All other payments for the services of a nurse-midwife enrolled in the Iowa Medicaid program shall be paid on the basis of the fee schedule for services provided nurse mid-wives and no separate payment shall be made to any other facility or provider in connection with the birth, other than a hospital, or ambulatory surgical center. The nurse-midwife fee schedule is based on 85% of the physician fee schedule.

Except as otherwise noted in the plan, state – developed fee schedules rates are the same for both governmental and private providers of certified nurse-midwife services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/policies-rules-and-regulations/covered-services-rates-and-payments/fee-schedules

18. HOSPICE SERVICES

Iowa Medicaid reimburses for hospice services in accordance with the requirements of Section 4306 of the State Medicaid Manual (Hospice Reimbursement).

Pursuant to Section 4307 of the State Medicaid Manual (Payment for Physician Services Under Hospice), when the Iowa Medicaid agency has been notified of the name of the physician who has been designated as the attending physician and is not a hospice employee, the Iowa Medicaid Agency will reimburse the attending physician in accordance with the physician fee schedule described in Item 5a.

19a. CASE MANAGEMENT SERVICES

For Target Group 1 (Adults with chronic mental illness, and severely emotionally disturbed children receiving services through the HCBS Children's Mental Health waiver); and Target Group 2 (Persons with a developmental disability, including mental retardation):

For the period July 1, 2010, through June 30, 2018, reimbursement rates for case management providers will be established on the basis of a 15 minute unit consistent with 2 CFR, part 200 as implemented by HHS at 45 CFR, Part 75. Case Management services, as described in Supplement 2 to Attachment 3.1-A, will be reimbursed on the basis of 100% of the provider's reasonable and necessary costs calculated retrospectively, as determined by the State Medicaid agency.

Interim Payment

The Department will make interim payments to Case Management providers based upon a projected cost report. Providers are required to submit a CMS-approved, Medicaid projected cost report on July 1 of each year for the purpose of establishing a projected rate for the new fiscal year, thus avoiding underpayment or overpayment.