STATE OF IOWA
IOWA DEPARTMENT OF HUMAN SERVICES, IOWA MEDICAID ENTERPRISE (IME)

Instructions for Form 470-4829 Nursing Facility Enhanced Medicaid Payment Report

Each nursing facility shall submit information to the Department using Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, as a condition for receipt of the quality assurance assessment pass-through and quality assurance assessment rate add-on. The report shall demonstrate compliance by the nursing facility with the requirements for use of the quality assurance assessment pass-through and quality assurance assessment rate add-on.

Per Iowa Acts 2009 Senate File 476, "If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment

1) no less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers and

2) no less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff."

Provider Name and Identification Data

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

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

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

Date of Report: This form must be submitted annually no later than 90 days after facility's fiscal year end. The beginning period for all first time submissions will be **April 1, 2010.** Thereafter, the beginning date will correspond to the facility's fiscal year end. The ending period shall be the end date of the facility's fiscal year end. The first submission shall be for fiscal years ending September 30, 2010 and later. Providers with years ending between April 30, 2010 and August 31, 2010 will add the amounts for quarter April 1, 2010 through June 30, 2010 to the reports submitted for their year ends in FY 2011.

Section 1: Reconciliation of Quality Assurance Assessment Fee

Statistical Information

Line 1 - Total Medicaid days: Report the number of days that a bed was occupied in the facility for which Medicaid was the primary payor during the reporting period. Exclude leave days.

Line 2. - Total Medicare days: Report the number of days that a bed was occupied in the facility for which Medicare Part A or Part C was the payor during the reporting period. This includes any day where Medicare was the primary payor and there was a secondary payor for the same day (crossover), regardless if the secondary payor was Medicaid, private insurance or any other payor. Exclude leave days.

Line 3 - Hospice days: Report the number of days that a bed was occupied in the facility for which a resident was receiving Hospice benefits during the reporting period.

Line 4 - Total Other days: Report the number of days that a bed was occupied in the facility for a payor type other than Medicaid, Medicare Part A or Medicare Part C, or Hospice for the reporting period. Exclude leave days.

Line 5 - Total patient days: Sum of the number of days from above (sum of lines 1 through 4 from above)

NOTE: This field will automatically calculate based on information provided

Line 6 - Licensed beds during the period: Report the weighted average of beds available through the entire period.

Line 7 - Total days in during period: Total days in period should equal the number of beds reported multiplied by the number of days in the reporting period.

NOTE: This field will automatically calculate based on information provided

Quality Assurance Assessment Fee Remitted

Line 10 - Quality assurance assessment fee per bed day: The quality assurance assessment fee (pass-through) is $5.26 per patient day except if a nursing facility:

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

If a facility meets any of the criteria in a, b, or c the quality assurance assessment fee (pass-through) is $1.00 per bed day.

Lines 11 - 14 - Quality assurance assessment fee paid: Report the amount of the quality assurance assessment fees submitted for each quarter of the report period. This should tie to each of the Quality Assurance Assessment Calculations Worksheets submitted.

Quality Assurance Assessment Pass-through and Rate Add-on Payments Received

Lines 16 - 19 - Quality assurance assessment payments received: Report the amount of the quality assurance assessment pass-through (amount reported on line 10) and rate add-on (by rule this is $10) amount you received for each quarter of the report period. This should be equal to the pass-through, as calculated on line 10, plus the rate add-on of $10.00 per day multiplied by the Medicaid census for each quarter.

Certification Statement

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

Section 2: Demonstration of Wage and Employment Cost Change for the Period

The amounts reported in this section should correspond to provider calculations as to how much costs have changed since implementation of the QAAF program or since submission of previous reports. The increases for CNA wages and costs are for those changes that have occurred only to CNA classified employees. The increases for other employee wages and costs are for those changes to non-administrative classified employees. **Any costs listed in this section must have a descriptive narrative (Section 3) to support how and when the changes were implemented.** Any changes to policies not directly related to actual increases or decreases should not be reported (i.e. inclusion of a certain class of employees in an health insurance program that no one in that class enrolls in).

Line 1 - Wage Increases: Report the amounts calculated based upon the change in average hourly wages or from specific wage increases paid during the reporting period.

Line 2 - Bonuses and other wage adjustments: Report the amounts calculated based upon bonus programs or other special wage adjustments that the provider that was paid during the reporting period. The provider should also estimate payroll taxes and other benefits from these adjustments.

Line 3 - Changes in staffing patterns: Report the amounts calculated based upon changes in staff hours per patient day and changes to the employment related costs per patient day.

Line 4 Vacation, holiday and sick pay – PTO or leave benefits: Report the amounts calculated based upon changes in policies surrounding leave benefits and paid-time-off programs.

Line 5- Benefit programs - group health, group life, retirement: Report the amounts calculated based upon changes in the costs to the provider for group benefits. This could include health insurance, life insurance, retirement and savings plans.

Line 6- Education programs and advancement opportunities: Report the amounts calculated based upon costs to the provider for staff education or costs for career improvement or other advancement programs. These costs may include payments to either the specific program or reimbursements directly to the employee and may also include travel expenses (mileage, meals, lodging, etc.).

Line 7 - Tuition reimbursement programs: Report the amounts calculated based upon costs of tuition reimbursement programs and should be documented by specific employee and classified appropriately. In general, these plans must adhere to a specific set of guidelines for proper IRS wage and benefit treatment (IRS Publication 570). There are individual limits for the provider regarding this assistance and per employee limits based upon compensation.

Line 8 - Other costs: Report the amounts calculated based upon other costs of employment which may include payroll taxes, benefits or other special programs implemented by the provider.

Section 3: Narrative

Any costs listed in Section 2 must have a descriptive narrative to support how and when the changes were implemented.

This section is available for the provider to demonstrate calculations and other explanations of changes and/or programs that have been initiated since implementation of the QAA or the previous report. The information included here needs to include specific identification of cost adjustments or may offer general explanation of changes occurring during the reporting period. The calculations and demonstrations of the provider should also refer to any supporting schedules or documents including the basic data. The provider may also develop additional worksheets that can be attached to the reporting form.

Submission Requirements

This form must be submitted annually no later than 90 days after the end of the annual cost report period and will be initiated for cost report years ended September 30, 2010 and later. Providers with years ending between April 30, 2010 and August 31, 2010 will add the amounts for FY 2010 to the reports submitted for their year ends in FY 2011.

Completed forms should be submitted to the following address:

IME Provider Cost Audit and Rate Setting Contractor
PO Box 36450
Des Moines, IA 50315

An electronic form should be also be submitted to costaudit@dhs.state.ia.us

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