC-based payment system in October 1, 2008.	
Rehabilitation Agency	Medicare fee schedule		Currently the Medicaid fee schedule has a different Medicare fee schedule base year than the physician fee schedule. Recommend implementing changes to pay consistently between rehab agencies and physicians.	Medicare does not recognize a separate fee schedule for rehab agencies. The fee schedule is the same as the physician fee schedule.
Residential Care Facility	Cost-based with legislative cap	Rate Data Before Application of Legislative Cap of $26.95: Average Rate $54.38 Min Rate $19.52 Max Rate $174.99 Rate Date After Application Legislative Cap of $26.95: Average Rate $26.65 Min Rate $19.52 Max Rate $26.95 21 of 163 (12.88%) providers receive reimbursement at a rate under the legislative cap of $26.95		

NON-INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Practitioners				
Physician (Doctor of Medicine or Osteopathy)	Fee schedule (RBRVS) The current Medicaid fee schedule is based on RBRVS based on the fact that Medicare fee schedule (RBRVS) effective 2000/2001 was the basis of the Medicaid fee schedule.	Drugs fees are determined at AWP less 10%.	Medicare has implemented changes to the relative value units since Iowa fee schedule was implemented. Therefore the current Medicaid fee schedule does not recognize the relational changes within the various procedure codes. We recommend evaluating the effect, both clinically and financially, of not recognizing the changes in RVU. This is not a recommendation to pay 100% of the Medicare fee schedule but current RVUs could be implemented within the funding amount appropriated. Medicare fee schedule recognizes different RVUs for facility-based physicians and non-facility based physicians. The current Medicaid fee schedule does not recognize this difference. Based on initial review it does appear that hospitals could be overpaid. We recommend this be evaluated.	CMS updated the physician payment rates under the physician fee schedule for calendar year 2007. A 5% decrease was initially proposed due to changes in Sustainable Growth Factor as mandated in DRA 2005. However, the "Tax Relief and Health Care Act of 2006" eliminated the 5% physician fee cut that was schedule to go into effect 1/1/07. CMS then proposed a 10.1 percent decrease in payments to physicians that was to go into effect on January 1, 2008. Congress on December 19, 2007 passed legislation that stopped the 10.1% decrease. The "Medicare, Medicaid and SCHIP Extenders Act of 2007" replaced the 10.1% percent cut to the Medicare physician reimbursement rate in 2008 with a .5 percent increase through June 30, 2008. On July 15, 2008, Congress overrode President Bush's veto of legislation to block the physician pay cut. The "Medicare Improvements for Patients and Providers Act of 2008" removed the 10.6 percent physician cut and increased the rates by 1.1 percent to go into effect January 1, 2009.
Dentist	Fee schedule			

NON-INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Chiropractor	Fee schedule (RBRVS)		See comment for physician.	See comment for physician.
Physical Therapist	Fee schedule (RBRVS)		See comment for physician.	See comment for physician.
Audiologist	Fee schedule (RBRVS) for professional services, plus product acquisition cost and dispensing fee		See comment for physician.	See comment for physician.
Psychiatrist	Fee schedule (RBRVS, to the extent rendered/billed by psychiatrist or psychologist and then only for CPT coded services)		See comment for physician.	See comment for physician.
Podiatrist	Fee schedule (RBRVS)		See comment for physician.	See comment for physician.
Psychologist	Fee schedule (RBRVS)		See comment for physician.	See comment for physician.
CRNA	Fee schedule (RBRVS)		See comment for physician.	See comment for physician.
Nurse Practitioner	Fee schedule (RBRVS)	Paid at 85% of the Physician Fee Schedule Amount	See comment for physician.	See comment for physician.
Certified Nurse-midwife	Fee schedule (RBRVS)	Paid at 85% of the Physician Fee Schedule Amount	See comment for physician.	See comment for physician.
Patient Manager (Primary Care Physician)	Capitated administrative fee			
Optician	Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost.		See comment for physician.	See comment for physician.
Optometrist	Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost		See comment for physician.	See comment for physician.
Clinical Social Worker	Medicare deductibles / coinsurance			
Services / Supplies				
Hospice	Medicare-based prospective rates, based on level of care provided	Rates established by CMS. Statewide rates with geographic wage adjustments.		
Clinics	Fee schedule			
Ambulance Service	Fee schedule (Cost-based for critical access hospital-based ambulance)			

NON-INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Independent Laboratory	Fee schedule		Medicaid fee schedule is based on the Medicare Independent Lab fee schedule. Rule and statute provides automatic updates at the time Medicare fee schedule is updated. It is anticipated that there would be updates during SFY 2009 with an effective date of 1/1/09.	
X-Ray	Fee schedule (paid under either a Physician or Clinic billing)			
Pharmacy / Drugs	Lower of: AWP minus 12%, usual and customary, or the MAC price (state or federal), plus dispensing fee			
Lead Investigations	Fee schedule			
Hearing Aid Dealer	Fee schedule for professional services, plus product acquisition cost and dispensing fee			
Orthopedic Shoe Dealer	Fee schedule			
Medical Equipment and Prosthetic Devices Provider	Fee schedule			
Supplies	Fee schedule			
Other Agency / Organization Reimbursements				
Ambulatory Surgical Center	Fee schedule	The ASC fee schedule divides procedures into nine payment groups based on similar cost. For the non-facility fee the physician would bill separately.		
Birthing Center	Fee schedule			
Community Mental Health Center	100% Medicaid Cost with Retrospective Cost Settlement			

NON-INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
EPSDT Screening Center	Fee schedule			Cost limits on government units if implemented by CMS will impact this program. Federal administration plans to issue Medicaid regulations aimed at curbing reimbursement for some school-based services particularly transportation costs for low-income students with disabilities.
Maternal Health Center	Fee schedule			
Area Education Agency	Fee schedule		Medicaid is in the process of implementing a reimbursement methodology based on 100% of Medicaid cost with a retrospective cost settlement.	Cost limits on government units if implemented by CMS will impact this program. Federal administration plans to issue Medicaid regulations aimed at curbing reimbursement for some school-based services particularly transportation costs for low-income students with disabilities. This is under federal moratorium until April 1, 2009.
Local Education Agency	Fee schedule		Medicaid is in the process of implementing a reimbursement methodology based on 100% of Medicaid cost with a retrospective cost settlement.	Cost limits on government units if implemented by CMS will impact this program. Federal administration plans to issue Medicaid regulations aimed at curbing reimbursement for some school-based services particularly transportation costs for low-income students with disabilities. This is under federal moratorium until April 1, 2009.

IOWA MEDICAID – BASIS OF REIMBURSEMENT

NON-INSTITUTIONAL	BASIS OF REIMBURSEMENT	RATE/COST STATISTICS	PROPOSED/CURRENT MEDICAID INITIATIVES	CURRENT FEDERAL INITIATIVES
Targeted Case Management	Cost-based w/cost settlement	Interim rates are paid per unit. One unit equals one month. FY07 Actual Average Rates: W0574/W0578/W1330/W1409 - $232.85 W0579 - $259.67 W0580 - $400.93	Medicaid is in the process of implementing an interim payment methodology based on 15-minute increments to become effective 7/1/09.	President's FY 2008 budget includes proposal to reduce federal Medicaid reimbursement for TCM services to a standard 50% rather than a higher matching rate for most states.
Health Maintenance Organization	Predetermined capitation rate			
Managed Mental Health and Substance Abuse	Predetermined capitation rate			
HCBS Waiver Service Provider	Negotiated rates Retrospectively limited prospective rates and fee schedules	Negotiated and retrospectively limited prospective rates can vary significantly.		
Adult Rehabilitation Option	Cost-based with cost settlement (100% of non-federal share paid by Counties, except for State cases for whom the State pays non-federal share)		New authorizations for ARO services are prohibited after 12/31/06 with all services ending no later than 6/30/07.	
Remedial Services Program	Cost-based with cost settlement. Rates are capped at 110% of the statewide average.	Cost settled rates can vary significantly. The first maximum rates will be effective for cost report periods ending in 2009 and will be revised annually on July 1st.		
Habilitation Services Waiver	Waiver under the State Plan. Services will be reimbursed using Cost-based methodology with fiscal year end cost settlement at 100% cost not to exceed the established limits.	Cost settled rates can vary significantly.		

Market Basket Definitions and General Information

Source: http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf

What is a Market Basket (MB)?

The market basket is described as a fixed-weight index because it answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period. As such, it measures "pure" price changes only. A market basket is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for mutually exclusive and exhaustive spending categories based upon type of expenditure. Then the proportion for total costs that each spending category represents is determined. These proportions are called cost or expenditure weights. The second step is to match each expenditure category to an appropriate price/wage variable, called a price proxy. In the third and final step, the price level for each spending category price proxy is multiplied by the expenditure weight for that category. The sum of these products (that is, weights multiplied by proxied index levels) for all cost categories yields the composite index level in the market basket in a given year.

What are market baskets used for?

The CMS market baskets are used to update payments and cost limits in the various CMS payment systems. The CMS market baskets reflect input price inflation facing providers in the provision of medical services.

Who is responsible for producing the market baskets?

The Office of the Actuary (OACT), within the Centers for Medicare and Medicaid Services (CMS), is responsible for producing the CMS market baskets. CMS determines the weights and proxies and a respected economic forecasting firm under contract to CMS (Global Insight, Inc.), forecasts the price levels for the individual proxies. The market basket levels and percent changes are released quarterly, with each new forecast containing an additional quarter's historical data.

Is there a Medicare market basket?

No, CMS does not produce a "Medicare" market basket. Individual market baskets are produced for many of the payment systems (inpatient hospital PPS, skilled nursing facility PPS, home health agency PPS, long-term care hospital PPS, inpatient rehabilitation hospital PPS, and physicians fee schedule) to accurately measure the price changes facing each of these providers.

How is a 4-quarter moving average percent change calculated?

The easiest way to illustrate how a 4-quarter moving average percent change is calculated is to use an example.

98Q4 99Q1 99Q2 99Q3 99Q4 00Q1 00Q2 00Q3

Sample MB Levels--1.010 1.015 1.022 1.031 1.039 1.048 1.056 1.062

For this example we are calculating the 4-quarter moving average percent change for the period ending 2000Q3 which represents the FY2000 increase.

Step One - Calculate the 4-quarter average of the levels

- Average for 4-qrtrs ending in 2000Q3: (1.062 + 1.056 + 1.048 + 1.039) / 4 = 1.051
- Average for 4-qrtrs ending in 1999Q3: (1.031 + 1.022 + 1.015 + 1.010) / 4 = 1.020

Step Two - Calculate the percent change between 2000Q3 and 1999Q3 4-quarter average index levels

The percent change between 2000Q3 and 1999Q3: ((1.051 / 1.020)) * 100) - 100) = 3.1%. This would be the 4-quarter moving average percent change for the sample market basket for the period ending 2000Q3. A similar calculation can be made for every quarter.

How are the forecasts developed and how often are they updated?

The market basket forecasts are developed on a quarterly basis by Global Insight Inc. under contract to CMS. Therefore, updates to the market baskets are available on a quarterly basis (lagged one quarter) with historical data also being updated at this time. Global Insight Inc. is a respected economic forecasting firm with the detailed macroeconomic and industry knowledge and expertise needed to forecast the price series used in the market baskets. The forecasts are available for a 10-year period.

What is the difference between the current market basket and the market basket used to update payments?

The payment updates for many of the prospective payment systems are determined using a forecasted market basket containing the latest available data at the time the final regulation is published. Once this update has been determined, it is generally not revised for more currently available data. However, because market basket data are updated quarterly, the current market basket may be different depending on the differences in forecasted data and data currently available.

What is market basket forecast error?

Because many of the current Medicare payment systems update payments on a prospective basis, the market basket increases used in those updates are a forecast of what those increases will be. The actual market basket increase for a given period can be higher or lower than the forecasted increase available at the time a payment update is determined. This phenomenon is commonly known as forecast error. For example, in June 2003 we were required to forecast the market basket increase for fiscal year 2004. The actual change in the market basket for FY2004 may be higher or lower than what we forecasted in June 2003 depending on market conditions. Our experience with hospital PPS updates suggests that these forecast errors are relatively small and are generally random around zero. Currently, only the hospital capital PPS and SNF PPS updates contain a MB forecast error correction.

How are quantity and intensity effects held constant in the market baskets?

A market basket measures the pure price change of inputs used by a provider in supplying healthcare services by using price data from the Bureau of Labor Statistics. There are two major components of the market basket: cost weights and price proxies. Cost weights measure the mix (intensity), quantity and prices of inputs used by a provider while the price proxies measure only the price change of the category being measured. Only the price proxies are updated quarterly; the cost weights are held constant, thereby holding quantity and intensity effects constant. In addition, we use price data from BLS for the majority of our price proxies (most notably PPI, CPI, ECI data) and these indexes too are

typically Laspyeres indexes and only measure the "pure" price change of the specific commodities they price. Hence, they do not bring quantity and intensity effects into the market basket this way. Therefore, a market basket only measures what it would cost in a later period to purchase the **same product** and the **same mix** of products purchased in the base period.

How are malpractice premiums measured for physicians?

Each year, CMS solicits professional liability premium data for physicians from a small sample of commercial carriers for use in the MEI. This information is not collected through a survey form, but instead is requested from a few national commercial carriers via letter. Generally between 5 and 8 carriers provide information on a voluntary basis. Our current methodology for reflecting malpractice price changes in the MEI collects premium data for a fixed level of coverage ($1 million per occurrence/$3 million per annual) for every specialty (risk class) in each state. Data is aggregated to a national level based on counts of physicians by specialty in each state (AMA data). The change in these levels from year to year represents the percent change in the category for a given year.

How often are the market baskets rebased?

Rebasing a market basket is mainly dependent upon data availability. Typically, a market basket is rebased every five years to coincide with the update of many secondary data sources, such as the Business Expenditure Survey from the Bureau of the Census and the input-output table data from Bureau of Economic Analysis. We continually monitor the cost weights in the market baskets to ensure they are reflecting the mix of inputs used in providing services. We will update the weights more frequently than every five years if we believe they do not meet this standard.

What sources of data are used for the market basket weights and price proxies?

The primary source of data used in constructing market basket weights is the Medicare Cost Reports. These data are supplied directly to CMS from providers and are the most current and complete data available for use in developing the weights. In all CMS market baskets (excluding the MEI), the Medicare Cost Reports are used to construct the weights of the major cost categories. Other data sources, such as the Bureau of the Census' Business Expenditure Survey and the Bureau of Economic Analysis' Benchmark Input-Output tables, are used as secondary sources to derive weights for detailed categories.

The primary data source for price proxies is Bureau of Labor Statistics data and includes Producer Price Indexes, Consumer Price Indexes, and Employment Cost Indexes. Producer Price Indexes (PPIs) measure changes in the prices producers receive for their output. PPIs are the preferable price proxies for goods and services that facilities purchase as inputs since these facilities generally make purchases in the wholesale market. Consumer Price Indexes (CPIs) measure changes in the prices of final goods and services purchased by the typical consumer. We use CPIs only if an appropriate PPI is not available, or if the expenditure more closely resembles a retail rather than wholesale purchase. Finally, Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. They are fixed weight indexes that only measure changes in wages and benefits per hour and are not affected by changes in occupational mix, making them an appropriate measure for our purposes. In addition, these data are well-established publicly available series that are published on a regular schedule, are available on a timely basis and reflect an appropriate level of detail necessary for use in our market baskets. These data also measure price changes only and do not reflect quantity or other non-price factor changes.

Why does the PPS hospital market basket use 1997 data for cost weights?

FY 1997 was selected as the base year for the current hospital market basket because it is the most recent year for which relatively complete data are available from all data sources. Medicare Cost Report data are supplied directly by hospitals. The independent secondary sources such as the Business Expenditure Survey from the Bureau of the Census and Benchmark input-output table data from the Bureau of Economic Analysis, also have 1997 as the latest data available and are used to fill in where cost report data were not available or appear to be incomplete. In addition, as the market basket was developed, the major cost category weights determined using the FY 1997 cost reports were re-created using FY 1998 and FY 1999 cost reports. These weights were found to be similar to those from the FY 1997 cost reports. Thus, 1997 data are the most recent and complete data available.

Are there separate market baskets for inpatient and outpatient hospital PPS?

No, there are not currently separate market baskets for inpatient and outpatient hospital PPS. While the Office of the Actuary has researched the feasibility of creating separate market baskets, we have not done so at this time because we have not been able to separate the cost categories developed from the Medicare Cost Reports separately into inpatient and outpatient services. There is also no secondary data source available to develop detailed weights for inpatient and outpatient services.

Why are there not separate market baskets for the various types of hospitals excluded from the inpatient hospital prospective payment system?

In 2002, OACT researched the feasibility of developing separate market baskets for the various types of PPS excluded hospitals, including inpatient rehabilitation facilities and long-term care facilities. This research included analyzing data sources for cost category weights, specifically the Medicare Cost Reports, and investigating other data sources on cost, expenditure, and price information specific to the individual market baskets. Our analysis indicated that the distribution of costs among major cost report categories for the individual market baskets is not substantially different from the 1997-based excluded hospital with capital market basket. We believe the 1997-based excluded hospital with capital market basket (which is currently used to update payments for rehabilitation and long-term care PPS) is an appropriate measure for reflecting the price changes of the different types of facilities.

Human Service Benefits and Provider Rate Calculations

The human service programs below are those with a growth mechanism for either client benefits or service rates. Some increases are mandatory, while others are discretionary. In either case, funding for the growth is not automatic and is only available through the annual appropriation process. Following is detail regarding the factors that impact benefit and rate calculations.

Medicaid & SCHIP Medicaid Expansion

CMS uses multiple market baskets to update payments and cost limits in the various CMS payment systems. The CMS market baskets reflect input price inflation facing providers in the provision of medical services. Following are several quarterly* index levels:

- Prospective Payment System (PPS) Hospital Market Basket (base year 2002) - updates inpatient hospital operating and outpatient PPS payments; updates cost limits for children's hospitals, cancer hospitals, and religious non-medical health care institutions
- Skilled Nursing Facility Market Basket (base year 2004) - updates skilled nursing facility PPS payments
- Home Health Agency Market Basket (base year 2003) - updates home health PPS payments
- PPS Hospital Capital Market Basket - updates inpatient hospital capital PPS payments (base year 2002
- RPL Market Basket (base year 2002) - updates inpatient rehabilitation PPS payments
- Medicare Economic Index (base year 2000) - used in conjunction with the Sustainable Growth Rate to update the physician fee schedule

*Reflects the GII 2008Q2 forecast with historical data through 2008Q1.
http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasketData.asp

Medicaid programs and services are varied and complex and, as stated previously, do not rely on a single index or market basket. While CMS sets provider payment upper limits, provider rate increases are not automatic and are contingent on state legislative and administrative approval. Following are specific factors taken into account in calculating Medicaid rate increases:

Hospital

- Rate re-basing is completed every three years; however, this re-basing must be budget neutral unless funding is provided by the Legislature.
- No inflationary factors are applied in the non-rebasing years unless legislatively approved.

Nursing Facility

- Rate re-basing is completed every two years; however, any resulting increases are capped by the legislatively mandated nursing facility budget.
- In the off year, acuity adjustments are made to the bed day rates, but no inflationary factors are applied unless legislatively approved.

ICF/MR -- ICF/MRs are paid the **lowest** of the following:

- Base Year Cost (base year occurs every 4 years) inflated annually by the CPI
- Actual Cost Report - ICF/MRs submit cost reports annually
- Cost-based reimbursement up to the 80th percentile. Costs for all ICF/MRs are ranked and then the 80th percentile is determined.

Cost-Based Providers

- Certain providers are reimbursed based on 100% of their actual costs. As a result, they would not be subject to fee-for-service increases or rate-rebasing.
- These providers include: Community Mental Health Centers, Critical Access Hospitals, Federally Qualified Health Centers, MR/CMI/DD Case Management Providers, and Rural Health Clinics.

Foster Family and Adoption Subsidy

Maintenance payments for children in the foster care or adoption subsidy programs are based on 65% of the USDA's estimated expenditures on a child by husband and wife (i.e., two-parent) families for the most recent prior calendar year for which information has been published. USDA's *costs to raise a child* are based on the 1990-92 Consumer Expenditure Survey data updated to current-year dollars using the Consumer Price Index.

The information is found in a report published annually by the Center for Nutrition Policy and Promotion titled Expenditures on Children by Families, (CY date). For example, the FY2010 budget is based on the CY 2007 report, which was published in March 2008. The report contains data by age group for several income ranges. The information is also broken out into a number of cost categories (housing, food, transportation, clothing, health care, child care and education, miscellaneous) for each age group within each income range. Iowa DHS use the average of the cost estimates for the urban Midwest and for rural areas based on the mid-range before-tax income estimate (which differs by geographical area). The estimate for health care costs and 50% of the estimates for child care and education costs are excluded because these are funded by other programs. This is not a federal mandate so the Iowa legislature may choose to notwithstand the Iowa Code.

State Supplementary Assistance (SSA)

Social Security Administration cost of living adjustment (COLA) increases impact two components of the State Supplementary Assistance program, Residential Care Facility and Dependent Person participants. The COLA adjustments are calculated using CPI indexes.

Child Care Assistance

States are required by the Federal Child Care and Development Fund (CCDF) Final Rule to ensure that families receiving child care assistance have equal access to comparable care purchased by private-paying parents. A market rate survey (MRS) is a federally approved tool that States use to achieve this program objective. DHS completes a market rate survey on a bi-

annual basis in even-numbered years and provides the range of private reimbursement rates for each type of care and type of provider. The maximum rates are then determined based on the selected percentile level. The maximum rates apply to licensed centers and registered child development homes and have historically been set at the 75th percentile. However, rate adjustments are not automatic. The Iowa Legislature appropriates the state funding and has wide discretion about which year's market rate survey and what percentile will be used to set rates.

Currently, Iowa uses the 75th percentile of the 2004 Market Rate Survey for licensed/registered child care providers. The rates for unregistered child care providers have been frozen at the 75th percentile of the 1998 Market Rate Survey as an incentive to become registered.

Food Assistance

Each Federal fiscal year, USDA adjusts the food assistance eligibility income requirements and monthly benefit amounts. The annual adjustments are based on the costs of the *Thrifty Food Plan*, a fundamental part of the U.S. food guidance system, and other statistical data as analyzed and calculated in the month of June. The adjustments take effect on October 1st of each year.