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iahsa
an association of non-profit senior services

IAHSA Facts

IAHSA represents **148** non-profit, providers of housing and health services for elderly and disabled residents across Iowa. The association is committed to helping its members provide quality healthcare, housing and services efficiently and effectively to benefit the individuals and families services.

IAHSA members care for over 13,000 residents in facility-based settings, representing:

- 5,549 licensed skilled nursing facility beds
- 1,690 certified assisted living programs
- 885 residential care facility beds
- 41 Continuing Care Retirement Communities (CCRCs)
- Over 5,208 independent housing units, some of which may be subsidized by government or the community sponsor

IAHSA members serve:

- Over 300 seniors annually in adult day programs
- Over 3,500 seniors annually in other home and community based services

IAHSA members employ over 8,000 persons and involve over 5,000 volunteers and trustees.

IAHSA members improve the quality of life for Iowans in their own homes or other community settings through outreach services such as:

- home health care
- transportation
- hospice care
- counseling/education/outreach
- congregate meals
- physical, speech, respiratory
- adult day care
- case management
- respite care
- home repair
- meals on wheels
- mental health outreach

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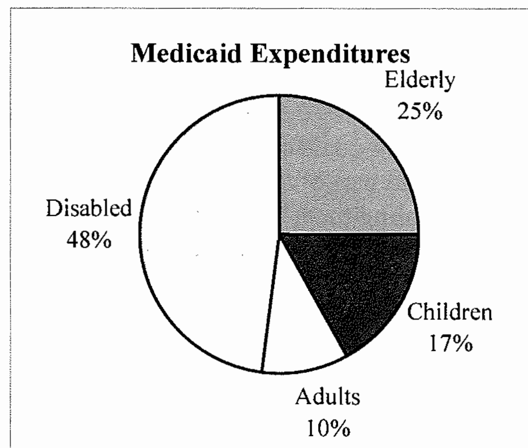
Medicaid Must be Adequately Funded

... To support Medicaid's mission, as well as to help the Iowa economy, promote home and community-based services while also preserving the safety net for the most needy and vulnerable nursing home population.

Medicaid: Supporting the Mission

The State of Iowa has committed to assure care for low-income frail elderly through the Medicaid program. Iowa's Medicaid program is required to pay for nursing home and home-health care for persons who qualify under the federal and State of Iowa criteria.

- Medicaid is the nation's largest payer of nursing home care, and each year, Medicaid helps millions of individuals with the cost of home-based long-term care services.
- In Iowa, health care spending for the elderly and disabled Iowans account for about three quarters (3/4) of the total cost of the Medicaid program.



For years, residents who pay for their care privately have had to take on some of the burden of caring for the Medicaid residents to ensure the level of quality care demanded by federal regulations was provided.

Provider rate cuts or freezes during SFY 2008 would have a serious effect on long-term care services for Iowa's 14,000 + frail and elderly Medicaid nursing residents. Provider rate cuts or freezes will also affect the State of Iowa's economy.

Medicaid Must be Adequately Funded

Medicaid: Good Iowa Economic Policy

Medicaid has become the largest single Federal funding source in Iowa and has a significant impact on Iowa's economy. The Medicaid program has a panel of 36,000 dedicated providers including all 116 of Iowa's hospitals, over 9,000 physician providers, and providers of medical equipment, pharmacies, long-term care providers and many other healthcare providers of all types.[1]

If *new* business activity, jobs, and wages are to be generated, money must flow into Iowa from outside. For example, visits by out-of-state tourists or the sale of manufacturing products to purchasers outside the State of Iowa bring new spending into the state, contributing to the economic growth.

The purchase of health care services through Medicaid brings new money into Iowa in the form of federal matching dollars. This injection of new dollars has a positive and measurable impact on Iowa business activity, available jobs, and aggregate state income.

Medicaid spending aids Iowa economies in both direct and indirect ways. Medicaid payments to nursing homes and other health-related business have a direct impact, paying for goods and services and supporting jobs in the State of Iowa. These dollars trigger successive rounds of earnings and purchases as they continue to circulate through the economy. Medicaid dollars create income and jobs for individuals directly, or even indirectly, associated with health care. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of auto dealerships, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on.

Iowa Medicaid spending has a greater economic impact than other state spending. Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increase because most state government expenditures simply reallocate spending from one sector on the economy to another. When Iowa increases its spending on Medicaid, by contrast, new federal matching dollars are brought into the State of Iowa's economy.[2]

[1] Iowa Department of Human Services Offer #401-HHS-003: Medical Assistance, Contracts, IowaCare and HIPP
[2] Medicaid: Good Medicine for Sate Economies, 2004 Update, A Report by Families USA

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Medicaid Must be Adequately Funded

Medicaid: What Can You Do?

1. **The Iowa General Assembly must recognize the responsibility to provide services to the frail elderly and increase the cap for the HCBS Elderly Waiver.**

   Polls, indicate that people would prefer to age in their homes, communities or in an assisted living program that provides a social model of care. The continuation of "rebalancing" long-term care should not inadequately fund or harm any provider of long-term care services. The State of Iowa should provide appropriate and high quality long-term care services based on the consumer's needs and an adequate payment system for the entire continuum of care.

2. **Preserve the "Safety Net"**

   However, in funding home and community- based services, the Iowa General Assembly must not compromise the safety net provided by nursing homes for the most needy and vulnerable population. Iowans currently have access to nursing home services within a short distance of their homes throughout Iowa. This allows continued contacts with family and friends.

   We support continuation of the case-mix reimbursement methodology for nursing facilities. It has created and supported the safety net for the frail elderly while assuring the dollars went for care.

   For the first time since implementation, the case-mix reimbursement methodology is funded for the July 1, 2006 rates. We support continuation of the case-mix reimbursement methodology for nursing facilities.

   The Iowa General Assembly needs to provide funds for the nursing facility Medicaid "rebasing" process. The nursing facility case-mix reimbursement system includes a provision to rebase the nursing facility Medicaid rates using the most current cost report data every other year. The rebase is set to occur in State Fiscal Year 2008 for nursing facility Medicaid rates effective July 1, 2007.

   IAHSA members will continue to provide the highest quality of care to Iowa's Medicaid recipients. Our Association will also continue to help the DHS, the IME and the legislature to help address the Medicaid budget, and we are very interested in helping the State of Iowa to find solutions. **However, we urge you to honor the agreement and continue to appropriate the funds necessary to meet the State of Iowa's obligation to Medicaid-eligible seniors receiving long-term care in case-mix funded nursing facilities.**

Nursing Facility Medicaid Budget History – SFY 2002-2008

Modified Price-Based Case-Mix Reimbursement System

IAHSA Position
IAHSA members will continue to provide the highest quality of care to Iowa's Medicaid recipients. Our Association will also continue to help the DHS, the IME and the legislature to help address the Medicaid budget, and we are very interested in helping the State of Iowa to find solutions. **However, we urge you to honor the agreement and continue to appropriate the funds necessary to meet the State of Iowa's obligation to Medicaid-eligible seniors receiving long-term care in case-mix funded nursing facilities.**

In 2001, SF 2193, the Iowa Senior Living Program Act, was passed directing the Department of Human Services to implement a case mix reimbursement methodology for Iowa's nursing facilities and skilled nursing facilities beginning July 1, 2001.

State Fiscal Year 2002
The first year of a phase-in 66.67% of Nursing Facility Rate was based on the "old flat rate" system and 33.33% was computed using the new case-mix system.

State Fiscal Year 2003
The second year of the phase-in 33.33% of Nursing Facility Rate was based on the old system and 66.67% was computed using the case-mix system.

State Fiscal Year 2004
100% of the Nursing Facility Rate was supposed to be computed using the legislated case-mix system. The case-mix system provides nursing facility rates to be "rebased" by using more current cost data every other year beginning in SFY 2004.

SFY 2004: The Iowa Legislature began to include a state budget cap on the nursing facility budget to contain costs. The inflation factor is used to regulate expenditures. DHS must request State Plan Amendments from CMS because of the changes in inflation factor, which has been fluctuating in response to the legislative cap on state expenditures.

House File 619

Capped the NF Budget: $147,252,856. The legislation directed DHS to adjust the inflation factor of the reimbursement rate calculation to provide reimbursement within the amount-projected.

Adjusted the Inflation Factor: The DHS projected nursing home expenditures after the required bi-annual rebasing and accounting for the HCFA/SNF inflation index for SFY 2004 would be $159,761,234 resulting in a shortfall of funds. Therefore, in order to comply with HF 619, the DHS adjusted the inflation factor of the case-mix rate calculation for each provider by -6.7% to remove the shortfall.

However, the US Congress granted the states an increased in the federal matching payments of 2.95% for the last two quarters of FFY 2003 and the first three quarters of FFY 2004. This one time money was available to the state amounted to around $47,000,000 in savings of state dollars from the Medicaid budget. The DHS calculations for SFY 2004 were based on the old federal matching rate and did not recognize the new rate. Therefore, the $47,000,000 was available to DHS to "fill" any Medicaid shortfall.

The nursing home profession worked with the DHS to show how the projected expenditures, because of the increased federal matching rate, would not be as much as projected. The DHS agreed and cut the reduction in the inflation factor of nursing facilities by -3.44% instead of -6.7 %.

The actual state dollars spent in State Fiscal Year 2004 was **$140,782,975.** If it were not for the federal state fiscal relief of the increase in FMAP, the state spending on the Medicaid nursing facility budget would have been **$149,003,919.**

The DHS also initiated "Savings Options" for the Medicaid nursing facility budget in SFY 2004:

1. The "hold harmless" provision was phased out. The "hold harmless" provision provided that a facility in SFY 2002 and 2003 received a lower daily rate under the new system than they received under the old flat rate system, plus they received an inflation adjustment. This was done to give those facilities time to adjust their business to the new system that pays based on the acuity of the residents.
2. The required minimum occupancy under the case mix was increased from 80% to 85%.
3. DHS eliminated the co-payment made by DHS for Medicare beneficiaries who are also eligible for Medicaid for services received as a Skilled Nursing patient.
4. DHS reduced the bed-hold payment factor from 75% to 42% of the established Medicaid rate for all nursing facilities eligible for bed hold payments.
5. DHS eliminated the payment of services for dual eligibles for skilled nursing services; therefore nursing facilities had to become Medicare certified, not get payment for services, or not admit dual eligibles.

State Fiscal Year 2005

House File 2298

Capped the NF Budget: $156,013,248.

- The legislation directed DHS, in cooperation with nursing facility representatives, to review projections for state funding expenditures for reimbursement of nursing facilities on a quarterly basis and the department would determine if an adjustment to the medical assistance reimbursement rate was necessary in order to provide reimbursement within the state funding amount.
- The legislation also directed DHS to adjust the inflation factor of the reimbursement rate calculation for only the nursing facilities reimbursed under the case-mix reimbursement system to maintain expenditures of the nursing facility budget within the $156,013,248.

Adjusted the Excess Payment Allowance: To include the HCFA/SNF index the Iowa General Assembly adjusted the excess payment amounts. Before SFY 2005, Nursing Facilities who were below 95% of the median for the direct-care cost component received an excess payment that was 100% of the difference between 95% of the median, not to exceed 10% of median. In SFY 2005, this adjusted amount was changed to 50% of the difference between 95% of median. The Iowa General Assembly also adjusted the non-direct care cost component excess payment allowance from 65% of the difference to 32.5% of the difference in SFY 2005.

State Fiscal Year 2006 – Rebasing Year

The Case-Mix Reimbursement System includes a provision to rebase the Medicaid rates using the most current cost data every other year. The rebase was set to occur in State Fiscal Year 2006 for the nursing facility Medicaid rates effective July 1, 2005.

House File 825

Allowed for "Rebasing": Increased the nursing facility budget 5.38%

Capped the NF Budget: $161.6 Million.

- The legislation also directed DHS to adjust the inflation factor of the reimbursement rate calculation for only the nursing facilities reimbursed under the case-mix reimbursement system to keep expenditures under the cap.
- The legislation directed DHS, in cooperation with nursing facility representatives, to review projections for state funding expenditures for reimbursement of nursing facilities on a quarterly basis and the department would determine if an adjustment to the medical assistance reimbursement rate was necessary in order to provide reimbursement within the state funding amount.

Allowed for Zero Inflation: The inflation factor applied from the midpoint of the cost report period to the first day of the state fiscal year rate period shall not be less than zero. The original projects were that a full SNF market basket inflation factor would not be possible with the amount of the cap.

The inflation factor has been historically applied in two parts.

1. Inflating costs forward from December 31st to July 1st of the subsequent year when the new payment rate becomes effective. All facilities are treated equally on this.
2. The second part is that if you have a cost report year ending before December 31st - say for example August 31st - the costs should first be inflated to December 31st to put the organization on par with everyone else and then inflated forward to July 1st of the subsequent year.

Neither inflation factor is being applied. Therefore, organizations that do not have calendar year ends are being hurt. By not inflating non-December 31 fiscal year ends forward to December 31, the Iowa Department of Human Services has not put these organizations on par and **allowed an inflation factor less than zero**.

House File 2734: Cap Was Adjusted: The SFY 2006 cap was first adjusted to $167, 042,326 and then was further adjusted in the Senate to $168,156,999.

- The language was retained that the inflation factor be adjusted if the quarterly projections were above or below the cap.
  - The nursing facility budget has a $1-2 million surplus of state funds due to lower than anticipated Medicaid paid days. An increase to the inflation factor was required to adjust for the surplus.[3]
- SFY 2006 cap was adjusted during the 2006 legislative session based on an estimated 1% decrease in bed days over the course of the year.
  - The actual decrease in bed days was 1.83%. Estimated total spending for the nursing facilities for SFY 2006 is expected to be $163,506,483, under the cap by $4,650,516.[4]
- **July 1, 2006 Rates: DHS Submitted to CMS a State Plan Amendment: Effective July 1, 2006, total allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to July 1, 2006.**

House File 2734: Cap Was Further Adjusted: The Senate increased the cap to $168,156,999 and allowed for nursing facilities one-third of the Skilled Market Basket index for the last quarter of SFY 2006.

- The DHS submitted State Plan amendment to CMS that would have allowed them to:
  1. Provide for the original piece of the methodology that requires an adjustment to the inflation factor if expenditures are projected to be over or under the overall cap. Therefore, increase-nursing facility rates to spend up to the SFY 2006 cap.
  2. Apply the one-third of the Skilled Market Basket index for the last quarter of SFY 2006.
     - **However, because public notice was not given prior to the start of the final last quarter of the fiscal year, the Amendment was approved for only the last four days of SFY 2006 at a state cost of $164,000.**[5]

Legislative leaders and the Governor directed the DHS to resubmit this State Plan Amendment for the quarter beginning October 1, 2006. The amendment allows nursing facility rates to be adjusted to pay up to the SFY 2007 cap of $177,701,264. This is an increase of $11.2 million in total dollars and a cost of $4.3 million to the State. Since the cap is not equivalent to an appropriation, the funding for this increase had not previously been considered and is included in the SFY 2007 supplemental appropriation estimate.[6]

[3] Letter dated June 28, 2006 to the Governor and Legislative Leaders about the SPA for SFY 2006 Rates.
[4] August Medicaid forecast (Staff members from Department of Management, the Department of Human Services, and the Fiscal Services Division of the LSA met on August 25 to discuss estimated Medical Assistance expenditures for SFY 2006 and SFY 2007).
[5] August Medicaid forecast
[6] September Medicaid Forecast

Eliminated the Excess Payment Allowance: In SFY 2005, the Nursing Facilities who were below 95% of the median for the direct-care cost component received an excess payment that was 50% of the difference between 95% of the median, not to exceed 10% of median. The non-direct care cost component excess payment allowance was 32.5% of the difference in SFY 2005. The Iowa General Assembly eliminated the excess payment allowance.

State Fiscal Year 2007

House File 2734

Capped the NF Budget: $177,701,264[7]

- The legislation directed DHS, in cooperation with nursing facility representatives, to review projections for state funding expenditures for reimbursement of nursing facilities on a quarterly basis and the department would determine if an adjustment to the medical assistance reimbursement rate was necessary in order to provide reimbursement within the state funding amount.
- The legislation also directed DHS to adjust the inflation factor of the reimbursement rate calculation for only the nursing facilities reimbursed under the case-mix reimbursement system to maintain expenditures of the nursing facility budget within the specified amount.

Capped the Case-Mix NF Budget: $162,315,695

Allowed for Zero Inflation: The inflation factor applied from the midpoint of the cost report period to the first day of the state fiscal year rate period shall not be less than zero.

State Fiscal Year 2008

The Case-Mix Reimbursement System includes a provision to rebase the Medicaid rates using the most current cost data every other year. The rebase was set to occur in State Fiscal Year 2008 for the nursing facility Medicaid rates effective July 1, 2007.

The Iowa Department of Human Services Proposed Budget
The Iowa Department of Human Services proposed budget does not include rebasing nursing facility rates. The Iowa Medicaid Director, Gene Gessow stated to the Iowa Council on Human Services that the DHS proposed budget "speaks loudest for those that do not have a voice further down in the legislative/budget process."

The Iowa General Assembly needs to provide funds for the nursing facility Medicaid "rebasing" process. The nursing facility case-mix reimbursement system includes a provision to rebase the nursing facility Medicaid rates using the most current cost report data every other year. The rebase is set to occur in State Fiscal Year 2008 for nursing facility Medicaid rates effective July 1, 2007.

[7] The August Medicaid Forecast notes that the SFY 2007 cap is likely to be high by a least $4.7 million since SFY 2006 cap was used as the baseline. Additionally, if bed days continue to run lower than the 1% expected reduction, the gap between expenditures and the cap will be even greater.

Modified Price-Based Case-Mix Reimbursement System for Nursing Facilities "101"

Beginning July 1, 2001, the Department of Human Services began to reimburse nursing facilities under the medical assistance program in accordance with a phased-in, modified price-based case-mix reimbursement system that includes a case-mix adjusted direct-care component and a non-direct care component.

The modified price-based case-mix reimbursement rate was phased in over a three-year period.

COST REPORTS

Every year, most Medicaid Certified nursing facilities, except the Iowa Veteran's Home submit a cost report based on the closing date of the facility's fiscal year that incorporates the following information:

1. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

2. The starting and average hourly wage for each class of employees for the period of the report.

3. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

The cost report is submitted on a state-provided form and must follow detailed state rules.

DIRECT CARE COSTS VS. NON-DIRECT CARE COSTS

The Modified Price-Based Case-Mix Reimbursement System as created establishes two cost components.

1. ***Direct Care Component*** means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.

2. ***Non-Direct Care Component*** means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the cost reports.

Modified Price-Based Case-Mix Reimbursement System for Nursing Facilities "101"

Provider Name...:	Page.........................:
Vendor Number..:	Date Run.....................:
Period Beginning.:	
Period Ending....:	Beginning Effective Date..:
Address............:	Total Bed Days...............:
City, State, Zip...:	Total Patient Days...........:
County.............:	Occupancy Percentage....:
Geographical Location.: Urban or Rural	85% of Total Bed Days.....:

Nursing Facility Case-Mix Payment Rate Summary

A. Direct Care Component
B. Non-Direct Care Component
C. Accountability Measure:

Case Mix Payment (A + B + C)

Computation of Case- Mix Reimbursement

Direct Care Component	Non-Direct Care Component
Total Direct Care Allowable Costs	Total Administrative, Environmental & Property Costs
Times Inflation Adjustment	Total Support Care and Other Health Care Costs
	Times Inflation Adjustment
Facility Statistics	*Facility Statistics*
A. Direct Care Per Patient Day Costs	A. Administrative, Environmental & Property Per Patient Day Costs
B. Facility Cost Report Period CMI	B. Support Care and Other Health Care Per Patient Day Costs
C. Normalized Cost Per Patient Day (A/B)	C. Total Non-Direct Care Patient Day Costs
D. Average CMI for Medicaid Residents	
E. Medicaid Case-Mix Adjusted Costs	*Non -Direct Care Rate Calculation*
Direct Care Rate Calculation	D. Statewide Median Non- Direct Care Cost
F. Statewide Median Direct Care Cost	E. Excess Payment Allowance Ceiling
G. [8]Excess Payment Allowance Ceiling	F. Potential Excess Payment Allowance
H. Potential Excess Payment Allowance	G. Excess Payment Allowance Cap
I. Excess Payment Allowance Cap	H. Excess Payment Allowance
J. Excess Payment Allowance	I. Non-Direct Care Costs Plus Excess Payment Allowance (C + H)
K. Medicaid Case Mix Adjusted costs Plus Excess Payment Allowance (E + J)	J. Overall Rate Component Limit (B x 110%)
L. Overall Rate Component Limit (F x 120% x D)	K. Non- Direct Care Component (Lesser of I or J)
M. Direct Care Component (Lesser of K or L)	

[8] In SFY 2005, the Iowa General Assembly Adjusted the Excess Payment Allowance and in SFY 2006, the Excess Payment Allowance was eliminated.

Computation of Case-Mix Reimbursement

Direct Care Component

Step 1: Determines the per diem direct care per patient day component costs.

DIRECT CARE PER PATIENT DAY COSTS AND INFLATION

The per diem allowable direct care allowable costs are established every other year based on the cost reports submitted by each facility.

Every other year the total reported allowable costs are adjusted using the CMS/SNF Market Basket Index published by Data Resources, Inc.

Total inpatient days/Total reported direct care allowable costs = Direct Care per Patient Day Costs

Direct Care per Patient Day X Inflation Adjustment

Step 2: Normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix (the acuity of the residents).

CASE MIX INDEX CALCULATION FOR DIRECT CARE COST COMPONENT

Case Mix means a measure of the intensity of care and services used by similar residents in a facility or the acuity of each resident.

- Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter.
- This RUG-III group shall be translated to the appropriate case-mix index. From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

Direct Care Allowable Costs (figured above) /Case-Mix Index = Normalized Cost Per Patient Day

The facility wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices.

Normalized Cost per Patient Day (figured above) X Average Case-Mix Index = Medicaid Case-Mix Adjusted Costs

Step 3: Calculates the patient-day-weighted medians for the direct care and non-direct care components. These medians are used in subsequent steps to establish rate component limits.

For each of the rate components (Direct Care and Non-Direct Care), a patient-day weighted median is established.

- The per diem normalized direct care cost for each facility is arranged from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.
- The per diem non-direct care cost for each facility is also arranged from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

Rebasing means effective July 1, 2003, and every second year after, the patient-day-weighted medians used in rate setting are recalculated.

Step 4: Calculates the potential excess payment allowance.

In SFY 2005, the Iowa General Assembly Adjusted the Excess Payment Allowance and in SFY 2006, the Excess Payment Allowance was eliminated.

Step 5: Calculates the reimbursement rate that is further subjected to the rate component limits in step 6.

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, not to exceed the rate component limits determined by the methodology in step 5.

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to step 2.

The facility wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices.

Normalized Cost per Patient Day (figured above) X Average Case-Mix Index = Medicaid Case-Mix Adjusted Costs

Step 6: Calculates rate component limits.

For non-state-operated nursing facilities **not located** in a Metropolitan Statistical Area, the direct care rate component limit is the direct care patient-day-weighted median times 120% of the median times the Medicaid average case-mix index pursuant to step 2.

For non-state-operated nursing facilities **located** in a Metropolitan Statistical Area, the direct care component limit is the direct care non-state-operated nursing facility patient-day-weighted median times 120% of the median specified times the ***wage index factor*** specified below times the Medicaid average case-mix index pursuant to Step 2.

- The ***wage index factor*** is determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed $8 per patient day.
- A rural nursing facility may request an exception to application of the urban geographic wage index based upon a reasonable demonstration of wages, locations, and total cost being equal to an urban facility.

COMPUTATION OF CASE-MIX REIMBURSEMENT

NON-DIRECT CARE COMPONENT

Step 1: Determines the per diem non-direct care per patient day component costs.

NON - DIRECT CARE PER PATIENT DAY COSTS AND INFLATION

The per diem allowable non-direct care allowable costs are established every other year based on the cost reports submitted by each facility.

Every other year the total reported allowable costs are adjusted using the CMS/SNF Market Basket Index published by Data Resources, Inc.

Administrative, Environmental & Property Per Patient Day Costs
Support Care and Other Health Care Per Patient Day Costs
= Total Non-Direct Care Patient Day Costs
X inflation adjustment
= Non-Direct Care Allowable Costs

*** For Administrative, Environmental & Property the greater of actual or 85% of total bed days is used to calculate the per diem costs.**

Step 2: Calculates the patient-day-weighted medians for the non-direct care component. These medians are used in subsequent steps to establish rate component limits.

The per diem non-direct care cost for each facility is arranged from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

Rebasing means effective July 1, 2003, and every second year after, the patient-day-weighted medians used in rate setting shall be recalculated.

Step 3: Calculates the potential excess payment allowance.

In SFY 2005, the Iowa General Assembly Adjusted the Excess Payment Allowance and in SFY 2006, the Excess Payment Allowance was eliminated.

Step 4: Calculates the reimbursement rate that is further subjected to the rate component limits in step 5.

The Medicaid reimbursement rate is based on allowable costs, updated every other year (rebasing), not to exceed the rate component limits determined by the methodology in step 4.

- The non-direct care component is equal to the provider's allowable per patient day costs

Step 5: Calculates rate component limits.

Notwithstanding the reimbursement rate established in Step 4 in no instance will a non-direct care rate component for non-state-operated nursing facilities **located or not located** in a Metropolitan Statistical Area, be greater than the patient day median times 110% of the median.

COMPUTATION OF CASE-MIX REIMBURSEMENT

ACCOUNTABILITY MEASURES

Calculates the additional reimbursement based on accountability measures.

Additional reimbursement for non-state-owned facilities, based on accountability measures, is available. Accountability measures are nursing facility characteristics that indicate the quality of care, efficiency, or commitment to care for certain resident populations. These characteristics are objective, measurable, and, when considered in combination with each other, deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

In order for a nursing facility to qualify for additional Medicaid reimbursement for accountability measures, it must achieve a minimum score of 3 points. The maximum available points are 11. Additional Medicaid reimbursement will be available in the following amounts.

0 - 2 points	No additional reimbursement
3 - 4 points	1 % of the direct care and non-direct care cost component patient-day-weighted medians
5 - 6 points	2 % of the direct care and non-direct care cost component patient-day-weighted medians
7 or more points	3 % of the direct care and non-direct care cost component patient-day-weighted medians

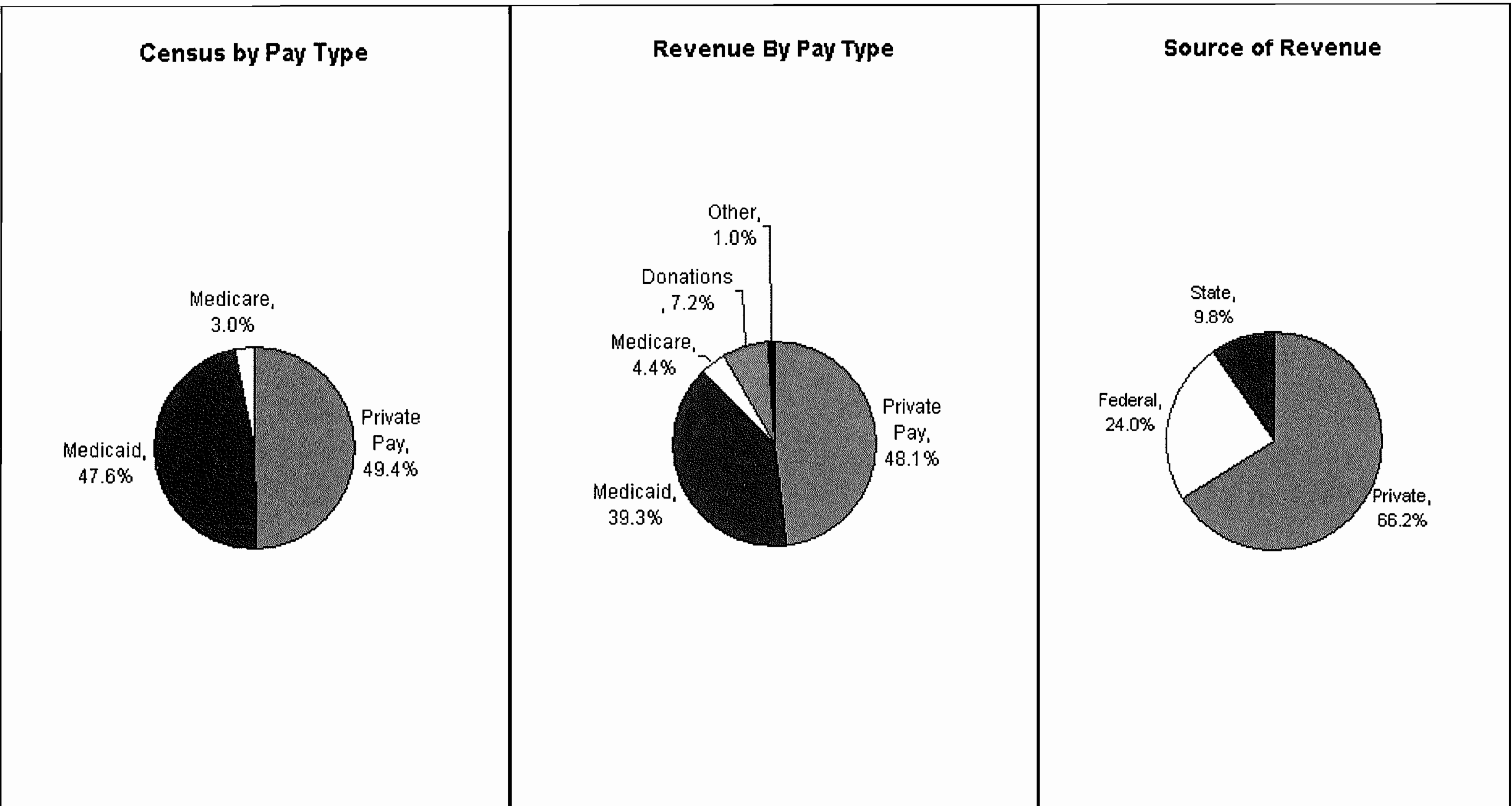
The Iowa Medicaid enterprise shall award points based on the following ten measures:

1. Deficiency-free survey
   - Value: 2 points
2. Regulatory compliance with survey
   - Value: 1 point
3. Nursing hours provided.
   - Value: 1 point for a nursing facility that falls between the fiftieth and seventy-fifth percentiles
   - 2 points for a nursing facility at or above the seventy-fifth percentile
4. Resident satisfaction
   - Value: 1 point
5. Resident advocate committee resolution rate
   - Value: 1 point
6. High employee retention rate
   - Value: 1 point
7. High occupancy rate
   - Value: 1 point
8. Low administrative costs
   - Value: 1 point
9. Special licensure classification
   - Value: 1 point
10. High Medicaid utilization
    - Value: 1 point

Census by Payer Type	
Private Pay	49.4%
Medicaid	47.6%
Medicare	3.0%

% Revenue By Payer-Type	
Private Pay	48.1%
Medicaid	39.3%
Medicare	4.4%
Donations	7.2%
Other	1.0%

Source of Revenue	
Private	66.2%
Federal	24.0%
State	9.8%



	Fiscal Year	Total Beds	Total Patient Days	Title XIX Days	Percent Title XIX	Cost Per Day	1-Apr-06 T-19 Rate	1-Jul-06 T-19 Rate
Bishop Drumm Care Center	7/1/02-6/30/03	150	54,186	19,805	36.55%	$ 101.50		
	7/1/03-6/30/04	150	54,031	21,704	40.17%	$ 120.65		
	7/1/04-6/30/05	150	54,207	22,911	42.27%	$ 133.47		
							$ 122.02	$ 128.57

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What Medicaid Means to Bishop Drumm Retirement Center

Bishop Drumm Retirement Center is a Continuing Care Retirement Center located in Johnston. In total, about 290 elderly people live on the campus, including 150 residents of the Skilled Nursing Facility (Bishop Drumm Care Center).

Bishop Drumm was originally established by the Religious Sisters of Mercy in 1939. When operations first began, there was no Medicaid program. The Sisters managed to provide quality services with operational revenue from privately paying residents and philanthropic support from the community. At that time, very little support was obtained from publicly funded programs.

When the Medicare and Medicaid programs were established in the mid-sixties, the Bishop Drumm Home became certified for Title XIX, and increased governmental support was obtained. At that time, most of the residents had minimal care needs that could now be handled in a Residential Care Facility or an Assisted Living Program.

Sr. Beatrice Marie Costello became administrator of the Bishop Drumm Home in 1974, and she still lives on the campus. According to Sr. Bea, costs were kept very low, but the Medicaid program was helpful in providing reimbursement for indigent residents, however, the support amounted to only 76% of the cost of care. Bishop Drumm had regular cash flow problems, and on some occasions, the Sisters would have to borrow money to make payroll. Nevertheless, the Sisters had faith, and they always managed to pay the bills

In 2002, Bishop Drumm became certified for Medicare and additional public funding became available.

Today, the payer-mix at Bishop Drumm Care Center is as follows:

- 49.4% privately paying
- 47.6% Medicaid-eligible
- 3.0% Medicare.

Current operational revenue by pay type is as follows:

- 48.1% - Privately-paying residents
- 7.2% - Donations for operations
- 39.3% - Medicaid-eligible residents
- 4.4% - Medicare

Source of revenue for Bishop Drumm Care Center:

- 66.2% Private (includes donations and client participation portion of Medicaid)
- 24.0% Federal (includes Medicare and Federal portion of Medicaid funding)
- 9.8% State (state portion of Medicaid funding)

The implementation of the Case Mix Reimbursement System has had a very positive impact on Bishop Drumm Care Center. Under the previous system where reimbursement was capped at the 75 percentile, the reimbursement for Bishop Drumm was always far below costs. Although Medicaid reimbursement is still below costs, the gap has narrowed from what it would have been under the old system. Currently, Medicaid reimbursement is equal to about 87% of costs:

Average per diem costs	$148.48
Current Medicaid rate	$128.57
Current per diem gap	$ 19.91
Projected Medicaid census for FY07	26,162 resident days
Projected Medicaid gap for FY07	$520,885

(based on 1/31/07 YTD financials)

Bishop Drumm Care Center – Summary of Statement of Operations

Overall financial performance (FY 07 – Jan 31, 2007 YTD annualized):

Net revenue on operations	$ 7,905,300	
Operating expenses	$ 8,131,300	
Gain (Loss)	$ (226,000)	
Operating margin		(2.9%)
Philanthropic Support	$ 500,000	
Gain (Loss)	$ 274,000	
Margin		3.5%

The introduction of the case mix reimbursement system has had another positive impact on long-term care facilities in Iowa. The system does a much better job of recognizing direct care costs, which are the costs that have the most impact on the quality of care needed by the elderly residents.

However, for the case mix reimbursement system to work well, it is essential that rebasing occur on a regular basis. The original legislative intent of the system was that rebasing occurs every two years. The last time it was rebased was December 31. 2004. We urge the legislature to rebase the case mix reimbursement system again this year.

The needs of Iowa's elderly poor are great. Rebasing the case mix reimbursement system will assure that resources are used for services that are most needy by some of the state's most vulnerable citizens.