



Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-381

Employees' Manual, Title 8
Medicaid Appendix

May 16, 2014

**INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED
(ICF/ID) MANUAL TRANSMITTAL NO. 14-1**

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY
DISABLED (ICF/ID)**, Title Page, new; Table of Contents, new;

Chapter I, **General Program Policies**, Title Page, Table of Contents
(pages 1, 2, and 3), pages 1 through 50, and the following forms:

470-4166	<i>Iowa Medicaid Provider Form Request</i>
470-5047	<i>Certificate of Medical Necessity for Waiver Assistive Devices</i>
470-5048	<i>Certificate of Medical Necessity for Consumer-Directed Attendant Care</i>
470-5049	<i>Certificate of Medical Necessity for Environmental Modification</i>
470-5050	<i>Certificate of Medical Necessity for Home and Vehicle Modification</i>
470-5051	<i>Certificate of Medical Necessity for Prevocational Services</i>
RC-0113	<i>List of Emergency Diagnosis Codes</i>

Chapter II, **Member Eligibility**, Title Page, Table of Contents (pages 1
and 2), pages 1 through 63, and the following forms:

470-2747	<i>Foster Care Provider Medical Letter</i>
470-2747(S)	<i>Foster Care Provider Medical Letter (Spanish)</i>
470-2979	<i>Proof of Application for Medicaid</i>
470-1911	<i>Medical Assistance Eligibility Card</i>
470-2580	<i>Presumptive Medicaid Eligibility Notice of Decision</i>
470-2580(S)	<i>Presumptive Medicaid Eligibility Notice of Decision (Spanish)</i>
470-4164	<i>IowaCare Medical Card</i>
470-3931	<i>Medically Needy Expense Deletion Request</i>
470-4299	<i>Verification of Emergency Health Care Services</i>
470-4299(S)	<i>Verification of Emergency Health Care Services (Spanish)</i>
470-2927	<i>Health Services Application</i>
470-2927(S)	<i>Health Services Application (Spanish)</i>

470-4990	<i>Application for Authorization to Make Presumptive Medicaid Eligibility Determination for Children</i>
470-2582	<i>Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations</i>
470-4855	<i>Application: Presumptive Health Care Coverage for Children</i>
470-4855(S)	<i>Application: Presumptive Health Care Coverage for Children (Spanish)</i>
470-2579	<i>Application for Authorization to Make Presumptive Medicaid Eligibility Determinations for Pregnant Women</i>
470-2629	<i>Presumptive Medicaid Income Calculation</i>
470-3864	<i>Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)</i>

Chapter III, **Provider-Specific Policies**, Title Page, new; Table of Contents (pages 1, 2, and 3), new; pages 1 through 64, new; and the following forms:

470-0664	<i>Financial and Statistical Report for Purchase of Service Contracts, new</i>
470-0374	<i>Resident Care Agreement, new</i>
470-0042	<i>Case Activity Report, new</i>
470-0254	<i>Iowa Medicaid – Provider Enrollment Application, new</i>
CMS-1539	<i>Medicare/Medicaid Certification and Transmittal, new</i>
470-0030	<i>Financial and Statistical Report, new</i>
470-0373	<i>Voluntary Contribution Agreement, new</i>

Chapter IV, **Billing Iowa Medicaid**, Title page, Contents (pages 1, 2, and 3), pages 1 through 160, and the following forms:

470-3969	<i>Claim Attachment Control</i>
UB-04	<i>Claim Form (CMS-1450)</i>
CMS-1500	<i>Health Insurance Claim Form</i>
	<i>ADA 2012 Dental Claim Form</i>
470-0039	<i>Iowa Medicaid Long Term Care Claim</i>
470-4708	<i>Medicare Crossover Invoice (Professional)</i>
470-4707	<i>Medicare Crossover Invoice (Institutional)</i>
470-2486	<i>Claim for Targeted Medical Care</i>
470-0829	<i>Request for Prior Authorization</i>
470-3970	<i>Prior Authorization Attachment Control</i>
470-3744	<i>Provider Inquiry</i>
470-0040	<i>Adjustment Request</i>
470-4987	<i>Recoupment Request</i>

Appendix, Title Page, Table of Contents, and pages 1 through 27

Summary

This letter transmits a new manual for providers of Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). The manual is comprised of five sections:

- ◆ Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- ◆ Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- ◆ Chapter III explains Medicaid requirements specific to ICF/IDs. The chapter:
 - Aligns with current policies, procedures, and terminology.
 - Ensures that current contact information is provided.
 - Includes links to forms to ensure that the most recent version of the form is accessible.
- ◆ Chapter IV contains instructions and forms to bill Iowa Medicaid. It also applies to all provider types.
- ◆ The Appendix contains directories of local offices of the Department of Human Services and the Social Security Administration and EPSDT care and coordination agencies.

Date Effective

Upon receipt.

Material Superseded

None.

Additional Information

The new provider manual can be found at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/ICF.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider

**Intermediate Care Facilities for the
Intellectually Disabled (ICF/ID)**

Page

1

Date

May 1, 2014

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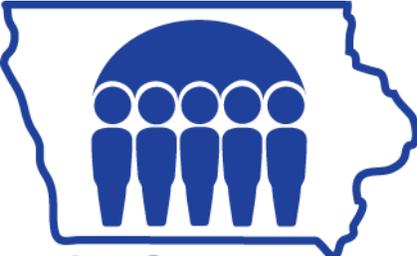
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III. Provider-Specific Policies



Iowa Department
of Human Services



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. INTERMEDIATE CARE FACILITIES ELIGIBLE TO PARTICIPATE

This manual contains the policies and procedures governing care in intermediate care facilities for the intellectually disabled (ICFs/ID), when provided under the Medicaid program. The Medicaid program is administered by the states under regulations established by the United States Department of Health and Human Services. Facilities may become certified as Medicaid providers by meeting program, administrative, and facility conditions of participation.

The policies in this manual are from rules promulgated for the Medicaid ICF/ID program by the Department of Human Services at 441 Iowa Administrative Code (IAC) Chapter 82. These are based on Code of Federal Regulations sections entitled "Conditions of Participation for Intermediate Care Facilities for the Intellectually Disabled," found at 42 CFR 483, Subpart I.

The Department of Health and Human Services has provided further clarification through interpretive guidelines prepared to assist survey agencies, program participants, and certifying agencies to identify program intent. These guidelines are published as an addendum to the ICF/ID licensing rules at 481 CFR 64.

In this manual, Medicaid members who receive care in an ICF/ID are referred to as "residents." The Department of Human Services is referred to as "the Department."

B. ADMINISTRATION

1. Governing Body

The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- ◆ Exercise general policy, budget, and operating direction over the facility;
- ◆ Set the qualifications for the administrator of the facility (in addition to those already set by state law); and
- ◆ Appoint the administrator.



2. Records

The facility shall, at a minimum, maintain the following records:

- ◆ All records required by the Department of Public Health and Department of Inspections and Appeals.
- ◆ Residents' medical records.
- ◆ Records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Medicaid program, including the authority for and the date of administration of the treatment, drugs, or services.
- ◆ Documentation in each resident's record which enables the Department to verify that each charge is due and proper before payment.
- ◆ Financial records maintained in the standard, specified form including the facility's most recent audited cost report *Financial and Statistical Report for Purchase of Service Contracts*, form 470-0664. Click [here](#) to view a sample of the form online.
- ◆ Census records, to include:
 - The date,
 - Number of residents at the beginning of each day,
 - Names of residents admitted, and
 - Names of residents discharged.
- ◆ Resident accounts.
- ◆ In-service education records.
- ◆ Inspection reports pertaining to conformity with federal, state, and local laws.
- ◆ Disaster-preparedness reports.
- ◆ All other records as may be found necessary by the Department in determining compliance with any state or federal regulations.

Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer. All records shall be retained within the facility upon change of ownership.

Provider Agency		
Period of Report	From	To

SCHEDULE A: REVENUE REPORT

Revenues:	Total Revenue	Revenue for Schedule D Expense Deduction*
Fee for Service:		
Iowa State Department of Human Services	\$ _____	
County Board of Supervisors	_____	
Private Clients	_____	
Department of Education (Voc Rehab) (service fees only)	_____	
United Way (service fees only)	_____	
Social Security, SSI, SSA	_____	
Other	_____	
Service, Reimbursement or Investment Income:		
Work Services Revenues	\$ _____	\$ _____
Food Reimbursement (DOE)	_____	_____
Investment Income	_____	_____
_____	_____	_____
_____	_____	_____
Other (attach schedule)	_____	_____
Contributions: (Schedule must be attached:)		
United Way: Contributions not restricted or appropriated** to a specific individual	\$ _____	
Restricted to specific individuals*	_____	\$ _____
Other: Contributions not restricted or appropriated** to a specific individual	_____	
Restricted to specific individuals*	_____	\$ _____
Government Grants:	_____	_____
Total Revenue	\$ _____	*\$ _____

* Income which must be deducted from total service expense on Schedule D.

** Agencies must have documentation or support which identifies purposes of contributions reported.

Provider Agency		
Period of Report	From	To

SCHEDULE B: STAFF NUMBERS AND WAGES

Job Classification and Title	Number of Staff			Gross Wages
	Full Time	Part Time	FTEs	
Administrative #2110 Job Title _____				
Administrative Total.....				
Professional #2120 Job Title _____				
Professional Total.....				
Direct Client Care #2130 Job Title _____				
Direct Client Care Total				
Clerical #2150 Job Title _____				
Clerical Total				
Other Staff Wages #2190 Job Title _____				
Other Staff Wages Total.....				
Total: ALL JOB CLASSIFICATIONS AND TITLES.....				

The maximum amount of wages chargeable to Purchase of Services for any one employee is \$40,000 annually. If an employee is paid in excess of \$40,000, the excess must be reported as "Other Nonreimbursable Costs" in column 3 of Schedule D or charged to Excluded Services (use column 5 of Schedule D).

Provider Agency		
Period of Report	From	To

SCHEDULE C: PROPERTY AND EQUIPMENT DEPRECIATION AND RELATED PARTY PROPERTY COSTS

PROVIDER -OWNED EQUIPMENT BUILDINGS

Description:	Original Cost	Depreciation Recorded Prior Years	Method	Annual % Rate	Recorded Depreciation Expense	Straight-Line Depr.
Equipment:						
Building equipment						
Departmental equipment						
Other equipment _____						
Office furniture and fixtures						
Motor vehicles _____						
Total						
Buildings:						
Buildings						
Additions						
Leasehold improvements _____						
Other _____						
Total						
Total Equipment and Buildings						

RELATED PARTY PROPERTY COST

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook? Yes No

2. Schedule of Lessor's Costs:

If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property _____

Property taxes _____

Mortgage interest on property _____

Insurance _____

Other (describe) _____

Total _____

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		1	2	3	4	5	6	7	8	9	10
Acc No.	Account Title	Total Expense	Fund-Raising Cost	Other Nonreim-burseable Costs	Adjusted Cost: Col 1 minus Cols 2 & 3						Indirect Service Cost
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	TOTAL WAGES										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	TOTAL BENEFITS										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	TOTAL PAYROLL TAXES										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	TOTAL PROFESSIONAL FEES										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	TOTAL SUPPLIES										
2600	TELEPHONE AND TELEGRAPH										
2700	POSTAGE AND SHIPPING										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	TOTAL OCCUPANCY EXPENSE										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		11	12	13	14	15	16	17	18	19	20
Acc No.	Account Title										
2110	Administrative Staff										
2120	Professional Direct Staff										
2130	Other Direct Staff										
2150	Clerical Staff										
2190	Other Staff										
2100	TOTAL WAGES										
2210	Health Benefits										
2220	Retirement Plan										
2290	Other Benefits										
2200	TOTAL BENEFITS										
2310	FICA Expense										
2320	Unemployment										
2350	Worker's Compensation Insurance										
2300	TOTAL PAYROLL TAXES										
2450	Medical and Psych. Serv. Purchased										
2470	Audit and Accounting										
2480	Attorney Fees										
2490	Other Nonmedical										
2400	TOTAL PROFESSIONAL FEES										
2510	Office Supplies										
2530	Medical Supplies										
2540	Recreation and Craft Supplies										
2550	Food										
2590	Other Supplies										
2500	TOTAL SUPPLIES										
2600	TELEPHONE AND TELEGRAPH										
2700	POSTAGE AND SHIPPING										
2810	Rent of Space										
2820	Buildings and Grounds Supplies										
2830	Utilities										
2840	Care of Buildings and Grounds										
2870	Interest										
2880	Insurance and Property Taxes										
2890	Other Occupancy Expense										
2800	TOTAL OCCUPANCY EXPENSE										

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

		Direct Service Cost									
Acc No.	Account Title	1	2	3	4	5	6	7	8	9	10
		Total Expense	Fund-Raising Costs	Other Nonreim-burseable Costs	Adjusted Cost: Col 1 minus Cols 2 & 3						Indirect Service Cost
3100	OUTSIDE PRINTING AND ART WORK										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	TOTAL TRANSPORTATION										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	TOTAL CONFERENCES AND CONVENTIONS										
3400	SUBSCRIPTIONS AND PUBLICATIONS										
3510	Clothing and Personal Needs										
3520	Other										
3500	TOTAL ASSISTANCE										
4100	ORGANIZATION MEMBERSHIPS										
4200	AWARDS AND GRANTS										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	TOTAL EQUIPMENT REPAIRS & PURCHASE										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	TOTAL DEPRECIATION										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	TOTAL MISCELLANEOUS										
TOTAL EXPENSES											
ALLOCATION OF INDIRECT SERVICE COSTS											
Total Service or Maintenance Cost After Allocation of Indirect											
* Program Income or Reimbursements											
* United Way Contributions Restricted to Specific Individuals											
* Other Contributions Restricted to Specific Individuals											
* Government Grants											
Total Service or Maintenance Cost After Deductions											
Units of Service											
UNIT COST											

Provider Agency		
Period of Report	From	To

SCHEDULE D: EXPENSE REPORT

Direct Service Cost

		11	12	13	14	15	16	17	18	19	20
Acc No.	Account Title										
3100	OUTSIDE PRINTING AND ART WORK										
3210	Mileage and Auto Rental										
3250	Agency Vehicles Expense										
3280	Automobile Insurance										
3290	Other Related Transportation										
3200	TOTAL TRANSPORTATION										
3310	Staff Development and Training										
3320	Annual Meeting and Business Conf.										
3300	TOTAL CONFERENCES AND CONVENTIONS										
3400	SUBSCRIPTIONS AND PUBLICATIONS										
3510	Clothing and Personal Needs										
3520	Other										
3500	TOTAL ASSISTANCE										
4100	ORGANIZATION MEMBERSHIPS										
4200	AWARDS AND GRANTS										
4310	Agency Vehicle Repair										
4320	Other Equipment Repair or Purchase										
4300	TOTAL EQUIPMENT REPAIRS & PURCHASE										
4410	Agency Vehicles										
4420	Equipment										
4480	Buildings and Leasehold										
4400	TOTAL DEPRECIATION										
4910	Moving and Recruitment										
4920	Liability Insurance										
4930	Miscellaneous										
4900	TOTAL MISCELLANEOUS										
	TOTAL EXPENSES										
	ALLOCATION OF INDIRECT SERVICE COSTS										
	Total Service or Maintenance Cost After Allocation of Indirect										
	* Program Income or Reimbursements										
	* United Way Contributions Restricted to Specific Individuals										
	* Other Contributions Restricted to Specific Individuals										
	* Government Grants										
	Total Service or Maintenance Cost After Deductions										
	Units of Service										
	UNIT COST										

Provider Agency _____		
Period of Report	From _____	To _____

SCHEDULE E: COMPARATIVE BALANCE SHEET

ASSETS, LIABILITIES, AND EQUITY

	BALANCE AT END OF	
	Current Period	Prior Period
ASSETS:		
Cash _____	\$ _____	\$ _____
Receivable from clients _____	_____	_____
Receivable from others _____	_____	_____
Property and equipment:		
Land _____	_____	_____
Buildings and equipment _____	_____	_____
Less allowance for depreciation _____	_____	_____
Net property and equipment _____	_____	_____
Investments and other assets _____	_____	_____
TOTAL ASSETS	_____	_____
LIABILITIES AND EQUITY:		
Accounts payable _____	\$ _____	\$ _____
Accrued taxes (payroll and property) _____	_____	_____
Other liabilities _____	_____	_____
_____	_____	_____
Notes and mortgages _____	_____	_____
Total liabilities _____	_____	_____
Equity or fund balance _____	_____	_____
TOTAL LIABILITIES AND EQUITY	_____	_____

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	\$	_____
Add:		
TOTAL REVENUE from Schedule A _____	\$	_____
Other revenue. Explain _____		_____
_____		_____
_____		_____
Deduct:		
TOTAL EXPENSES from Schedule D _____		_____
Other expenses. Explain _____		_____
_____		_____
_____		_____
TOTAL EQUITY OR FUND BALANCE END OF PERIOD	\$	_____

Provider Agency		Vendor No.
Period of Report:	From	To

SCHEDULE F: COST ALLOCATION PROCEDURES
(To be completed by providers which offer more than one service)

Costs are allocatable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocatable to a service if it is treated consistently with other costs incurred for the same purpose in like circumstances, and if it:

- (1) Is incurred specifically for the service,
- (2) Benefits the service and can be distributed in reasonable proportion to the benefits received, and
- (3) Is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocatable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies or to avoid other restrictions imposed by law or terms of an award.

DIRECT COSTS:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your method of allocating joint service cost consistently followed from year to year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are costs allocated to services in reasonable proportion to benefits received? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Additional comments regarding allocation of joint service costs: | <input type="checkbox"/> | <input type="checkbox"/> |

INDIRECT COST:

- | | | |
|---|--------------------------|--------------------------|
| 1. Are indirect costs distributed on a basis of total direct service or cost? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used? | | |
| 3. Is the basis for distributing indirect cost the same as that used in the previous year? | <input type="checkbox"/> | <input type="checkbox"/> |

Provider Agency		
Period of Report	From	To

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART 2

	Gross Total Attributable to:
Residual Cost NOT Included in Schedule G, Part 1	Shelter
Remainder of Program <u>Direct</u> Costs (Total Program Schedule D Direct - Part 1 Direct)	
Remainder of Program <u>Indirect</u> Cost (Total Program Schedule D Direct - Part 1 Indirect)	
PROGRAM TOTALS for PART 2	

UNIT COST DETERMINATION

SERVICE PERCENTAGE FROM SCHEDULE G PART 1

TOTAL PART 2 SERVICE COST

TOTAL SERVICE COST FROM PART 1

GRAND TOTAL SERVICE COST

DEDUCTIONS FROM SERVICE COST FROM SCHEDULE D

GRAND TOTAL SERVICE COST AFTER DEDUCTIONS

MAINTENANCE PERCENTAGE FROM SCHEDULE G PART 1

TOTAL PART 2 MAINTENANCE COST

TOTAL MAINTENANCE COST FROM PART 1

GRAND TOTAL MAINTENANCE COST

DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D

GRAND TOTAL MAINTENANCE COST AFTER DEDUCTIONS

UNITS OF SERVICE

SERVICE COST PER UNIT

MAINTENANCE COST PER UNIT

TOTAL COST PER UNIT

ALLOCATION OF STAFF TIME WORK SHEET

(Use separate form for each staff type)

TYPE OF STAFF: _____

Enter the percent of time spent on maintenance activities here: _____ LINE 1

Enter the percent of the time spent on service activities here: _____ LINE 2

Add line 1 and line 2 and enter result here: _____ LINE 3

Divide line 1 by line 3 and enter result here: _____ LINE 4

Divide line 2 by line 3 and enter result here: _____ LINE 5

Enter the percent of time spent on administrative activities here: _____ LINE 6

Multiply line 4 by line 6 and enter result here: _____ LINE 7

(This is the percentage of administrative time allocated to maintenance.)

SUBTRACT line 7 from line 6 and enter result here: _____ LINE 8

(This is the percentage of administrative time allocated to service.)

ADD line 1 and line 7 and enter result here: _____
(This is the total percentage of time allocated to maintenance. Use this percentage to allocate staff cost to maintenance.)

ADD line 2 and line 8 and enter result here: _____
(This is the total percentage of time allocated to service. Use this percentage to allocate staff cost to service.)

* The combined percent of time spent on maintenance, service, and administrative activities should total 100%.



a. Personal Needs Accounts

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. This accounting system is subject to audit by state representatives and must meet the following criteria.

- ◆ Upon a resident's admission to the facility, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger must be kept current on a monthly basis. The facility may combine this accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger sheet must be maintained for each resident.
- ◆ When something is purchased for the resident and is not a direct cash disbursement to the resident, the expenditure item in the ledger must be supported by a dated receipt signed by the resident or the resident's legal representative. The receipt must indicate the article furnished for the resident's benefit.
- ◆ Personal funds must not be turned over to persons other than the resident's legal representative or other persons selected by the resident. With the consent of the resident (if the resident is able and willing to give consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, an itemized dated receipt signed by the resident or the representative shall be deposited in the resident's file.
- ◆ The receipts for each resident must be kept until canceled by auditors. The ledger and receipts for each resident shall be made available for periodic audits by an accredited DIA representative. The representative shall make an audit certification at the bottom of the ledger sheet. Support receipts may then be destroyed.
- ◆ Upon a resident's death, a receipt must be obtained from the next of kin or the resident's guardian before releasing the balance of personal needs funds. When the resident has been receiving a grant from the Department for all or part of the personal needs, any funds shall revert to the Department. The Department shall turn the funds over to the resident's estate.



b. Resident Records

The facility must:

- ◆ Develop and maintain a record keeping system that:
 - Includes a separate record for each resident, and
 - Documents the resident's health care, active treatment, social information, and protection of the resident's rights.
- ◆ Provide each identified residential living unit with appropriate aspects of each resident's record.
- ◆ Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records.
- ◆ Develop and implement policies and procedures governing the release of any resident information, including consents necessary from the resident or parents (if the resident is a minor) or legal guardian.
- ◆ The resident record must include, at a minimum:
 - Physician orders
 - Progress or status notes
 - Preliminary evaluation
 - Comprehensive functional assessment
 - Individual program plan
 - [Form 470-0374, Resident Care Agreement](#)
 - Program documentation
 - Medication administration records
 - Nurses' notes
 - [Form 470-0042, Case Activity Report](#)

Any person who makes an entry in a resident's record must make it legibly, date it, and sign it. The facility must provide a legend to explain any symbol or abbreviation used in a resident's record.



Iowa Department of Human Services
ICF/ID Resident Care Agreement

This contract is between the Iowa Department of Human Services (DHS),

Resident _____,

and _____, an intermediate care facility for persons with intellectual disabilities, agree that:

- Effective: _____, the resident was admitted to the facility.
- The facility shall provide the resident with personal, medical, and habilitative services as specified in the *Medicaid Provider Manual for Intermediate Care Facilities for Persons with Intellectual Disabilities*.
- The resident (or the resident's legal representative) shall pay directly to the facility the amount of *client participation determined by DHS*. DHS shall pay the balance of the allowable payment for care directly to the facility.
- Any overpayments to the facility shall be treated in the manner specified in Item C. 2., Section II of the agreement for intermediate care facilities for persons with intellectual disabilities existing between the facility and DHS.
- Should the facility maintain the personal needs account for the resident, this function shall be performed in accordance with procedures outlined in the *Medicaid Provider Manual for Intermediate Care Facilities for Persons with Intellectual Disabilities*.
- Resident discharge or transfer shall be voluntary or otherwise justified, and may only be effected following appropriate notification and consultation with DHS, the resident (and legal representative or family), and the attending physician. The facility shall coordinate any alternate placement arrangements.
- If a resident is discharged from the facility on other than the last day of the month, a refund based on the daily payment rate must be made to the resident or the resident's legal representative of estate for any prepaid days of care not received.

By signing this contract the facility, the resident, and DHS accept all its provisions, none of which shall limit the responsibilities of the signing parties to abide by current or subsequently imposed laws, rules, and regulations.

Iowa Department of Human Services Signature	Date
Intermediate Care Facility Signature and Title	Date
Address	
Resident Signature (or Representative)	Date
Medicaid #	



Case Activity Report

Complete this form when a Medicaid applicant or member enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

1. Member Data

Name		Date Entered Facility
Social Security Number	State ID	Case Number

2. Facility Data

Provider Number/NPI Number	Facility Type:		
	<input type="checkbox"/> Nursing facility	<input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Swingbed
	<input type="checkbox"/> ICF/ID	<input type="checkbox"/> PMIC	<input type="checkbox"/> Hospice
	<input type="checkbox"/> PACE	<input type="checkbox"/> RCF	<input type="checkbox"/> MHI
Name		DHS Per Diem	
Street Address	City	State	Zip
Signature of Person Completing Form		Date Completed	
Contact Name		Contact Phone Number	

3. Level of Care

This information is determined by IME Medical Services Unit, Medicare or by a managed care contractor. For clarification, PMIC must indicate if this is PMIC mental health or PMIC substance abuse. Do not complete this section for hospice.

Level of Care	Level of Care Process:	Effective Date
	<input type="checkbox"/> IME Medical Services <input type="checkbox"/> Medicare	
	<input type="checkbox"/> Managed care <input type="checkbox"/> Utilization Board	
	<input type="checkbox"/> Out-of-state skilled preapproval	

4. Medicare Information for either Skilled Patients or Hospice Patients in Facilities

If there is any change in this coverage, please notify the county DHS office.

Do you expect this stay to be covered by Medicare?	Expected dates of Medicare coverage
<input type="checkbox"/> No <input type="checkbox"/> Yes, see dates:	_____ through _____

5. Discharge Data

Date of Discharge _____	Reason for Discharge
<u>Last Month in Facility</u> (for residents who transfer to another facility or level of care):	<input type="checkbox"/> Died
_____ Days in facility	<input type="checkbox"/> Hospital stay (less than 10 days, form is not required)
_____ Reserve bed days	<input type="checkbox"/> Transferred to another facility
_____ Non-covered days	Name _____
_____ Total billing days on claim to fiscal agent	Level of care, if known _____
	<input type="checkbox"/> Moved to new living arrangement
	Address, if available _____

If you have any questions, please contact IME Provider Services, 1-800-338-7909, locally 515-256-4609, or by email at imeproviderservices@dhs.state.ia.us.

Instructions for Preparing the Case Activity Report:

- ◆ When a current resident applies for Medicaid, complete sections 1, 2, and 3. Enter the resident's first name, middle initial, and last name as they appear on the *Medical Assistance Eligibility Card*. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- ◆ When a Medicaid applicant or member enters the facility or changes level of care, complete sections 1, 2, and 3 and, if applicable, section 4.
- ◆ When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4.
- ◆ When a Medicaid applicant or member dies or is discharged, complete sections 1, 2, and 5.
- ◆ This form must be completed within two business days of the action.
- ◆ The administrator or designee responsible for the accuracy of this information should sign in section 2.

Distribution Instructions for NFs, Hospice, Community ICF/IDs, SNFs, and Swingbed:

Mail, email or fax a copy to the DHS Centralized Facility Eligibility Unit. Keep a copy.

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 email: facilities@dhs.state.ia.us

Note: Form 470-2618, *Election of Medicaid Hospice Benefit*, must accompany this *Case Activity Report* for hospice patients.

Distribution Instructions for PMICs:

Mail, email or fax a copy to the DHS Centralized Facility Eligibility Unit. Keep a copy.

Centralized Facility Eligibility Unit – PMIC
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040 email: CSAPMIC@dhs.state.ia.us

Distribution Instructions for PACE:

Mail, email or fax a copy to the Woodbury Adult Intake Team. Keep a copy.

Woodbury Adult Intake Team
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4014 email: 97cmz2@dhs.state.ia.us

Distribution Instructions for RCFs, MHIs, and State Resource Centers:

Mail or fax a copy to your county DHS income maintenance worker. Keep a copy.



3. Services Provided Under Agreements with Outside Sources

If a service required under this manual is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care. The agreement shall:

- ◆ Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.
- ◆ Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this manual. If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment.

The facility shall ensure that outside services meet the needs of each resident.

C. APPEALS OF ADVERSE ACTIONS

Any action of the Department with respect to the facility (not the resident) which an ICF/ID believes is unwarranted or incorrect may be appealed to the director of the Department. If the appeal involves a particular resident, the resident must appeal, but may be helped by the facility or any other interested person.

This appeal process should be used only after exhausting normal administrative processes. Any person or facility wishing to appeal a Department action or decision must do so within 30 days of notification of the action or decision. Appeal requests should be directed to the office taking the action.

Information concerning appeals may be obtained by contacting:

Appeals Liaison
Department of Human Services
1305 E Walnut Street
Des Moines, IA 50319-0114

When the Department takes a decertification action for reasons unrelated to the survey report, the appeal is filed with the Department. The hearing is held by the Department of Inspections and Appeals, but the final decision is issued by the Department of Human Services.



Appeals of decertification actions not initiated by the Department are handled differently from other appeal proceedings. When the Department of Inspections and Appeals has surveyed a facility and found the facility to be in substantial noncompliance with Medicaid rules, the Department of Human Services may deny continued program certification. For decertification, the following conditions apply:

- ◆ When decertification is contemplated, the Department of Human Services shall send timely and adequate notice to the facility.
- ◆ Request for a hearing shall be made to the Department of Inspections and Appeals within 15 days of the notice of decertification.
- ◆ At any time before or after an evidentiary hearing, the Department of Inspections and Appeals will be willing to negotiate an amicable resolution or discuss the possibility of settlement with the facility owner.

When a final decision is issued, that decision is binding upon the Department of Human Services.

D. ARRANGEMENTS MADE WITH THE RESIDENT

1. Financial Participation

A resident's payment for care may include any voluntary payments made by family members toward the cost of care. The resident's member participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made.

All of a resident's income in excess of authorized exemptions is applied toward the cost of care. The resident retains \$50 of income for personal needs. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the cost of ICF/ID care for the month. The facility is responsible for collecting the resident's financial participation.



All resident income above the authorized exemption is applied to the cost of care, beginning with the first month of admission as a Medicaid resident in the following instances:

- ◆ Residents leaving the facility for the purpose of hospitalization, nursing facility care or skilled care who remain on the Medicaid program and later return to the ICF/ID
- ◆ Residents changing from private-pay status to Medicaid status while residing in an ICF/ID
- ◆ Residents transferring from an out-of-state ICF/ID to an Iowa facility

A resident who has moved from an independent living arrangement to an ICF/ID may have limited first-month member participation due to maintenance or living expenses connected with the previous living arrangement. A Department income maintenance worker determines how much of the resident's income may be protected in order to defray expenses.

It is essential that the resident, someone acting in the resident's behalf, or the administrator of the ICF/ID immediately notify the district office of the Social Security Administration and the Department's Centralized Facility Eligibility Unit when an SSI beneficiary enters the facility and when an SSI beneficiary is discharged. Use form [470-0042, Case Activity Report](#), to notify the Department.

This is necessary so that incorrect SSI payments can be avoided and overpayments or underpayments through the Medicaid program do not occur.

If a resident transfers from one ICF/ID to another during a month, any remaining financial participation shall be taken to the new facility and applied to the cost of care at that facility. Present policy concerning differential payment for reserve bed days may change the use of financial participation when residents are absent from the facility. See [Periods of Service for Which Payment Will Be Authorized](#).

Administrators should ensure that the correct amount of financial participation is collected, particularly in cases where the resident may transfer from the facility.

The Department determines member participation. The Department determines client participation and informs the facility via the Iowa Medicaid Portal Access (IMPA) system. Refer to [Informational Letter 1317](#) regarding instructions to register for access to the IMPA system. The facility is responsible to collect the client participation amount as indicated in IMPA.



2. Personal Needs Allowance

All Medicaid residents of an ICF/ID have a small income which is intended to cover the purchase of necessary clothing and incidentals. This is called the personal needs allowance.

If the resident has personal income, the first \$50 of income is retained for these personal needs and an additional amount up to \$65 is allowed from earned income only. If the resident's income is less than the personal needs allowance, the difference between the income and the personal needs allowance is usually paid to the resident through the Supplemental Security Income Program.

As its name suggests, the personal needs allowance is an allotment of money provided for the resident to spend on such personal needs and articles as the resident wishes. To the extent feasible, the resident should be encouraged to see the money as personal funds and should be managed by the resident. The resident should be encouraged to view the money as personal funds.

If the resident is unable to manage personal funds, the guardian should manage the funds to meet the personal needs of the resident.

The personal needs allowance is seen as one method of improving the quality of life for those persons needing an ICF/ID living situation. The money can serve as a way for the resident to maintain control over a segment of personal life and environment, and a way for the resident to individualize himself or herself in an institutional setting.

No Medicaid resident or responsible party shall be charged for items not specifically requested by the resident or responsible party. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.



Policy concerning the responsibility for payment of non-legend drugs and for payment of certain legend drugs not payable through Medicaid is sometimes misinterpreted by facilities and the general public. The main points of the Department's long-standing policy in this area are as follows:

- ◆ If a physician prescribes a non-legend drug by brand name, the facility is expected to provide that particular brand to the resident. The expense is shown as an audit cost to the facility.
- ◆ If a physician does not specify a brand name in an order for a non-legend drug, it is proper that the facility offer a house brand stocked by the facility. If a resident insists upon other than the house item, it is always the responsibility of the facility to make the first offer to provide any non-legend drug prescribed by a physician.
- ◆ A physician may order a prescription drug for which the Medicaid program will not make payment, since the drug is on the list of products classified by the Food and Drug Administration as lacking adequate evidence of effectiveness.

If so, the physician and resident shall be advised that Medicaid does not pay for the item and that the facility cannot accept responsibility for payment, since such non-covered drugs are not to be shown as an audit cost on the financial and statistical report. If the physician or the resident insists on the item in question, it becomes the responsibility of the resident or a responsible third party to deal with the pharmacy providing the drug.

If the personal needs fund exceeds the Medicaid eligibility limit, the person loses Medicaid eligibility until resources are within this limit as of the first moment of the first day of a month.

3. Medicare, Veterans, and Similar Benefits

All medical resources available to the resident must be used to pay for the cost of the resident's ICF/ID care. Such resources include private health or accident insurance carried by the resident, or by others on the resident's behalf, trusts set up for medical care, and services reasonably available through other publicly supported programs, such as Medicare, veterans benefits, vocational rehabilitation, etc.

When a facility receives information that not all resources available to a resident are being used, notify the Department in writing.



The following is a suggested format:

To: _____ County Department of Human Services
From: _____ (Name of Facility)
Subject: _____ (Member Name)

We have received information that this resident may:

- ◆ Be eligible for veteran's benefits
- ◆ Have other potential resources to pay for care as described below...
- ◆ Not be eligible for Medicaid because...

Send documentation to:

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kaneshville Blvd.
Council Bluffs, IA 51503-4470

Fax: (515) 564-4040
email: facilities@dhs.state.ia.us

4. Resident Care Agreement

The ICF/ID shall enter into [ICF/ID Resident Care Agreement, form 470-0374](#), with a Medicaid-eligible resident (or the resident's relative, guardian, or trustee) upon admission to the facility.

Iowa law requires that each person residing in a health care facility be covered by a contract that lists the duties, rights, and obligations of all parties. Consequently, for Medicaid residents, form 470-0374 is a three-party contract between the facility, the resident, and the Department, which will serve to meet this requirement.



E. AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS

Upon proper identification, field auditors of the Department of Inspections and Appeals or representatives of the U.S. Department of Health and Human Services shall have the right to audit billings to the Department and receipts of member participation. The audit shall ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed.

Upon proper identification, field auditors of the Department of Inspections and Appeals or representatives of Health and Human Services shall have the right to audit records of the facility to determine proper handling of personal needs funds.

The resident or family shall not be charged for such items as Chux, toilet paper, hospital gowns, or other maintenance items, since these items are properly included in the computation of the audit cost.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility.

On the auditor's recommendation, the Department shall request repayment of sums inappropriately billed to the Department or collected from the resident. Repayment shall be made by the facility either to the Department or to the resident involved.

The facility has 60 days to review the audit and repay the requested funds or present supporting documentation which shows that the requested refund amount, or part of it, is not justified.

When the facility fails to comply, the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25% of the average of the last six monthly payments to the facility. The withholding shall continue until the entire refund is recovered.

In the event the audit results indicate significant problems, they may be referred to the attorney general's office for whatever action is appropriate.

When exceptions are taken during an audit which are similar to the exceptions taken in a previous audit, the Department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75% of the current payment rate.



F. CERTIFICATION PROCESS

A public or private facility wishing to obtain a provider agreement to serve Medicaid-eligible residents in an ICF/ID must proceed in the manner set forth below.

1. Certification of Need

Service providers seeking Medicaid certification for ICF/ID conversion or construction shall address the following requirements of the Iowa Medicaid program before filing certificate of need applications.

a. Inclusion in the Community

Written plans shall demonstrate individualized consumer access to and utilization of service and resources typically used by other residents of the area in which the proposed facility is to be located. The distance, availability of transportation, convenience of parking and physical accessibility to people with a range of disabilities shall be considered.

The program name and home location must blend with characteristics of other homes in the area. There must be a broad range, number, and type of opportunities for social activities and interactions for individuals or groups small enough in size to be assimilated into the activity.

b. Family-Scale Size

Written plans shall demonstrate that the proposed facility will meet family-scale size conditions of two to eight persons per environment or be a size that would be common to the area or neighborhood in which the facility is proposed to be located.

c. Location in Community Residential Neighborhood

If the proposed facility is located within a community residential neighborhood, written plans shall demonstrate the use of an existing structure or new construction which is consistent with the size and style of the neighborhood.



The proposed facility shall not be located contiguous to another licensed health care facility or residential program for persons with disabilities. The number of residential programs for persons with disabilities in a community should be relative to community size, so that the number of programs is in keeping with the number, types, and range of services and supports in the community.

If the proposed facility is located outside a community residential neighborhood, written plans shall demonstrate how these conditions shall be met and shall explain why a location outside a community residential neighborhood would be beneficial for the particular consumer population to be served.

Written plans shall be submitted to the following addresses:

Iowa Medicaid Enterprise
Bureau of Long-Term Care
100 Army Post Road
Des Moines, IA 50315

Health Facilities Council
Iowa Department of Public Health
321 E 12th Street
Des Moines, IA 50319

The Health Facilities Council shall consider the requirements set forth in this rule when reviewing certificate of need applications.

2. License

To participate in the Medicaid program, a facility shall be licensed as an intermediate care facility for the intellectually disabled by the Department of Inspections and Appeals (DIA) under the Department of Inspections and Appeals rules 481 IAC Chapter 64.

A conditional license can be granted a new facility when there is a finding that in all probability the facility will be in full compliance upon commencement of operations.

The DIA shall grant the applicant a conditional license based upon information supplied by the applicant and the approved facility plans and construction.



3. Provider Agreements

An ICF/ID must be certified by the DIA for participation as an ICF/ID before a provider agreement may be issued. The effective date of a provider agreement may not be earlier than the date of certification.

For facilities without deficiencies, the provider agreement shall be issued for a period not to exceed 15 months. The agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the Department may:

- ◆ Elect to execute an agreement for a term less than the period of certification,
- ◆ Elect not to execute an agreement, or
- ◆ Cancel an agreement.

For facilities with deficiencies, a new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies, up to a period of 15 months. Or a new provider agreement may be issued for a period of up to 15 months, subject to automatic cancellation 60 days following the scheduled date for correction, unless:

- ◆ Required corrections have been completed, or
- ◆ The survey agency finds and notifies the Department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

There will be no new agreement if the facility continues to be out of compliance with the same standards at the end of the term of agreement.

The Department may, for good cause, elect not to execute an agreement. Good cause is defined as a continued or repeated failure to operate an ICF/ID in compliance with Medicaid rules.



Iowa Medicaid - Provider Enrollment Application

Please complete and return this Provider Enrollment Application along with a signed Provider Agreement. We appreciate your effort in providing this information and your participation in the Iowa Medicaid Program. Thank you!

Questions in completing this application: Iowa Medicaid Enterprise Provider Services Unit at (800) 338-7909 or (515) 256-4609.

Section A: General Information

Practice Information

1. Legal Name (as it appears on your income tax return)

2. **Taxpayer Identification Number (TIN):** Enter the nine-digit Federal Employer Identification Number (FEIN) of the business OR the Social Security Number (SSN) of the individual for which this application is being filed. This is the number under which all income will be reported to the Internal Revenue Service for Federal 1099 purposes.

Indicate type: FEIN or SSN (check one) **List the number here:**

3. For Healthcare Providers: Primary Organizational NPI

4a. Primary Physical Location*

4b. Suite Number

4c. City

4d. State

4e. Zip Code

5. County

6. Phone Number

7. Fax Number

8a. Check Appropriate Box

Individual/Sole Proprietor Corporation Partnership Other _____

8b. Is your organization a participating "340B" provider? Yes No

9a. Mailing Address (Medicaid-related correspondence, if different from above)

9b. City

9c. State

9d. Zip Code

10. Email Address for Medicaid-Related Correspondence

Payment Information

11a. Payment Method: *Electronic Funds Transfer **Debit Card

NOTE: *EFT REQUIRES COMPLETION OF AUTHORIZATION FORM (470-4202)

**** Debit Card is only an option if an individual is doing business under a Social Security Number (in box 2)**

11b. Pay-to Address (only used for debit card mailing and 1099s)

Address

Suite Number

City

State

Zip Code

For Pharmacies Only

12a. Enter the National Council for Prescription Drug Programs (NCPDP) Number

12b. Acknowledgement for pharmacies located outside the state of Iowa: According to the Iowa Administrative Code 657-19.2(155A), a pharmacy located outside of Iowa shall apply for and obtain, pursuant to provisions of 657-8.35(155A), a nonresident pharmacy license from the board prior to providing prescription drugs, devices, or pharmacy services to an ultimate user in this state. Please complete the acknowledgement below.

Check one:

- The rule listed above does not apply to the pharmacy that is applying to be a provider with the Iowa Medicaid Program.
- The rule listed above does apply to this pharmacy; please attach a copy of the Iowa nonresident pharmacy license.

For Independent Lab Only

13a. 10-digit Clinical Laboratory Improvement Amendments (CLIA) Number

13b. Effective Date

13c. Termination Date

14. Leave Blank (For Future Use)

15. Leave Blank (For Future Use)

Section B: Organizational Data – Master Provider Listing

Use this list to identify your provider type code. Enter the type code in box 16.

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification document(s) as indicated on the list below.
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.
- **Categories in bold below are considered Moderate or High risk and subject to a pre/post enrollment site visit and other enhanced screening requirements.**

Type Code	Category	Primary Certification	Additional Certification
1	General Hospital	CMS certification	License *CLIA
2	Physician MD	License	*CLIA
3	Physician DO	License	*CLIA
4	Dentist	License	
5	Podiatrist	License	
6	Optometrist	License	
7	Optician		
8	Pharmacy	License	Medicare enrollment
9	Home Health Agency	CMS certification	
10	Independent Lab	CLIA certificate	Medicare enrollment
11	Ambulance	License	
12	Medical Supplies	Medicare enrollment	
13	Rural Health Clinic	CMS certification	
14	ESRD	CMS certification	
15	Physical Therapist	License	Medicare enrollment
16	Chiropractor	License	Medicare enrollment
17	Audiologist	License	
18	Skilled Nursing Facility	DIA/CMS certification	License
19	Rehab Agency	CMS certification	
20	Intermediate Care Facility	DIA/CMS certification	License
21	Community Mental Health	Bureau of Community Services	
22	Family Planning	Dept Public Hlth approval	
23	Residential Care Facility	License (DIA)	
25	ICF/ID State	DIA/CMS certification	License
26	Mental Hospital	CMS certification	License
27	Community-Based ICF/ID	DIA/CMS certification	License
29	Psychologist	License	NRHSPP cert
30	Screening Center	Dept Public Health approval	
31	Hearing Aid Dealer	License	
32	Occupational Therapists	License	Medicare enrollment
34	Orthopedic Shoe Dealer		
35	Maternal Health Center	DHS approval	
36	Ambulatory Surgical Center	CMS certification	
38	Certified Nurse Midwife	License	Board cert *CLIA
39	Birthing Center	DHS approval	
40	Area Education Agency	IA Dept of Education Agreement	
41	Psych Medical Inst. Children (PMIC)	DIA license	
42	Case Manager	DHS approval	
44	CRNA	License	Board cert
45	Hospice	CMS certification	*CLIA
48	Clinical Social Worker	License	Medicare enrollment
49	Federal Qualified Health Center (FQHC)	CMS certification	HRSA grant
50	Nurse Practitioner	License	Board cert *CLIA
52	Nursing Facility - Mentally Ill	DIA/CMS certification	License
54	County Relief	DHS approval	
55	Lead Investigation Agency	Dept Public Hlth approval	
56	Local Education Agency	IA Dept of Education Agreement	
57	Early Access Service Coordinator	IA Dept of Education Agreement	
58	PACE	CMS PACE agreement	
62	Behavioral Health	License	
63	Behavioral Hlth Intervention Svcs (BHIS)	Magellan enrollment welcome letter	
64	Habilitation Services	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
69	Independent Speech Pathologist	License	
71	Health Home	TransforMED self-assessment or NCQA recognition	Health home agreement
72	Public Health Agency	Board of Health Jurisdiction letter	
76	Accountable Care Organization		ACO agreement
99	Waiver	HCBS application required	

Please copy this information and complete one for each individual professional and institutional category that is part of this business and subject to the Iowa Medicaid provider agreement.

16. Type Code		17. Licensee or DBA Name		18a. Tax ID (for billing entity)	
18b. Social Security Number		18c. Date of Birth		19. Requested Effective Date of Enrollment*	
20a. Primary Service Address		City		State	Zip
20a1. Primary Address Phone Number		Fax		Email	
20b. Additional Service Address		City		State	Zip
20b1. Additional Service Address Phone Number		Fax		Email	
20c. Additional Service Address*		City		State	Zip
20c1. Additional Service Address Phone Number		Fax		Email	
21. Pay-to Address		City		State	Zip
22. Mailing Address		City		State	Zip
23a. National Provider Identifier (NPI)			23b. Taxonomy Code (if applicable)		
24a. Primary Professional License or Certification Number – Please attach a copy of your license/certification documents.			24b. 10-Digit CLIA Number		24c. State Issued
24d. Initial Effective Date	24e. Current Expiration Date		24f. CLIA Effective Date	24g. CLIA Expiration Date	
25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.					
26. Primary Specialty* (if applicable)			27. Secondary Specialty* (if applicable)		
28. Has there ever been disciplinary action against this provider's license by a licensing board in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please attach an explanation.					

29a. Has the provider ever been sanctioned by Medicare or any state health program?

Yes No If "Yes," please attach an explanation.

29b. Has the provider been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or the Title XX services program?

Yes No If "Yes," please attach an explanation.

Payment Method Information: EFT is required when billing under a Federal Tax ID Number. Debit Card is only an option if an individual is doing business under a Social Security Number.

Group Linkage Information*

Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:

30a. Organizational NPI

30b. Organizational Taxonomy

30c. Organization Location Zip

31. Are you currently enrolled in another state's Medicaid/CHIP program?

Yes No If "Yes," please list the state and what program you are enrolled in:

32. Are you currently enrolled with Medicare? Yes No

The provider certifies that the information submitted on this enrollment is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

33a. Printed Name of Legal Entity

33b. Printed Name and Title of Authorized Signatory

33c. Signature of Authorized Signatory

33d. Signature Date

**Please mail this completed Provider Application and all applicable attachments to:
Iowa Medicaid Enterprise, Attn: Provider Enrollment,
PO Box 36450, Des Moines, Iowa 50315**

Instructions for Completing the Iowa Department of Human Services Iowa Medicaid Provider Enrollment Application

- Please type or print information.
- If any field is not applicable, please enter N/A.
- If extra space is needed to answer any questions, please attach any additional pages.
- An incomplete form may delay the approval of this application.
- Please do not complete shaded areas.

Section A: General Information

This section is completed only for Tax IDs enrolling with Iowa Medicaid for the first time. **(See note on page 8.)**

Practice Information

1. Enter the full name of the practice as it appears on your income tax return.
2. Enter the nine-digit Federal Employer Identification Number (FEIN) of the business or the Social Security Number (SSN) of the individual for which this application is being filed. **Note:** If you are adding an individual to an existing group, enter the FEIN of the group. Check the box to indicate which number you are listing.
3. Enter your Primary Organizational NPI. This is the NPI you will use to bill Iowa Medicaid. If you are not a "health care provider" as defined at 45 C.F.R. §160.103, please complete the Atypical Declaration Form.
4. Primary physical location:
 - a. Enter the street number of your primary office location.
 - b. Enter your suite or apartment number.
 - c. Enter the city name.
 - d. Enter the state name.
 - e. Enter the zip code.
5. Enter the county name.
6. Enter the phone number.
7. Enter the fax number.
8. Check the box that best matches the type of business being enrolled:
 - a. Check the appropriate box.
 - b. The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. A 340B provider is able to acquire drugs through that program at significant discounted rates. Because of the discounted acquisition cost on these drugs, such are not eligible for the Medicaid drug rebate. State Medicaid programs are obligated to assure that rebates are not claimed on these drugs. Please refer to Informational Letter 699 for more information.
9. Mailing address for Medicaid-related correspondence:
 - a. Enter the mailing address if it is different from the address provided in box 4.
 - b. Enter the city name.
 - c. Enter the state name.
 - d. Enter the zip code.
10. Enter the email address for Medicaid-related correspondence.

Payment Information

11. Payment method:
 - a. Check one box: An Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business. A debit card is only an option if an individual is doing business under a Social Security Number in box 2.
 - b. Enter the pay-to address: This address is used for mailing of the debit card and 1099s.

Pharmacies Only

12. Pharmacies only enter:
 - a. The National Council for Prescription Drug (NCPDP) number.
 - b. Acknowledgement: If you are a pharmacy that is located outside of the state of Iowa, check one box.

Independent Labs Only

13. Independent labs enter:
 - a. The 10-digit Clinical Laboratory Improvement Amendments (CLIA) certification code. Please attach a copy of your current CLIA certification.
 - b. The effective date.
 - c. The termination date.

Note: If you are enrolling more than one location, please attach CLIA certification for each location.

14. Leave blank (For Future Use)
15. Leave blank (For Future Use)

Section B: Organizational Data - Master Provider Listing

Page 3 is a listing of Iowa Medicaid provider types. Use this list to identify your provider type code and to determine whether additional certifications are required for enrollment. Enter the type code in box 16 of the application. Attach the required additional certification to your application.

Page 4 is used to enroll individual/group professional or institutional categories (from the listing) that are part of the business and subject to the Iowa Medicaid Provider Agreement. Additional copies of page 4 must be completed for each individual within the organization who is being enrolled.

Note: Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

16. Enter the type code from the list on page 3.
17. Enter the licensee or "doing-business-as" name. For individuals that are part of an organization, list the individual's name.
18.
 - a. Tax ID: Enter the Tax ID of the entity to which payment will be made.
 - b. Social Security Number (SSN): Enter the nine-digit SSN for the individual entered in box 17. No entry is required if it is an organization.
 - c. Date of birth: Enter the DOB for the individual entered in box 17. No entry is required if it is an organization.
19. Enter the requested effective date of the enrollment.
20. Enter the physical address of the service location. Note that each service location must be listed for which medical records are stored, or for where MediPASS patients are seen. Make additional copies of page 4 as needed to indicate more than three service locations.
 - a. Enter the primary service address.
 - a1. Enter the phone number, fax number, and email address of the service location for which the application is being made.
 - b. Enter an additional service location, if any.
 - b1. Enter the phone number, fax number, and email address of the additional service location.
 - c. Enter a third additional service address, if any.
 - c1. Enter the phone number, fax number, and email address of the additional service location.
 21. Enter the pay-to address. The address is only needed if the NPI being enrolled will be the pay-to.

Note: Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business and the NPI in box 23a will be the pay-to NPI. This address is used for mailing the debit card and 1099s.

22. Enter the mailing address.
23. Enter the National Provider Identifier (NPI).
 - a. Enter the NPI of the individual or organization named in box 17.
 - b. Enter the taxonomy code of the billing provider. **Note:** If the individual listed in box 17 is a member of a group, this box is not required and may be left blank.
24. Primary professional license or certification number:
 - a. Enter the primary professional license or certification number and attach a copy of your license or certification documents, as listed on page 3 for the type code listed in box 16.
 - b. Enter the 10-digit Clinical Laboratory Improvement Amendments (CLIA) Certification code. If you are providing lab services which require CLIA certification, submit a copy of your current CLIA certification.
 - c. Enter the state in which this license or certification was issued.
 - d. Enter the initial effective date of the license listed in box 24a.
 - e. Enter the license expiration date for the license listed box 24a.
 - f. Enter the effective date for the CLIA certificate listed in box 24b.
 - g. Enter the expiration date for the CLIA certificate listed in box 24b.
25. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A. If the provider is a physician, this must be entered.
26. For physicians only: Enter the primary specialty, if applicable.
27. For physicians only: Enter the secondary specialty, if applicable.
28. Check the Yes box if there has ever been disciplinary action against this provider's license by a licensing board in any state and attach an explanation. Check No if there has not been any disciplinary action.
29.
 - a. Check the Yes box if Medicare or any state health program has ever sanctioned the provider and attach an explanation. Check No if there have not been sanctions.
 - b. Check the Yes box if convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program and attach an explanation. Check No if there has not been any convictions.
30. Group linkage information: If the individual referenced in box 17 will be linked to a group, enter the group information here. **Note:** If the NPI, taxonomy, and zip code provided do not match a group already enrolled in Iowa Medicaid, the application will be returned for corrections. Page 4 must be completed to enroll a group.
 - a. Enter the organization NPI with which the individual profession is associated. This is the NPI under which payments will be made.
 - b. Enter the organizational taxonomy code.
 - c. Enter the organizational zip code.
31. Check Yes or No if you are enrolled in another state's Medicaid or CHIP program. If yes, please list the states and the program.
32. Check Yes or No if you are enrolled with Medicare.
33. Certification:
 - a. Enter the printed name of the legal entity.
 - b. Enter the printed name and title of the authorized signer.
 - c. The authorized signatory signs here.
 - d. Enter the date of the signature.

Note: If you are a new Tax ID enrolling with Iowa Medicaid for the first time, you must complete the Ownership and Control Disclosure online before your Tax ID will be activated. To start this task it is necessary to designate a contact person for your organization using form 470-5112. This will provide access to the online tool used to disclose ownership and control.

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART 1 - TO BE COMPLETED BY STATE SURVEY AGENCY

<p>1. MEDICARE/MEDICAID PROVIDER NO. <input style="width:100%;" type="text"/> L1</p>	<p>3. NAME AND ADDRESS OF FACILITY <input style="width:100%; height: 20px;" type="text"/> L3</p>	<p>4. TYPE OF ACTION: 1. INITIAL SURVEY 2. RECERTIFICATION 3. TERMINATION 4. CHOW 5. VALIDATION 6. COMPLAINT 7. ON SITE VISIT 8. TERMINATION OF ICF BEDS 9. OTHER <input type="checkbox"/> L8</p>
<p>2. STATE VENDOR OR MEDICAID NO. <input style="width:100%; height: 20px;" type="text"/> L2</p>	<p>STATE <input style="width: 40px; height: 20px;" type="text"/> L5</p>	
<p>5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP <input style="width:100%; height: 20px;" type="text"/> M M D D Y Y L9</p>	<p>7. PROVIDER/SUPPLIER CATEGORY 01 HOSPITAL 04 SNF 09 ESRD 14 CORF 02 SNF/ICF (DUALLY CERTIFIED) 05 HHA 10 ICF 15 ASC 03 SNF/ICF (DISTINCT PART) 06 LAB 11 IMR 16 HOSPICE 07 X-RAY 12 RHC <input style="width: 40px; height: 20px;" type="text"/> 08 OPT/SF 13 PTIP L7</p>	
<p>6. DATE OF SURVEY <input style="width:100%; height: 20px;" type="text"/> M M D D Y Y L34</p>	<p>9. FISCAL YEAR ENDING DATE <input style="width: 40px; height: 20px;" type="text"/> M M D D L35</p>	
<p>8. ACCREDITATION STATUS <input type="checkbox"/> 0 UNACCREDITED 1 JCAHO <input type="checkbox"/> 2 AOA 3 OTHER L10</p>	<p>10. THE FACILITY IS CERTIFIED AS: A. IN COMPLIANCE WITH PROGRAM REQUIREMENTS COMPLIANCE BASED ON: <input type="checkbox"/> 1 - ACCEPTABLE POC B. NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS: A/B (IF APPLICABLE CODES 1-9) <input style="width: 60px; height: 20px;" type="text"/> L12</p>	
<p>11. LTC PERIOD OF CERTIFICATION (a) From <input style="width: 60px; height: 20px;" type="text"/> (b) To <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y</p>	<p>AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS: <input type="checkbox"/> 2 - TECHNICAL PERSONNEL <input type="checkbox"/> 6 - SCOPE OF SERVICE LIMITED <input type="checkbox"/> 3 - 24HR RN <input type="checkbox"/> 7 - MEDICAL DIRECTOR <input type="checkbox"/> 4 - 7-DAY RN (RURAL SNF) <input type="checkbox"/> 8 - PATIENT ROOM <input type="checkbox"/> 5 - LIFE SAFETY CODE <input type="checkbox"/> 9 - BEDS PER ROOM</p>	
<p>12. TOTAL FACILITY BEDS <input style="width: 60px; height: 20px;" type="text"/> L18</p>	<p>14. LTC CERT. BED BREAK DOWN A 18 SNF B. 18/19 SNF C. 19 SNF D. ICF E. IMR F. SNF/ICF DUALLY CERT. <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> L37 L38 L39 L42 L43 L40</p>	
<p>13. TOTAL CERTIFIED BEDS <input style="width: 60px; height: 20px;" type="text"/> L17</p>	<p>15. FACILITY MEETS 1861(e)(1) or 1861(j)(1) <input type="checkbox"/> 1 - YES <input type="checkbox"/> 2 - NO L15</p>	
<p>16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE IN REMARKS) <input style="width: 100%; height: 40px;" type="text"/></p>		

<p>17. SURVEYOR SIGNATURE <input style="width: 100%; height: 20px;" type="text"/> M M D D Y Y L19</p>	<p>18. STATE SURVEY AGENCY APPROVAL <input style="width: 100%; height: 20px;" type="text"/> M M D D Y Y L20</p>
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PART II - TO BE COMPLETED BY CMS REGIONAL OFFICE OR SINGLE STATE AGENCY

<p>19. DETERMINATION OF ELIGIBILITY 1 - FACILITY IS ELIGIBLE TO PARTICIPATE 2 - FACILITY IS NOT ELIGIBLE TO PARTICIPATE <input type="checkbox"/> L21</p>	<p>20. COMPLIANCE WITH CIVIL RIGHTS ACT <input type="checkbox"/></p>	<p>21. 1 - STATEMENT OF FINANCIAL SOLVENCY (CMS-2572) 2 - OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT (CMS 1513) <input type="checkbox"/> 3 - BOTH OF THE ABOVE</p>
<p>22. ORIGINAL DATE OF PARTICIPATION <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L24</p>	<p>23. LTC AGREEMENT BEGINNING DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L41</p>	<p>24. LTC AGREEMENT ENDING DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L25</p>
<p>25. LTC EXTENSION DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L27</p>	<p>27. ALTERNATIVE SANCTIONS A. SUSPENSION OF ADMISSIONS <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L44 B. RESCIND SUSPENSION DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L45</p>	
<p>28. TERMINATION DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L28</p>	<p>29. INTERMEDIARY/CARRIER NO. <input style="width: 60px; height: 20px;" type="text"/> L31</p>	<p>26. TERMINATION ACTION VOLUNTARY 1 - MERGER, CLOSURE 2 - DISSATISFACTION WITH REIMBURSEMENT 3 - RISK OF INVOLUNTARY TERMINATION 4 - OTHER REASON FOR WITHDRAWAL INVOLUNTARY 5 - FAILURE TO MEET HEALTH/SAFETY 6 - FAILURE TO MEET AGREEMENT OTHER 7 - PROVIDER STATUS CHANGE <input type="checkbox"/> L30</p>
<p>31. RO RECEIPT OF CMS-1539 <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L32</p>	<p>30. REMARKS <input style="width: 100%; height: 40px;" type="text"/></p>	<p>32. DETERMINATION APPROVAL DATE <input style="width: 60px; height: 20px;" type="text"/> M M D D Y Y L33</p>
<p>DETERMINATION APPROVAL</p>		



The Department may at its option extend an agreement with a facility for two months under either of the following conditions:

- ◆ The health and safety of the residents will not be jeopardized thereby, and, the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.
- ◆ It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

When it becomes necessary to cancel or refuse to renew a Medicaid provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents. See also [APPEALS OF ADVERSE ACTION](#).

4. Survey and Certification

The procedures to be followed in certifying a facility as meeting Medicaid requirements involve the facility, the Department of Inspections and Appeals (DIA), and the Department of Human Services. Before a provider agreement may be issued, the DIA must recommend certification as an ICF/ID, and the Department must certify the facility as a Medicaid vendor.

All survey procedures and the certification process shall be in accordance with the U.S. Department of Health and Human Services publication "Providers Certification State Operations Manual." The necessary steps leading to certification and issuance of a provider agreement for an existing facility are as follows:

- ◆ The facility shall request an application form from the Department.
- ◆ The Department shall transmit [Iowa Medicaid – Provider Enrollment Application, form 470-0254](#), and a provider manual to the facility. The facility shall complete its portion of the application form and submit it to the Department.
- ◆ The Department shall review the application form and retain it until the DIA completes the *Medicare/Medicaid Certification and Transmittal*, CMS-1539. Click [here](#) to view a sample of the form online.
- ◆ DIA schedules and completes a survey of the facility in conjunction with the Fire Marshal's office. At the time of initial survey for a new facility, the applicant must meet as many physical, administrative, and service contract requirements as possible. The applicant should plan on meeting all other requirements for full compliance including those for staff, services, and operations for the residents at the scheduled resurvey.



The initial survey of the facility shall be for the purpose of determining what recommended limited-term (less than 15 months) provider agreement should be entered into with the applicant. In the event the facility is to be recommended for limited or conditional certification, a resurvey shall occur no later than 30 days before the expiration of the facility's certification. At that time, survey for full compliance for recertification shall occur.

- ◆ The DIA notifies the applicant of any deficiencies and asks for a plan for correction of the deficiencies. In the event the facility is not to be recommended for limited or conditional certification, the DIA shall notify the applicant regarding reasons for its negative recommendations. The applicant shall then arrange for a resurvey by the DIA to occur when the objections which caused the negative recommendations to be made are removed.
- ◆ The facility shall submit a plan of correction within 10 days after receipt of the written statement of deficiencies from the DIA Health Facilities Division. The DIA must approve this plan before the facility can be certified.
- ◆ The DIA evaluates the survey findings and the full compliance plan of correction, and either recommends the facility for certification as an ICF/ID or recommends denial of certification. The date of certification will be the date of approval for the plan of correction.

If the DIA survey indicated deficiencies in the areas of American National Standards Institution, Life Safety Code, or environment and sanitation, a timetable detailing corrective measures shall be submitted to the DIA before a provider agreement can be issued. This timetable will not exceed two years from the date of initial certification and will detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances:

- The DIA determines that the facility can make corrections within the two-year period.
- During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.
- The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.



- ◆ When certification is recommended, the DIA notifies the Department recommending terms and conditions of a provider agreement.
- ◆ The Department reviews the certification data and:
 - Transmits the provider agreement as recommended, or
 - Transmits the provider agreement for a term less than recommended by the DIA or elects not to execute an agreement.

G. MEDICAID ELIGIBILITY

See [CHAPTER II. MEMBER ELIGIBILITY](#) for rules regarding Medicaid eligibility.

1. Application Procedure

Financial eligibility for Medicaid is determined by the Department Centralized Facility Eligibility Unit (CFEU) under rules established by the Department. Facilities should advise persons needing help with the costs of medical care to contact the Department office in the county in which they reside.

Persons whose monthly income indicates they would be eligible for SSI must apply for the SSI program at the district office of the Social Security Administration serving the area in which the facility is located. (After the month of entry to the facility, only persons with a monthly income less than \$50 need to apply for SSI.)

Persons whose income is over SSI standards must apply to the Department. Such people, commonly referred to as persons in the "300% group," are:

- ◆ Financially eligible for Medicaid in a medical facility providing monthly income is not in excess of 300% of SSI income limits, and
- ◆ Resources are within SSI limits.

Eligibility requires a 30-consecutive-day period of residence in a medical institution. A resident may have been in more than one facility during the month or needed more than one level of care but must have been in a medical institution during the 30-day period. Residents whose deaths occur during the 30-consecutive-day period of residency will be considered eligible if there was continuous residency.



The Department predetermines Medicaid eligibility for persons having monthly income of \$50 or more. For persons with monthly income of less than \$50, redetermination of eligibility is done by the district office of the Social Security Administration.

2. Continued Stay Reviews

Continued stay reviews are the responsibility of the Iowa Medicaid Enterprise (IME). Continued stay reviews are performed at least yearly. Their purpose is to determine if the resident continues to need the ICF/ID level of care.

3. Eligibility for Services

Contact the Iowa Medicaid Enterprise (IME) on, or preferably before, admission of a resident who is expected to be financially eligible for Medicaid. Also contact IME when a resident who has been admitted on private pay decides to apply for Medicaid. (The IME reviews ICF/ID admissions and transfers only when documentation is provided which verifies a referral from a case management program.)

The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

- ◆ Diagnoses; summaries of present medical; social and, where appropriate, developmental findings; medical and social family history; mental and physical functional capacity; prognoses; range of service needs; and amounts of care required.
- ◆ An evaluation of the resources available in the home, family, and community.
- ◆ An explicit recommendation with respect to admission (or in the case of persons who make application while in the facility, with respect to continued care in the facility).
- ◆ Where it is determined that ICF/ID services are required by a person whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.



- ◆ An individual plan for care, which shall include:
 - Diagnosis, symptoms, complaints or complications indicating the need for admission;
 - A description of the functional level of the resident;
 - Written objective;
 - Orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives;
 - Plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.
- ◆ Written reports of the evaluation and the written individual plan of care, which shall be delivered to the facility and entered in the resident's record at the time of admission or, in the case of persons already in the facility, immediately upon completion.

Medicaid-eligible persons may be admitted to an ICF/ID upon the certification of a licensed physician of medicine or osteopathy that there is a necessity for care at the facility. Medicaid payment will be made for ICF/ID care only upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the IME Medical Services Unit.

a. Placement Approved

When placement has final approval of the Department, payment will be authorized retroactive to the date of the resident's admission to the facility, if appropriate.

The beginning date of eligibility shall be no more than 90 days before the first day of the month in which application was filed with the Department. Eligibility can be granted retroactively for the three months before application, provided that eligibility existed at that time.



b. Placement Not Approved

Denial decisions are made in writing and sent to the member, the attending physician, the case manager, and the facility.

Upon notice of disapproval, the facility should put the resident's discharge plan into effect, in cooperation with the resident and the resident's family. A county office worker will be contacting the facility to monitor the progress made in effecting the discharge plan.

H. PHYSICAL ENVIRONMENT

The facility shall provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately-equipped and sound-treated areas for hearing and other evaluations conducted in the facility) to enable staff to provide residents with needed services as required by this manual and as identified in each resident's individual program plan.

1. Bedrooms

Bedrooms shall be rooms that have at least one outside wall. Each bedroom shall have direct outside ventilation by means of windows, air conditioning, or mechanical ventilation. If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the resident. The window shall be no more than 44 inches measured to the window sill above the floor. If the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, the window must be no more than 36 inches measured to the window sill above the floor.

Bedrooms shall accommodate no more than four residents, unless granted a variance. DIA may grant a variance from the limit of four residents per room only if a physician, who is a member of the interdisciplinary team and who is a qualified intellectual disability professional, certifies that each additional resident is so severely medically impaired as to require direct and continuous monitoring during sleeping hours. The certifying physician shall document the reasons why housing in a room of four or fewer persons would not be medically feasible.



Bedrooms shall be equipped with or located near toilet and bathing facilities. Multiple-resident bedrooms must measure at least 60 square feet per resident. Single rooms must measure at least 80 square feet. In all facilities initially certified or in buildings constructed or with major renovations or conversions, bedrooms shall have walls that extend from floor to ceiling.

The facility shall provide each resident with:

- ◆ A separate bed of proper size and height for the convenience of the resident
- ◆ A clean, comfortable mattress and bedding appropriate to the weather and climate
- ◆ Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident
- ◆ Suitable storage space, accessible to residents, for personal possessions such as televisions, radios, prosthetic equipment, and clothing
- ◆ Adequate clean linen and dirty linen storage areas

The facility shall provide space and equipment for daily out-of-bed activity for all residents who are not yet mobile, except those who have a short-term illness or those few residents for whom out-of-bed activity is a threat to health and safety.

2. Disaster Plans and Drills

The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions. Drills shall ensure that all personnel on all shifts, including live-in and relief staff, are trained to perform assigned tasks, and are familiar with the use of the facility's fire protection features.

The facility shall actually evacuate residents during at least one drill each year on each shift and make special provisions for the evacuation of residents with physical disabilities. During fire drills, residents may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.



The facility shall:

- ◆ File a report and evaluation on each evacuation drill;
- ◆ Evaluate the effectiveness of emergency and disaster plans and procedures;
- ◆ Investigate all problems with evacuation drills, including accidents; and
- ◆ Take corrective action.

3. Resident Bathrooms

The facility shall provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the residents. The facility shall provide for individual privacy in toilets, bathtubs, and showers.

4. Safety

The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations, and codes pertaining to health, safety, and sanitation.

The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to residents.

In areas of the facility where residents who have not been trained to regulate water temperature are exposed to hot water, the facility shall ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases. The facility shall implement successful corrective action in affected problem areas. The facility shall maintain a record of incidents and corrective actions related to infections. The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with residents and their food.



The facility shall have floors that have a resilient, nonabrasive, and slip-resistant surface. If the area used by residents is carpeted and serves residents who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor, the carpeting shall be nonabrasive. Exposed floor surfaces and floor coverings shall promote mobility in areas used by residents and promote maintenance of sanitary conditions.

The facility shall remove or cover interior paint or plaster containing lead so that it is not accessible to residents. Lead-free paint shall be used inside the facility.

Except as specified in this manual, the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference. DIA may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings, as permitted by the LSC.

A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

For facilities that meet the LSC definition of a health care occupancy, the Health Care Financing Administration may waive specific provisions of the LSC for a period it considers appropriate, if the waiver would not adversely affect the health and safety of the residents and rigid application of specific provisions would result in an unreasonable hardship for the facility.

DIA may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's residents.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard, as long as the facility continues to remain in compliance with that edition of the code.

For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the DIA may apply the state's fire and safety code as specified above.



I. PROTECTION OF RESIDENTS' RIGHTS

The facility shall ensure the rights of all residents. Therefore the facility shall:

- ◆ Inform each resident, parent (if the resident is a minor), or legal guardian of the resident's rights and the rules of the facility.
- ◆ Inform each resident, parent (if the resident is a minor), or legal guardian, of the resident's:
 - Medical condition,
 - Developmental and behavioral status,
 - Attendant risks of treatment, and
 - Right to refuse treatment.
- ◆ Allow and encourage individual residents to exercise their rights as residents of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.
- ◆ Allow individual residents to manage their financial affairs and teach them to do so to the extent of their capabilities.
- ◆ Ensure that residents are not subjected to physical, verbal, sexual, or psychological abuse or punishment.
- ◆ Ensure that residents are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.
- ◆ Provide each resident with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.
- ◆ Ensure that residents are not compelled to perform services for the facility and ensure that residents who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.
- ◆ Ensure residents the opportunity to communicate, associate, and meet privately with individuals of their choice, and to send and receive unopened mail.
- ◆ Ensure that residents have access to telephone with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.



- ◆ Ensure residents the opportunity to participate in social, religious, and community group activities.
- ◆ Ensure that residents have the right to retain and use appropriate personal possessions and clothing, and ensure that each resident is dressed in the resident's own clothing each day.
- ◆ Permit a husband and wife who both reside in the facility to share a room.

The facility shall establish and maintain a system that ensures a full and complete accounting of residents' personal funds entrusted to the facility on behalf of residents and precludes any commingling of resident funds with facility funds or with the funds of any person other than another resident. The resident's financial record shall be available on request to the resident, parent (if the resident is a minor), or legal guardian.

1. Communication with Residents, Parents, and Guardians

The facility shall promote participation of parents (if the resident is a minor) and legal guardians in the process of providing active treatment to a resident, unless their participation is unobtainable or inappropriate. The facility shall answer communications from residents' families and friends promptly and appropriately. The facility shall promptly notify the resident's parents or guardian of any significant incidents or changes in the resident's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

The facility shall promote visits by persons with a relationship to the resident (such as family, close friends, legal guardians, and advocates) at any reasonable hour, without prior notice. This is consistent with the right of that resident's and other residents' privacy, unless the interdisciplinary team determines that the visit would not be appropriate. The facility shall promote visits by parents or guardians to any area of the facility that provides direct resident care services to the resident, consistent with the rights of that resident and other residents' privacy.

The facility shall promote frequent and informal leaves from the facility for visits, trips, or vacations.



2. Health Care Services

The facility shall furnish, maintain in good repair, and teach residents to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the residents.

a. Dental Services

The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each resident from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the resident's oral condition, shall be performed no later than one month after admission to the facility, unless the examination was completed within 12 months before admission.

Periodic examination and diagnosis shall be performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease. A review of the results of examination and entry of the results shall be entered in the resident's dental record.

If appropriate, dental professionals shall participate in the development, review, and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

The facility shall provide education and training in the maintenance of oral health.

The facility shall ensure comprehensive dental treatment services that include the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health shall be available to resident.

If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each resident, with a dental summary maintained in the resident's living unit. If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the resident's living unit.



b. Dietetic Services

Each resident shall receive a nourishing, well-balanced diet, including modified and specially prescribed diets. The resident's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets, including those used as a part of a program to manage inappropriate resident behavior.

A qualified dietitian shall be employed either full-time, part-time, or on a consultant basis, at the facility's discretion. If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability, and activity. Foods proposed for use as a primary reinforcement of adaptive behavior shall be evaluated in light of the resident's nutritional status and needs.

Each resident shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community. Not more than 14 hours shall elapse between a substantial evening meal and breakfast of the following day. On weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast. Not less than 10 hours shall elapse between breakfast and the evening meal of the same day, except as provided above.

Menus shall be prepared in advance and shall provide a variety of foods at each meal.

Menus shall be different for the same days of each week and adjusted for seasonal change. Menus shall include the average portion sizes for menu items. Menus for food actually served shall be kept on file for 30 days.

Food shall be served in appropriate quantity, at appropriate temperature, and in a form consistent with the developmental level of the resident.



The facility shall serve meals for all residents, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. The facility shall provide table service for all residents who can and will eat at a table, including residents in wheelchairs. The facility shall equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.

The facility shall supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each resident receives enough food, and to ensure that each resident eats in a manner consistent with the resident's developmental level. Staff shall ensure that each resident eats in an upright position, unless otherwise specified by the interdisciplinary team or the physician.

c. Laboratory Services

Laboratory means an entity for the microbiological, serological, chemical, hematological, radio-bioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded, and reported.



The laboratory director shall ensure that the staff:

- ◆ Has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;
- ◆ Is sufficient in number for the scope and complexity of the services provided; and
- ◆ Receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801. The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

d. Pharmacy Services

The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its residents. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

A pharmacist with input from the interdisciplinary team shall review the drug regimen of each resident at least quarterly. The pharmacist shall report any irregularities in residents' drug regimens to the prescribing physician and interdisciplinary team. The pharmacist shall prepare a record of each resident's drug regimen reviews and the facility shall maintain that record.

As appropriate, the pharmacist shall participate in the development, implementation, and review of each resident's individual program plan, either in person or through written report to the interdisciplinary team.



The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. An individual medication administration record shall be maintained for each resident. The system shall ensure that:

- ◆ All drugs are administered in compliance with the physician's orders.
- ◆ All drugs, including those that are self-administered, are administered without error.
- ◆ Unlicensed personnel are allowed to administer drugs only if state law permits.
- ◆ Residents are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.
- ◆ The resident's physician is informed of the interdisciplinary team's decision that self-administration of medications is an object for the resident.
- ◆ No resident self-administers medications until the resident demonstrates the competency to do so.
- ◆ Drugs used by residents while not under the direct care of the facility are packaged and labeled in accordance with state law.
- ◆ Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security. The facility shall keep all drugs and biologicals locked, except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Residents who have been trained to self-administer drugs may have access to keys to their individual drug supply.

The facility shall maintain records of the receipt and disposition of all controlled drugs. The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.). If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.



Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

Drugs and biologicals packaged in containers designated for a particular resident shall be immediately removed from the resident's current medication supply if discontinued by the physician.

e. Physician Services

The facility shall provide or obtain preventive and general medical care for each resident. The facility shall ensure the availability of physician services 24 hours a day. To the extent permitted by state law, the facility may use physician assistants and nurse practitioners to provide physician services as described in this manual.

A physician shall participate in the establishment of each newly admitted resident's initial individual program plan.

The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a resident if the physician determines that an individual resident requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

The facility shall provide or obtain annual physical examinations of each resident that include, at a minimum, the following:

- ◆ Evaluation of vision and hearing.
- ◆ Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.
- ◆ Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.
- ◆ Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American academy of Pediatrics, or both.



f. Nursing Services

The facility shall provide residents with nursing services in accordance with their needs. These services shall include:

- ◆ Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.
- ◆ The development, with a physician, of a medical care plan of treatment for a resident when the physician has determined that an individual resident requires such a plan.
- ◆ A review of their health status for those residents certified as not needing a medical care plan. This review shall be by a direct physical examination by a licensed nurse.
 - Reviews shall be done quarterly or more frequently, depending on resident need, and be recorded in the resident's record.
 - Reviewers shall result in any necessary action including referral to a physician to address resident health problems.
- ◆ Other nursing care as prescribed by the physician or as identified by resident needs.
- ◆ Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:
 - Training residents and staff as needed in appropriate health and hygiene methods.
 - Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.
 - Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the residents.



3. Management of Inappropriate Resident Behavior

The facility shall develop and implement written policies and procedures that govern the management of inappropriate resident behavior, consistent with the provisions staff conduct toward residents. These procedures shall specify all facility-approved interventions to manage inappropriate resident behavior.

Procedures shall address:

- ◆ The use of time-out rooms, physical restraints, and drugs to manage inappropriate behavior,
- ◆ The application of painful or noxious stimuli,
- ◆ Staff members who may authorize the use of specified interventions, and
- ◆ A mechanism for monitoring and controlling the use of these interventions.

The procedures shall designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.

Before using more restrictive techniques, the facility shall ensure that the resident's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

Interventions to manage inappropriate resident behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of residents are adequately protected. Techniques to manage inappropriate behavior shall never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program.

The use of systematic interventions to manage inappropriate resident behavior shall be incorporated into the resident's individual program plan. Standing or as-needed programs to control inappropriate behavior are not permitted.



a. Drug Usage

Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team. Drugs shall be used only as an integral part of the resident's individual program plan that is directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs are employed. Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

The facility shall not use drugs in doses that interfere with the individual resident's daily living activities. Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirements, for desired responses and adverse consequences by facility staff. These drugs shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

b. Oversight Committee

The facility shall designate and use a specially constituted committee or committees consisting of:

- ◆ Members of facility staff,
- ◆ Parents,
- ◆ Legal guardians,
- ◆ Residents (as appropriate),
- ◆ Qualified persons who have either experience or training in contemporary practices to change inappropriate resident behavior, and
- ◆ Persons with no ownership or controlling interest in the facility to:
 - Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to resident protection and rights.



- Ensure that these programs are conducted only with the written informed consent of the resident, parent (if the resident is a minor), or legal guardian.
- Review, monitor, and make suggestions to the facility about its practices and programs as they relate to:
 - Drug usage,
 - Physical restraints,
 - Time-out rooms,
 - Application of painful or noxious stimuli,
 - Control of inappropriate behavior,
 - Protection of resident rights and funds, and
 - Any other area that the committee believes needs to be addressed.

These provisions for committee review may be modified only if, in the judgment of the Department of Inspections and Appeals, court decrees, state law, or regulations provide for equivalent resident protection and consultation.

c. **Physical Restraints**

The facility may employ physical restraint only:

- ◆ As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.
- ◆ As an emergency measure, but only if absolutely necessary to protect the resident or others from injury.
- ◆ As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for resident protection during the time that a medical condition exists.

Authorization to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the resident is restrained or stable. The facility shall not issue orders for restraint on a standing or as needed basis.



A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints and shall be released from the restraint as quickly as possible. A record of these checks and usage shall be kept.

Restraints shall be designated and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort. Barred enclosures shall not be more than three feet in height and shall not have tops. Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each two-hour period in which restraint is employed. A record of the activity shall be kept.

d. Time-Out Rooms

A resident may be placed in a room from which egress is prevented only if the following conditions are met:

- ◆ The placement is a part of an approved systematic time-out program.
- ◆ The resident is under the direct constant visual supervision of designated staff.
- ◆ The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Placement of a resident in a time-out room shall not exceed one hour. Residents placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets. The facility shall keep a record of time-out activities.

4. Safeguarding Personal Property

The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

- ◆ Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.
- ◆ Providing adequate storage facilities for the resident's personal effects.



- ◆ Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

5. Staff Treatment of Residents

The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the resident. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment. Staff should not punish a resident by withholding food or hydration that contributes to a nutritionally adequate diet.

The facility shall prohibit the employment of people with a conviction or previous employment history of child or resident abuse, neglect or mistreatment.

The facility shall ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures. The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.



J. PROVISION OF SERVICES

Each resident shall receive a continuous active treatment program. "Active treatment" means aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this manual. Active treatment shall be directed toward:

- ◆ The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible.
- ◆ The prevention or deceleration of regression or loss of current optimal functional status.

"Active treatment" does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program.

Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the resident is encouraged. Participation by the resident, the resident's parents (if the resident is a minor), or the resident's legal guardian is required unless that participation is unobtainable or inappropriate.

1. Individual Program Plan

Each resident shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the resident's needs, as described by the comprehensive functional assessments, and to designing programs that meet the resident's needs.

Within 30 days after admission, the interdisciplinary team shall prepare for each resident an individual program plan.

The individual program plan shall describe relevant interventions to support the resident toward independence. Plans shall include, for those residents who lack them, training in personal skills essential for privacy and independence until it has been demonstrated that the resident is developmentally incapable of acquiring them.



Personal skills include, but are not limited to:

- ◆ Toilet training,
- ◆ Personal hygiene,
- ◆ Dental hygiene,
- ◆ Self-feeding,
- ◆ Bathing,
- ◆ Dressing,
- ◆ Grooming, and
- ◆ Communication of basic needs.

The plan shall identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support. Plans shall provide the residents who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

Plans shall include opportunities for resident choice and self-management.

The plan shall state the specific objectives necessary to meet the resident's needs, as identified by the comprehensive assessment and the planned sequence for dealing with those objectives. These objectives shall be stated separately, in terms of a single behavioral outcome. They shall be assigned projected completion dates and be expressed in behavioral terms that provide measurable indices of performance. Objectives shall be organized to reflect a developmental progression appropriate to the individual and be assigned priorities.

Each written training program designed to implement the objectives in the individual program plan shall specify:

- ◆ The person responsible for the program.
- ◆ The methods to be used and the schedule for use of the method.
- ◆ The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
- ◆ The inappropriate resident behaviors, if applicable.
- ◆ Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.



A copy of each resident's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the resident, and to the resident, parents (if the resident is a minor) or legal guardian. The plan shall identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

a. Program Implementation

As soon as the interdisciplinary team has formulated a resident's individual program plan, each resident shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Except for those facets of the individual program plan that must be implemented only by licensed personnel, each resident's individual program plan shall be implemented by all staff who work with the resident, including professional, paraprofessional and nonprofessional staff.

Data relative to accomplishment of the criteria specified in individual program plan objectives shall be documented in measurable terms. The facility shall document significant events that are related to the resident's individual program plan and assessments and that contribute to an overall understanding of the resident's ongoing level and quality of functioning.

b. Program Monitoring and Change

The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary. This includes, but is not limited to, situations in which the resident:

- ◆ Has successfully completed an objective or objectives identified in the individual program plan,
- ◆ Is regressing or losing skills already gained,
- ◆ Is failing to progress toward identified objectives after reasonable efforts have been made,
- ◆ Is being considered for training toward new objectives.



At least annually, the interdisciplinary team shall review the comprehensive functional assessment of each resident for relevancy and update it as needed. The individual program plan shall be revised, as appropriate.

2. Resident Assessment

Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted before admission. The comprehensive functional assessment shall take into consideration the resident's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable. The assessment shall identify:

- ◆ The presenting problems and disabilities and, where possible, their causes,
- ◆ The resident's specific developmental strengths,
- ◆ The resident's specific developmental and behavioral management needs,
- ◆ The resident's need for services, without regard to the actual availability of the services needed, and
- ◆ Physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors, or independent living skills necessary for the resident to be able to function in the community, and vocational skills, as applicable.

3. Staff Conduct Toward Residents

The facility shall develop and implement written policies and procedures for the management of conduct between staff and residents. These policies and procedures shall:

- ◆ Promote the growth, development, and independence of the resident,
- ◆ Address the extent to which resident choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible,
- ◆ Specify resident conduct to be allowed or not allowed, and
- ◆ Be available to all staff, residents, parents of minor children, and legal guardians.



To the extent possible, residents shall participate in the formulation of these policies and procedures.

Residents shall not discipline other residents, except as part of an organized system of self-government, as set forth in facility policy.

K. RESIDENT ADMISSIONS

Before placement in an ICF/ID, all eligible persons shall be referred through an approved case management program and through the Department.

The case management program shall identify any appropriate alternatives to the placement and shall inform the consumer or the consumer's representative of the alternatives. Once informed, the consumer or legal representative is free to select any option for which the consumer qualifies, including ICF/ID care.

Upon receipt of an initial ICF/ID request, the Department shall take one of the following actions:

- ◆ Refer the ICF/ID request to IME for level of care determination,
- ◆ Offer a home- or community-based alternative, or
- ◆ Refer the person back to the case management program for further consideration of service needs.

The Department's action must take place within 30 days of receipt of a referral.

Persons seeking Medicaid payment for ICF/ID placement must be referred to IME by the Department with responsibility for the person. If IME approves ICF/ID level of care, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

Persons who are admitted by the facility shall be in need of and receiving active treatment services. Admission decisions shall be based on a preliminary evaluation of the person that is conducted or updated by the facility or by outside sources.



The preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health, and nutritional status. The evaluation shall determine if the facility can provide for the person's needs and if the person is likely to benefit from placement in the facility.

Do not house residents of grossly different ages, developmental levels, and social needs in close physical or social proximity, unless the housing is planned to promote the growth and development of all those housed together.

Do not segregate residents solely on the basis of their physical disabilities. Integrate residents who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

It is important that people being placed feel that their needs and perceptions have been understood, and that placement is designed to achieve positive goals. The following procedures are recommended to enhance the comfort and early adjustment of a person to this new living arrangement:

- ◆ Orient the resident to the physical plant and the facility staff.
- ◆ Introduce the resident to other residents and encourage the resident to become well acquainted early with those in the immediate living area.
- ◆ Discuss the resident's medical records and care plan with the resident.
- ◆ Encourage the resident to continue with interests and social responsibilities and contacts as early as possible after admission.
- ◆ Discuss the resident's placement, feelings about the placement, and progress, goals, and plans with the resident periodically.
- ◆ Give the resident the opportunity to discuss with the administrator and other staff members the resident's condition and the reasons for coming to the facility.
- ◆ Encourage the resident to express feelings about admission and to ask questions to alleviate any concerns and anxieties.



L. STAFF

1. Direct Care Staff

The facility shall provide sufficient direct care staff to manage and supervise residents in accordance with their individual program plans. The facility shall not depend upon residents or volunteers to perform direct care services for the facility.

Direct care staff is defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. There shall be responsible direct care staff on duty and awake on a 24-hour basis when residents are present to take prompt, appropriate action in cases of injury, illness, fire or other emergency, in each defined residential living unit housing:

- ◆ Residents for whom a physician has ordered a medical care plan;
- ◆ Residents who are aggressive, assaultive or security risks;
- ◆ More than 16 residents; or
- ◆ Fewer than 16 residents within a multi-unit building.

There shall be a responsible direct care staff person on duty on a 24-hour basis when residents are present to respond to injuries and symptoms of illness and to handle emergencies in each defined residential living unit housing:

- ◆ Residents for whom a physician has not ordered a medical care plan;
- ◆ Residents who are not aggressive, assaultive or security risks; and
- ◆ 16 or fewer residents.

Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to residents:

- ◆ The staff-to-resident ratio is 1 to 3.2 for each defined residential living unit serving:
 - Children under the age of 12,
 - Severely and profoundly intellectually disabled residents,
 - Residents with severe physical disabilities,
 - Residents who are aggressive, assaultive, or security risks, or
 - Residents who manifest severely hyperactive or psychotic-like behavior.



- ◆ The staff-to-resident ratio is 1 to 4 for each defined residential living unit serving moderately intellectually disabled residents.
- ◆ The staff-to-resident ratio is 1 to 6.4 for each defined residential living unit serving residents who function within the range of mild intellectual disability.
- ◆ When there are no residents present in the living unit, a responsible staff member must be available by telephone.

Provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct resident care duties.

2. Nursing Staff

The facility shall employ or arrange for licensed nursing services sufficient to care for residents' health needs including those residents with medical care plans. Nurses providing services in the facility shall have a current license to practice in the state.

The facility shall use registered nurses as appropriate and required by state law to perform the health services specified in this manual. If the facility uses only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse. Non-licensed nursing personnel who work with residents under a medical care plan shall do so under the supervision of licensed persons.

3. Professional Program Staff

Each resident shall receive the professional program services needed to implement the active treatment program defined in each resident's individual program plan. The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.



Professional program staff shall be licensed, certified, or registered, as applicable to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

- ◆ To be designated as an occupational therapist, a person shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
- ◆ To be designated as an occupational therapy assistant, a person shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.
- ◆ To be designated as a physical therapist, a person shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
- ◆ To be designated as a physical therapy assistant, a person shall be eligible for certification as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.
- ◆ To be designated as a psychologist, a person shall have at least a master's degree in psychology from an accredited school.
- ◆ To be designated as a social worker, a person shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
- ◆ To be designated as a speech-language pathologist or audiologist, a person shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.
- ◆ To be designated as a professional recreation staff member, a person shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.



- ◆ To be designated as a professional dietitian, a person shall be eligible for registration by the American Dietetic Association.
- ◆ To be designated as a human services professional, a person shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling, and psychology).

If the resident's individual program plan is being successfully implemented by the facility staff, professional program staff meeting these qualifications are not required, except for qualified intellectual disability professionals, who must meet the requirements set forth here or be a doctor or nurse.

Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process. Professional program staff shall work directly with residents and with paraprofessional, nonprofessional, and other professional program staff who work with residents. Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

4. Qualified Intellectual Disability Professional

Each resident's active treatment program shall be integrated, coordinated, and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disability and is one of the following:

- ◆ A doctor of medicine or osteopathy
- ◆ A registered nurse
- ◆ A person who holds at least a bachelor's degree in a professional category as specified in [Professional Program Staff](#)

5. Staff Training Program

Provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently. For employees who work with residents, focus training on skills and competencies directed toward residents' developmental, behavioral, and health needs.



Staff shall be able to demonstrate the skills and techniques necessary to:

- ◆ Administer interventions to manage the inappropriate behavior of residents.
- ◆ Implement the individual program plans for each resident for whom they are responsible.

M. TRANSFER AND DISCHARGE

If a resident is to be either transferred or discharged, the facility shall have documentation in the resident's record that the resident was transferred or discharged for good cause. The facility shall provide a reasonable time to prepare the resident and the resident's parents or guardian for the transfer or discharge (except in emergencies).

A transfer or discharge from an ICF/ID should be planned as carefully and thoroughly as an admission to the facility. It is desirable that the resident and the facility staff achieve understanding about the resident's current needs, condition, and programs, and the probable duration of stay in the ICF/ID. Such understandings make for better morale and adjustment to facility life on the part of the resident, and are particularly important to good transfer and discharge planning.

Good transfer and discharge planning begins at the time of the resident's admission and continues during the stay in the facility. Such planning involves gathering information, much of which should be available from the social history completed at the resident's admission.

Important considerations include the resident's medical condition and prognosis, family support system, previous living arrangement, and the resident's preferred living arrangement. Based on these factors, a preliminary analysis of alternatives for the resident is used to develop a discharge plan, which is subject to revision as the resident's condition changes.

For a resident whose condition is improving, the plan shall be made progressively more specific and time-limited. If a resident's condition becomes worse, the plan may need to be revised accordingly.

Consequently every resident's situation must be periodically reviewed to assess the effectiveness of the current plan in response to individual needs.



The facility social worker is the interdisciplinary team member responsible for coordination. As such, the social worker is the staff person in the best position to conduct these reviews and monitor progress toward achievement of objectives which will make eventual discharge possible. This requires good communication channels with the resident, the family, the physician, and others involved with the resident.

The facility social worker must be aware of what community resources are available to assist the resident in making a successful transfer to a different living arrangement. The county office of the Department is a useful informational resource in this last regard, but primary responsibility for discharge planning remains with the ICF/ID.

In the event of a forced move, such a revocation of license or Medicaid certification, fire or other disaster, discharge assistance will be furnished by the Department.

The Department will also assist in particularly difficult or complex cases where the facility has been unsuccessful in arranging an appropriate alternative. But in most cases, the Department expects that the ICF/ID possesses the necessary information and professional resources to coordinate discharge planning efforts effectively.

1. Administrative Procedures

At the time of the discharge, the facility shall develop a final summary of the resident's developmental, behavioral, social, health, and nutritional status.

With the consent of the resident, parents (if the resident is a minor) or legal guardian, the facility shall provide a copy to authorized persons and agencies. The facility shall also provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

In the event that a resident is transferred to another health facility, transfer information should be summarized from the facility's records in a copy to accompany the resident. This information should include:

- ◆ A transfer form of diagnosis
- ◆ Activities of daily living information
- ◆ Transfer orders
- ◆ Nursing care plan
- ◆ Physician's orders for care
- ◆ The resident's personal record
- ◆ The resident's personal needs fund record



If a Medicaid resident requests transfer or discharge, or there is another person requesting this for the resident, the facility administrator shall promptly notify the Department by means of the [Case Activity Report, form 470-0042](#).

This should be done in sufficient time to permit a case manager or DHS social worker to assist in the decision and planning for the transfer or discharge, if needed. This also allows the Department enough time to complete the necessary paperwork, assuring a smooth discharge or transfer for the resident.

When a resident leaves the ICF/ID during the month, any unused portion of the resident's income must be refunded. The following example illustrates the procedure used in calculating refunds due the resident:

Mr. S has a monthly member participation of \$300. The facility in which Mr. S resides has a per diem rate of \$100. In a normal month, Mr. S pays for the first three days of his care ($\$100 \times 3 \text{ days} = \300) and the state pays for the remainder of the month.

If Mr. S leaves the facility on the third of the month, the facility must make a \$100 refund to Mr. S ($\$300 \text{ minus } \$200 \text{ (2 days' care)} = \100). If he leaves the home on the fourth of the month or later, no refund is normally due. An exception could arise if reserve bed days are involved.

2. Closing of Facility

The contract between the Department and an ICF/ID requires a 60-day notice before closing. Administrators planning or considering closing a facility should notify their county Department office, Iowa Medicaid Enterprise (IME) Bureau of Long-Term Care, and the Iowa Department of Inspections and Appeals Health Care Facility Division as soon as possible. The moving of residents often takes longer than expected. Sufficient notice can ease the problem considerably.

We suggest that the administrator and the Department confer about the closing and together make plans so that the goal for closing can be accomplished in a smooth manner.



Facilities should not make their own plans to move residents. Residents must be given a choice of enrolled qualified providers. Those residents receiving care under Medicaid are a financial responsibility of the Department. All plans for these people must be approved by the Department.

The county and regional offices of the Department will help in planning for moving into or out of facilities. These services are available to all Medicaid residents and to other residents on request.

3. Department Procedures

When an ICF/ID notifies the Department by means of the [Case Activity Report, form 470-0042](#), that a resident has been discharged (through death, return to own home, etc.), the income maintenance worker must enter the necessary information to close the Medicaid ICF/ID case through the computer system.

When a resident is transferred to another Medicaid facility within the county, the income maintenance worker enters the necessary information concerning the transfer.

4. Reasons for Discharge or Transfer

A Medicaid resident may be **involuntarily** discharged from an ICF/ID only if one of the following conditions exists:

- ◆ Discharge is necessary for medical reasons.
- ◆ The resident must be discharged for the resident's welfare or for the welfare of other residents.
- ◆ The resident does not make payment for ICF/ID care (resident participation).

Other instances where a resident may be discharged or transferred include the following:

- ◆ The resident wants to leave the facility. In the absence of a guardianship or other legal restraint, the resident may do so upon request.
- ◆ The resident's physician or family requests transfer or discharge. With agreement by the resident, this must then be done.



- ◆ The resident's guardian or other legal representative may request it.
- ◆ A finding that ICF/ID care is no longer medically necessary may terminate Medicaid payments, causing a person to seek other living arrangements for financial reasons.
- ◆ Death of the resident, closing or sale of the facility, fire, remodeling, revocation of license, etc.

5. Transfer of Residents by Ambulance

In some emergency cases, such as the closing of a facility or the loss of Medicaid certification by a facility, residents may need to be transferred from one facility to another by ambulance. Arrangements can be made to pay for this service through the Medicaid program.

Before transfer by ambulance, a worker from the county office of the Department must provide the Bureau of Long-Term Care with the information necessary to process the claim and authorize the Iowa Medicaid Enterprise (IME) to make payment. Close coordination between the Bureau of Long-Term Care, county offices, and facilities will be required in all emergency situations.

N. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Iowa Medicaid enrolled nursing facilities and residential care facilities bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software, PC-ACE Pro 32, available through www.edissweb.com. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

1. ICF/ID Provider Assessment Fee

As required by Iowa Code section 249A.21, licensed ICFs/ID certified to participate in the Medicaid program that are not operated by the state are obligated to pay a monthly assessment fee to the Department.

The amount of the provider assessment fee is 5.5 percent of the facility's total annual revenue for the preceding fiscal year, divided by the number of months of operations during the preceding fiscal year.

**Welcome to the
IOWA DEPARTMENT OF HUMAN SERVICES
ELECTRONIC FINANCIAL AND STATISTICAL REPORT**

The Financial and Statistical Report is now available in a Version 97 Excel workbook .

The Workbook contains the following 21 worksheets:

Certification	E
Statistical Data	F
A	G
A - 1	H
A - 2	H - 1
B	I
C	I - 1
C - 1	SUPPORTING SCHEDULE (1)
D	SUPPORTING SCHEDULE (2)
D - 1	EDITS
	PRINT

Please refer to the Iowa Department of Human Services Division of Medical Services General Instructions prior to completing the Financial and Statistical Report.

Workbook Structure

The Workbook contains an electronic version of each schedule of the paper version of the Financial and Statistical Report. Supporting schedules (worksheets) may be added to the workbook, but no schedules should be deleted. The tab name assigned to each worksheet corresponds to the related cost report schedule. For example, the tab labeled C contains Schedule C-Schedule of Expenses, H contains Schedule H-Nursing Facility Wages and Hours. Four schedules have been added which are specific to the electronic version: Supporting Schedule (1), Supporting Schedule (2), Edits and Print.

Each worksheet in the Workbook can be accessed by clicking on the corresponding tab at the bottom of the screen. A scroll bar is available at the bottom of the screen to navigate through the tab bar.

Supporting Schedules

Two worksheets, Supporting Schedules 1 and 2, are available within the Workbook so that you may provide additional information if necessary. The worksheets are formatted to fit a single page (8 1/2" x 11"). If your information is larger than the defined area it may cause your cost report to print incorrectly when utilizing the print buttons provided in the Print worksheet. It is suggested that large files be included in the Workbook by adding a new worksheet at the end of the Workbook after the Print worksheet.

Printing Options

Print options are found in the last tab of the Workbook titled Print. When you click on this tab, you will find two buttons which have been programmed to print paper copies. The top button will print the Financial and Statistical Report and the Edit Report. The bottom button will print the Financial and Statistical Report only. Additional worksheets added to the basic Workbook will need to be printed individually by using the Print option found in the File menu.

The print buttons found in the Print worksheet may not be compatible with certain PC and printer configurations. Therefore, if you experience problems printing, you may need to alter margins, page break settings, etc. in order to print the Financial and Statistical Report.

**IOWA DEPARTMENT OF HUMAN SERVICES
FINANCIAL AND STATISTICAL REPORT**

[11101] Facility Name		[11201] Federal ID Number	
Physical Address (Required)			
[12102] Street	[12103] City	[12104] State	[12105] Zip
Period of Report		[12110] County	
[13101] From:	[13102] To:		
[14101] Date Facility Entered Program	[14102] Date Owner Acquired Facility	[14120] FYE (mm/dd)	
[15101] Type of Control (Check Only One)			
GOVERNMENT	NON-PROFIT ORGANIZATION	PROPRIETARY	
<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<input type="checkbox"/> Church Operated <input type="checkbox"/> Church Related <input type="checkbox"/> Other Non-Profit	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> "S" Corporation

[16101] VENDOR NUMBER BY TYPE OF FACILITY		
No.	Program Type	Vendor Number
1	Nursing Facility	
2	Residential Care Facility	
3	Assisted Living	
4	ICF/MR	
5	RCF/MR	
6	Other	

CERTIFICATION STATEMENT

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

[17101] An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expense is attached.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Questions concerning financial data included in this report should be directed to:		
Name	Position/Title	Telephone
Name of Officer or Administrator of Facility		Date
Title / Position		Telephone
Name of Preparer		Date
Preparer Company Name		Telephone
Signature of Preparer		Signature of Officer or Administrator of Facility

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.
Period of Report: From:	To:

[18101] Accounting Basis (Check only one)

Accrual
 Modified Cash
 Cash

[19101] Statistical Data

Line No.	Type of Facility	# Authorized Beds		Total Bed Days in Reporting Period (3)	Patient Days in Reporting Period		Medicaid Utilization Col 5/4 (6)	Percent Occupancy Col 4/3 (7)	Number of Admissions (8)	Number of Discharges (9)
		Start of Period (1)	End of Period (2)		Total (4)	Medicaid (5)				
1	Nursing Facility									
2	RCF									
3	Assisted Living - Grant Funded									
4	Assisted Living - Non-Grant Funded									
5	ICF/MR									
6	RCF/MR									
7	Other									
8	TOTAL									

[20101] Does this facility have an Assisted Living Grant? Yes No

[20102] Does this facility have a CCDI Unit? Yes No

[21101] Ownership Information

Line No.	Name of Owner (1)	% of Work Week Devoted to Business (2)	Title (3)	Salaries and Wages (4)	Social Security Number (5)	% Ownership in Home (6)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Note: Attach additional schedules as necessary to complete ownership information.

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.
Period of Report: From:	To:

SCHEDULE A TOTAL FACILITY REVENUE										
REVENUES	Line No.	Medicaid (1)	Medicare (2)	Private Pay (3)	Other (4)	Total (5)	Nursing Facility (6)	Other (7)	ENTER IN COLUMN 2 SCHEDULE C	
									Adjustment Amount (8)	Line No. (9)
RESIDENT REVENUE CENTERS:										
Routine daily service	211									
Pharmacy-drugs & medications	212									76
Routine medical supplies	213									70
Non-Routine medical supplies	214									71
Laboratory	215									78
X-Ray	216									77
Occupational Therapy	217									56
Physical Therapy	218									57
Speech Therapy	219									58
Respiratory Therapy	220									59
Professional care, physician	221									99
Beauty, barber shop	222									93
Personal purchases for residents	223									94
Activities	224									
Other Ancillary	225									
OTHER REVENUE CENTERS:										
Revenue from meals sold to guest & employee	226									75
Rental Income	227									
Income of telephone charges paid by	228									10
Purchase discounts, if recorded	229									
Revenues from supplies employees	230									
Rebates	231									
Religious Income	232									
Investment Income (see instructions)	233									88
Other	234									
Gifts	235									
Donations	236									
	237									
GROSS REVENUE	238									
DEDUCTIONS FROM REVENUE:										
Free Care and Allowances	239									
Provision for uncollectible accounts	240									
TOTAL DEDUCTIONS	241									
NET REVENUE	242									

AVERAGE PRIVATE PAY RATE	
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IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE A-1
NF CONVERSION / LTC SERVICE DEVELOPMENT GRANT REVENUE**

Assisted Living Grant Revenue

REVENUE	LINE NO.	Medicaid (1)	Waiver (2)	HUD Low Income Credits (3)	HCBS Rent Subsidy (4)	In-Home Care (5)	Private (6)
RESIDENT REVENUE							
Room	240						
Board	241						
Services	242						
Amenities	243						
	244						
Other	245						
Gifts	246						
Donations	247						
	248						
	249						
TOTAL ASSISTED LIVING REVENUE	250						

Service Development Grant Revenue

REVENUE	LINE NO.	Medicaid Revenue (1)	Waiver Revenue (2)	Private Revenue (3)	Number of Units Medicaid (4)	Number of Units Waiver (5)	Number of Units Private (6)
PROGRAM REVENUE							
Home Care	251						
Home Delivered Meals	252						
Adult Day Care	253						
Respite Care	254						
Transportation	255						
Chore Services	256						
PACE	257						
Other	258						
	259						
	260						
TOTAL SERVICE DEVELOPMENT GRANT REVENUE	261						

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE A - 2 DESCRIPTION OF LIVING UNITS										
ASSISTED LIVING - GRANT FUNDED										
Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)	Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate				
				Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)		
271	Type A	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
272	Type B	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
273	Type C	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
274	Type D	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
275	Type E	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
276	Type F	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
277	Type G	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
278	Type H	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
279	Type I	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
280	Type J	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								

SCHEDULE A - 2 DESCRIPTION OF LIVING UNITS										
ASSISTED LIVING - NON-GRANT FUNDED										
Line No. (1)	Type of Living Unit (2)	Number of Living Units (3)	Number of Square Feet (4)	Resident Days during Period		Monthly Rental Rate				
				Medicaid Residents (5)	Total Residents (6)	Medicaid Residents (7)		Non-Medicaid Residents (8)		
281	Type A	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
282	Type B	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
283	Type C	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
284	Type D	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
285	Type E	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
286	Type F	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
287	Type G	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
288	Type H	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
289	Type I	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								
290	Type J	One-bedroom					Room		Room	
		Two-bedroom					Board		Board	
		Efficiency								

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:		Vendor No.:	
Period of Report:	From	To:	

SCHEDULE B EXPENSE ADJUSTMENTS					
DESCRIPTION	LINE NO.	EXPENSE (1)	ALLOWABLE (2)	ENTER IN COLUMN 3, SCHEDULE C	
				Adjustment amount (3)	Line(s) # (4)
NONREIMBURSABLE EXPENSES:					
Provisions for income tax	411				95
Fees paid Board of Directors	412				97
Non-Working officer's salaries	413				98
Travel & Entertainment. See Instructions	414				16
Donations	415				100
Expenses of non-participating facilities	416				
Fund-raising expenses	417				
Pharmacy, drugs, and medications	418				76
Insurance premiums on life of officer, owner	419				96
Other expenses not related to resident care	420				
EXPENSE LIMITATIONS:		EXPENSE (1)	ALLOWABLE (2)		
Compensation of owners/related parties. See Instructions					
Position					
Administrator	421				1
Assistant Administrator	422				2
Management Fees	423				13
Nursing Director	424				40
Other	425				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control					
Rental Equipment	426				
Services & supplies (describe)	427				
	429				
Rental of Facility. See instructions.					
Payments	430				
Lessor's Cost:					
Depreciation	432				
Amortization	433				
Interest	434				
Property tax	435				
Other	436				
Return on Equity	437				
Reduction - IF Column 1 < Column 2					
Advertising expense in excess of the lesser of \$7,200 or an amount computed at 2% of daily revenue	439				17
Allowable Depreciation - Schedule D and D-1	440				84
Interest expense on loans from partners, proprietors, stockholders or related organizations. See Instructions.	441				88
EXPENSE ADDITIONS:		EXPENSE (1)	ALLOWABLE (2)		
Compensation of nonsalaried proprietors and partners or members of religious orders.					
Administrator	442				1
Nursing Director	443				40
Other	444				
TOTAL	445				

NOTE: Enter adjustments on Schedule C on the line for the expense center affected.

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From:	01/00/00	To:	01/00/00

SCHEDULE C SCHEDULE OF EXPENSES

SCHEDULE OF EXPENSES	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses		Resident Expenses (4)	Allocation Basis (5)	NF (6)	RCF (7)	Assisted Living (8)	ICF/MR (9)	RCF/MR (10)	Other (11)	Total Equals Column 4 (12)
			Sch. A. (2)	Sch. B (3)									
Administrator Wages	1				0								0
Business Office Wages	2				0								0
Employer's taxes (Admin.)	3				0								0
Grp.Life & Retire Benefits (Admin.)	4				0								0
Worker's comp. Insurance (Admin.)	5				0								0
Emp. Advertising / Recruit. (Admin.)	6				0								0
Criminal record checks (Admin.)	7				0								0
Education and training (Admin.)	8				0								0
Supplies (Admin.)	9				0								0
Telephone	10				0								0
Equipment rental (Admin.)	11				0								0
Home office costs	12				0								0
Management fees	13				0								0
Acct., legal & other professional fees	14				0								0
General liability insurance	15				0								0
Travel, entertainment, and auto	16				0								0
Advertising and public relations	17				0								0
	18				0								0
TOTAL ADMINISTRATIVE COSTS	19	0	0	0	0		0	0	0	0	0	0	0
Laundry wages	20				0								0
Housekeeping wages	21				0								0
Maintenance wages	22				0								0
Employer's taxes (Environ.)	23				0								0
Grp.Life & Retire Benefits (Environ.)	24				0								0
Worker's comp. Insurance (Environ.)	25				0								0
Emp. Advertising / Recruit. (Environ.)	26				0								0
Criminal record checks (Environ.)	27				0								0
Education and training (Environ.)	28				0								0
Supplies, laundry	29				0								0
Supplies, housekeeping	30				0								0
Supplies, maintenance	31				0								0
Utilities	32				0								0
Purchased services, laundry	33				0								0
Purchased services, housekeeping	34				0								0
Purchased services, maintenance	35				0								0
Equipment repairs	36				0								0
Equipment rental (Environ.)	37				0								0
	38				0								0
TOTAL ENVIRONMENTAL SERVICE COSTS	39	0	0	0	0		0	0	0	0	0	0	0
D.O.N. wages	40				0								0
R.N. wages	41				0								0
L.P.N. wages	42				0								0
C.N.A. wages	43				0								0
Activities wages	44				0								0
Social service wages	45				0								0
Employer's taxes (Dir. Health)	46				0								0
Grp.Life & Retire Benefits (Dir. Health)	47				0								0
Worker's comp. Insurance (Dir. Health)	48				0								0
Emp. Advertising / Recruit. (Dir. Health)	49				0								0
Criminal record checks (Dir Health)	50				0								0
Education and training (Dir Health)	51				0								0
Certified nursing aide training	52				0								0
Contracted professional social services	53				0								0
Professional support services	54				0								0
Contracted nursing services	55				0								0
Occupational Therapy	56				0								0
Physical Therapy	57				0								0
Speech Therapy	58				0								0
Respiratory Therapy	59				0								0
	60				0								0
TOTAL DIRECT PATIENT CARE COSTS	61	0	0	0	0		0	0	0	0	0	0	0
Medical record wages	62				0								0
Medical director	63				0								0
Dietary service wages	64				0								0
Employer's taxes (Support)	65				0								0
Grp.Life & Retire Benefits (Support)	66				0								0
Worker's comp. Insurance (Support)	67				0								0
Emp. Advertising / Recruit. (Support)	68				0								0
Criminal record checks (Support)	69				0								0
Routine supplies, patient care services	70				0								0
Non-routine supplies, patient care services	71				0								0
Supplies, dietary services	72				0								0
Supplies, activities	73				0								0
Supplies, social services	74				0								0
Food and nutritional supplements	75				0								0
Pharmacy services	76				0								0
X-ray services	77				0								0
Laboratory	78				0								0
Professional support services	79				0								0
Equipment rental (Support)	80				0								0
	81				0								0
TOTAL SUPPORT CARE COSTS	82	0	0	0	0		0	0	0	0	0	0	0
TOTAL PATIENT CARE SERVICE COSTS	83	0	0	0	0		0	0	0	0	0	0	0
Depreciation	84				0								0
Amortization	85				0								0
Real estate taxes	86				0								0
Facility lease	87				0								0
Interest	88				0								0
Property and casualty insurance	89				0								0
Building and grounds repairs	90				0								0
	91				0								0
TOTAL PROPERTY COSTS	92	0	0	0	0		0	0	0	0	0	0	0
Beauty and barber shops	93				0								0
Personal purchases for residents	94				0								0
Income taxes	95				0								0
Officer's life insurance	96				0								0
Director fees	97				0								0
Nonworking officers' salaries	98				0								0
Professional care (Physicians)	99				0								0
Contributions	100				0								0
	101				0								0
TOTAL OTHER COSTS	102	0	0	0	0		0	0	0	0	0	0	0
TOTAL OF ALL EXPENSES	103	0	0	0	0		0	0	0	0	0	0	0

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report:	From: 01/00/00	To:	01/00/00

Note: This schedule is required only if the facility has an assisted living grant.

SCHEDULE C-1 Assisted Living Expense Allocation								
SCHEDULE OF EXPENSES	Line No.	Allocation Basis (1)	Grant Funded Statistic (2)	Non-Grant Funded Statistic (3)	Total Statistic (4)	Grant Funded (5)	Non-Grant Funded (6)	Total Expenses (7)
Administrator Wages	1				0	0	0	0
Business office wages	2				0	0	0	0
Employer's taxes (Admin.)	3				0	0	0	0
Grp/Life & Retire Benefits (Admin.)	4				0	0	0	0
Worker's comp. Insurance (Admin.)	5				0	0	0	0
Emp. Advertising / Recruit. (Admin.)	6				0	0	0	0
Criminal record checks (Admin.)	7				0	0	0	0
Education and training (Admin.)	8				0	0	0	0
Supplies (Admin.)	9				0	0	0	0
Telephone	10				0	0	0	0
Equipment rental (Admin.)	11				0	0	0	0
Home office costs	12				0	0	0	0
Management fees	13				0	0	0	0
Acct., legal & other professional fees	14				0	0	0	0
General liability insurance	15				0	0	0	0
Travel, entertainment, and auto	16				0	0	0	0
Advertising and public relations	17				0	0	0	0
	18				0	0	0	0
TOTAL ADMINISTRATIVE COSTS	19					0	0	0
Laundry wages	20				0	0	0	0
Housekeeping wages	21				0	0	0	0
Maintenance wages	22				0	0	0	0
Employer's taxes (Environ.)	23				0	0	0	0
Grp/Life & Retire Benefits (Environ.)	24				0	0	0	0
Worker's comp. Insurance (Environ.)	25				0	0	0	0
Emp. Advertising / Recruit. (Environ.)	26				0	0	0	0
Criminal record checks (Environ.)	27				0	0	0	0
Education and training (Environ.)	28				0	0	0	0
Supplies, laundry	29				0	0	0	0
Supplies, housekeeping	30				0	0	0	0
Supplies, maintenance	31				0	0	0	0
Utilities	32				0	0	0	0
Purchased services, laundry	33				0	0	0	0
Purchased services, housekeeping	34				0	0	0	0
Purchased services, maintenance	35				0	0	0	0
Equipment repairs	36				0	0	0	0
Equipment rental (Environ.)	37				0	0	0	0
	38				0	0	0	0
TOTAL ENVIRONMENTAL SERVICE COSTS	39					0	0	0
D.O.N. wages	40				0	0	0	0
R.N. wages	41				0	0	0	0
L.P.N. wages	42				0	0	0	0
C.N.A. wages	43				0	0	0	0
Activities wages	44				0	0	0	0
Social service wages	45				0	0	0	0
Employer's taxes (Dir. Health)	46				0	0	0	0
Grp/Life & Retire Benefits (Dir. Health)	47				0	0	0	0
Worker's comp. Insurance (Dir. Health)	48				0	0	0	0
Emp. Advertising / Recruit. (Dir. Health)	49				0	0	0	0
Criminal record checks (Dir. Health)	50				0	0	0	0
Education and training (Dir. Health)	51				0	0	0	0
Certified nursing aide training	52				0	0	0	0
Contracted professional social services	53				0	0	0	0
Professional support services	54				0	0	0	0
Contracted nursing services	55				0	0	0	0
Occupational Therapy	56				0	0	0	0
Physical Therapy	57				0	0	0	0
Speech Therapy	58				0	0	0	0
Respiratory Therapy	59				0	0	0	0
	60				0	0	0	0
TOTAL DIRECT PATIENT CARE COSTS	61					0	0	0
Medical record wages	62				0	0	0	0
Medical director	63				0	0	0	0
Dietary service wages	64				0	0	0	0
Employer's taxes (Support)	65				0	0	0	0
Grp/Life & Retire Benefits (Support)	66				0	0	0	0
Worker's comp. Insurance (Support)	67				0	0	0	0
Emp. Advertising / Recruit. (Support)	68				0	0	0	0
Criminal record checks (Support)	69				0	0	0	0
Routine supplies, patient care services	70				0	0	0	0
Non-routine supplies, patient care services	71				0	0	0	0
Supplies, dietary services	72				0	0	0	0
Supplies, activities	73				0	0	0	0
Supplies, social services	74				0	0	0	0
Food and nutritional supplements	75				0	0	0	0
Pharmacy services	76				0	0	0	0
X-ray services	77				0	0	0	0
Laboratory	78				0	0	0	0
Professional support services	79				0	0	0	0
Equipment rental (Support)	80				0	0	0	0
	81				0	0	0	0
TOTAL SUPPORT CARE COSTS	82					0	0	0
TOTAL PATIENT CARE SERVICE COSTS	83					0	0	0
Depreciation	84				0	0	0	0
Amortization	85				0	0	0	0
Real estate taxes	86				0	0	0	0
Facility lease	87				0	0	0	0
Interest	88				0	0	0	0
Property and casualty insurance	89				0	0	0	0
Building and grounds repairs	90				0	0	0	0
	91				0	0	0	0
TOTAL PROPERTY COSTS	92					0	0	0
Beauty and barber shops	93				0	0	0	0
Personal purchases for residents	94				0	0	0	0
Income taxes	95				0	0	0	0
Officer's life insurance	96				0	0	0	0
Director fees	97				0	0	0	0
Nonworking officers' salaries	98				0	0	0	0
Professional care (Physicians)	99				0	0	0	0
Contributions	100				0	0	0	0
	101				0	0	0	0
TOTAL OTHER COSTS	102					0	0	0
TOTAL OF ALL EXPENSES	103					0	0	0

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE D
DEPRECIATION AND AMORTIZATION EXPENSE**

Description	Line No.	Construction in Process (1)	Asset Cost (2)	Depreciation Allowable in Prior Years (3)	Method (4)	Annual Rate % (5)	Recorded Depreciation Expense (6)	Straight Line Depreciation (7)
EQUIPMENT:								
Building Equipment (fixed)	750							
Department Equipment	751							
Other Equipment	752							
Office Furniture & Fixtures	753							
Motor Vehicles	754							
Equipment	755							
	756							
TOTAL	757							
BUILDINGS:								
Facility	758							
Additions	759							
Other	760							
	761							
Land Improvements	762							
	763							
TOTAL	764							
TOTAL BUILDINGS AND EQUIPMENT	765							

LEASEHOLD IMPROVEMENTS							
Description	Line No.	Construction (1)	Cost (2)	Prior Amount (3)	Period (4)	Recorded (5)	Straight Line (6)
	766						
	767						
	768						
	769						
	770						
	771						
TOTAL AMORTIZATION	772						

[77101] Questions:

1. Are the lessor or lessee the same person or group of persons or controlled by the same person or group of persons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the lease contain an option to purchase the leased property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From	To:

**SCHEDULE D-1
CHANGE OF OWNERSHIP**

[78101] Has the facility changed owners since June 18, 1984?

- YES** Complete this schedule
 NO This schedule does not apply

	Line No.	Previous Owner's Cost (1)	New Purchases Since Change (2)	Depreciation Allowable in Prior Years (3)	Allowable Straight-Line Depreciation (4)
EQUIPMENT:					
Building equipment (fixed)	780				
Department equipment	781				
Other equipment	782				
Office furniture & fixtures	783				
Motor vehicles	784				
	785				
Less equipment not purchased	786				
TOTAL	787				
BUILDINGS:					
Facility	788				
Additions	789				
Other	790				
	791				
Land Improvements	792				
	793				
Less buildings not purchased	794				
TOTAL	795				
TOTAL BUILDINGS AND EQUIPMENT	796				

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE E
COMPARATIVE BALANCE SHEET**

All information to be taken from the general ledger.	Line No.	Balance at the End of:	
		Current Period (1)	Prior Period (2)
ASSETS:			
Cash	801		
Investments (Money Market Certificate of Deposit, etc.)	802		
Receivable from residents	803		
Receivable from others	804		
Fixed Assets:	805		
Land	806		
Buildings and improvements	807		
Less allowance for depreciation (per books)	808		
Equipment (including motor vehicles)	809		
Less allowance for depreciation (per books)	810		
Leasehold Improvements	811		
Less allowance for amortization	812		
Construction in Process	813		
Other assets	814		
TOTAL ASSETS	815		
LIABILITIES:			
Accounts payable	816		
Accrued taxes (payroll and property)	817		
Other liabilities	818		
	819		
Notes and mortgages payable to officers, stockholders, owners, etc.	820		
Notes and mortgages payable to others	821		
TOTAL LIABILITIES	822		
EQUITY:			
Capital stock	823		
Paid-in surplus	824		
Retained surplus	825		
Partners' and proprietor's capital account(s)	826		
Partners' and proprietor's drawing account(s)	827		
Equity (nonprofit organization)	828		
TOTAL EQUITY	829		
TOTAL LIABILITIES AND EQUITY	830		

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report From:	To:

**SCHEDULE F
RECONCILIATION OF EQUITY**

	Line No.	Current Period
TOTAL EQUITY BEGINNING OF PERIOD	850	
Add:		
Net revenue from Schedule A	851	
Capital stock issued	852	
Partners' and proprietor's additional investment	853	
Other: Explain	854	
	855	
	856	
Deduct:		
Expenses per general ledger from Schedule C	857	
Capital stock retired	858	
Sub "S" corporation distribution	859	
Partners' and proprietor's withdrawals	860	
Dividends	861	
Other: Explain	862	
	863	
	864	
TOTAL EQUITY END OF PERIOD	865	

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE G
RELATED PARTY TRANSACTIONS**

[90101] Does this cost report include any costs associated with services, facilities or supplies furnished by a related party or organization?

Yes - Complete This Schedule

No - This Schedule Does Not Apply

Name of Related Party or Organization (1)	Line No.	Description of Service or Supplies (2)	Amount (3)	Schedule (4)	Line (5)
	900				
	901				
	902				
	903				
	904				
	905				
	906				
	907				
	908				
	909				
	910				
	911				
	912				
	913				
	914				
	915				
	916				
	917				
	918				

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From	To:

**SCHEDULE H
NURSING FACILITY WAGES AND HOURS**

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C NF (2)	Total Hours NF (3)	Average Hourly Wage (4)	Average Hours Per Patient Day (5)
1	Administrator wages					
2	Business Office wages					
12	Home office costs					
18						
20	Laundry wages					
21	Housekeeping wages					
22	Maintenance wages					
38						
40	D.O.N. wages					
41	R.N. wages					
42	Licensed Practical Nurses wages					
43	Certified Nurse Aides wages					
44	Activities wages					
45	Social Services wages					
52	Certified nursing aide training wages					
54	Professional support services					
55	Contracted nursing services					
56	Occupational Therapy					
57	Physical Therapy					
58	Speech Therapy					
59	Respiratory therapy					
60						
62	Medical Records Services wages					
63	Medical Director wages					
64	Dietary Service Wages					
81						
91						
93	Beauty and barber shops					
97	Director fees					
98	Nonworking officers' salaries					
99	Professional Care (Physicians)					
101						

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

**SCHEDULE H - 1
ASSISTED LIVING WAGES AND HOURS**

Sch C Line No.	Occupation or Employment Category	Entry Level Hourly Wage (1)	Total Wages Schedule C - 1 Assisted Living (2)	Total Hours Assisted Living (3)	Average Hourly Wage (4)	Average Hours Per Resident Day (5)	Allocation of Staff Time			
							Assisted Living % of time (6)	Nursing Facility % of time (7)	Service Development % of time (8)	Other % of time (9)
1	Administrator wages									
2	Business Office wages									
12	Home office costs									
18										
20	Laundry wages									
21	Housekeeping wages									
22	Maintenance wages									
38										
40	D.O.N. wages									
41	R.N. wages									
42	Licensed Practical Nurses wages									
43	Certified Nurse Aides wages									
44	Activities wages									
45	Social Services wages									
52	Certified nursing aide training wages									
54	Professional support services									
55	Contracted nursing services									
56	Occupational Therapy									
57	Physical Therapy									
58	Speech Therapy									
59	Respiratory therapy									
60										
62	Medical Records Services wages									
63	Medical Director wages									
64	Dietary Service Wages									
81										
91										
93	Beauty and barber shops									
97	Director fees									
98	Nonworking officers' salaries									
99	Professional Care (Physicians)									
101										

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SCHEDULE I
FULL TIME EMPLOYEE RETENTION AND TURNOVER RATES

- 1. Total number of W-2's _____
- 2. **Adjustment:** Number of W-2's for temporary or part-time employees _____
- 3. Total number of full time employees who worked anytime during the year. _____
- 4. **Adjustment:** Number of full time employees hired during the year _____
- 5. Total number of full time employees who were employed at the start of the year _____
- 6. **Adjustments:** Number of full time employees separated anytime during the year. _____
- 7. Number of full time employees who worked the entire year. _____

Full time employee retention rate	_____
Full time employee turnover rate	_____

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	Vendor No.:	0
Period of Report: From	01/00/00	To:	01/00/00

SCHEDULE I-1 **Nursing**
Facility Annual Calculation Of Employee Turnover

Total Number of Employees on the First day of each Month														Average for the Year	
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0.00
2	Business Office													0	0.00
20	Laundry													0	0.00
21	Housekeeping													0	0.00
22	Maintenance													0	0.00
40	D.O.N.													0	0.00
41	R.N.													0	0.00
42	Licensed Practical Nurses													0	0.00
43	Certified Nurse Aides													0	0.00
44	Activities													0	0.00
45	Social Services													0	0.00
62	Medical Records Services													0	0.00
63	Medical Director													0	0.00
64	Dietary Service													0	0.00
	Other Staff													0	0.00
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0.00

Total Number of Terminations Each Month														Average Turnover Rate	
Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	
1	Administrator													0	0%
2	Business Office													0	0%
20	Laundry													0	0%
21	Housekeeping													0	0%
22	Maintenance													0	0%
40	D.O.N.													0	0%
41	R.N.													0	0%
42	Licensed Practical Nurses													0	0%
43	Certified Nurse Aides													0	0%
44	Activities													0	0%
45	Social Services													0	0%
62	Medical Records Services													0	0%
63	Medical Director													0	0%
64	Dietary Service													0	0%
	Other Staff													0	0%
Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0%

Nursing Only		0%
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IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (1)

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	Vendor No.:
Period of Report: From:	To:

SUPPORTING SCHEDULE (2)

IOWA FINANCIAL AND STATISTICAL REPORT

NAME OF FACILITY:	VENDOR NUMBER(s):
PERIOD OF REPORT	FROM: TO:

EDIT CHECKS

Diagnostics Summary - Any differences indicate that numbers are not flowing properly between the schedules.
Note: These amounts will automatically fill in based on your completed Financial and Statistical Report

Schedule Reference	Amount	Reference
Schedule C		
Total Costs		Line 103 Column 4
Total Costs - Allocated		Line 103 Column 12
Difference		
Total Admin Costs		Line 19 Column 4
Total Admin Costs - Allocated		Line 19 Column 12
Difference		
Total Env Costs		Line 39 Column 4
Total Env Costs - Allocated		Line 39 Column 12
Difference		
Total Patient Care Costs		Line 83 Column 4
Total Patient Care Costs - Allocated		Line 83 Column 12
Difference		
Total Property Costs		Line 92 Column 4
Total Property Costs - Allocated		Line 92 Column 12
Difference		
Total Other Costs		Line 102 Column 4
Total Other Costs		Line 102 Column 12
Difference		

Schedule E		
Total Assets		Current Period Column - Total Assets
Total Liabilities & Equity		Current Period Column - Total Liabilities and Equity
Difference		

Schedule F		
Total Equity - Sch E		Current Period Column - Total Equity
Total Equity - Sch F		Total Equity End of Period
Difference		

COMPLETED SCHEDULES

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Schedules will automatically be determined based on your

Schedule	Required	Completed
Vendor Number	Yes	Warning - Schedule must be completed.
Certification Statement	Yes	Warning - Schedule must be completed.
Statistical Data	Yes	Warning - Schedule must be completed.
Schedule A - Total Facility Revenue	Yes	Warning - Schedule must be completed
Schedule A-1	N/A	N/A
Schedule A-2	No	N/A
Schedule C	Yes	Warning - This schedule must be completed.
Schedule C-1	No	N/A
Schedule D	Yes	Warning - Schedule must be completed
Schedule D-1	No	N/A
Schedule E	Yes	Warning - This schedule must be completed.
Schedule F	Yes	Warning - This schedule must be completed.
Schedule G	No	N/A
Schedule H	Yes	Warning - This schedule must be completed.
Schedule H-1	No	N/A
Schedule I	Yes	Warning - This schedule must be completed.
Schedule I-1	Yes	Warning - This schedule must be completed.

COMPLETED QUESTIONS

Diagnostics Summary - Any Warning message must be resolved.
Note: Required Questions will automatically be determined

Schedule	Required	Completed
Certification Statement [15101]	Yes	Warning - Question must be answered
Certification Statement [17101]	Yes	Warning - Question must be answered
Statistical Data [18101]	Yes	Warning - Question must be answered
Statistical Data [20101]	Yes	Warning - Question must be answered
Statistical Data [20102]	Yes	Warning - Question must be answered
Schedule D [77101]	Yes	Warning -Part 1 and 2 must be answered.
Schedule D-1 [78101]	Yes	Warning - Question must be answered
Schedule G [90101]	Yes	Warning - Question must be answered



The assessment fee is calculated based on information reported on the facility's *Financial and Statistical Report* for the most recent fiscal year end.

The Department will increase each facility's Medicaid rate by an amount equal to 5.5 percent of the total annual revenues for the preceding fiscal year to account for the provider assessment fee. The increase in Medicaid rates is effective upon implementation of the provider assessment fee.

Each year following the submission and review of the *Financial and Statistical Report*, the Department or its contractor will notify each facility of the amount of monthly assessment fee that is due.

The assessment fee is subject to adjustment based on any adjustments made to the financial and statistical reports. The Department will deduct each facility's monthly provider assessment fee from their monthly medical assistance payments.

2. Method of Reimbursement

The Medicaid program reimburses ICFs/ID under a cost-related vendor payment system, with a per diem set for each facility. This rate is established on the basis of financial and statistical data submitted by the facility on the [Financial and Statistical Report, form 470-0030](#). The financial data submitted by the facility is audited by the accounting firm under contract with the Department.

a. Out-of-State Facilities

Payment will be made for care in out-of-state ICFs/ID. Out-of-state facilities shall abide by the same policies as in-state facilities, with the following exceptions:

- ◆ Out-of-state providers will be reimbursed at the same rate they are receiving from their state of residence subject to the maximum allowable cost ceiling.
- ◆ Out-of-state facilities shall not submit financial and statistical reports.
- ◆ Payment for periods when residents are absent for visits or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.



b. Payment to New Facility

(1) Budget

A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date.

The Medicaid per diem rate for a new facility is based on the submitted budget, subject to review by the accounting firm under contract with the Department. The rate is subject to the maximum allowable cost ceiling. The beginning rate for a new facility is effective with the date of Medicaid certification.

(2) First Six Months

Following six months of operation as a new community-based Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. This financial and statistical report establishes a rate which may include inflation but will not include an incentive. The rate computed from this cost report is adjusted to 100 percent occupancy and continues to be subject to the maximum allowable cost ceiling.

(3) Second Six Months (Base Rate)

Following the first 12 months of operation as a Medicaid-certified ICF/ID, the facility shall submit a cost report for the second six months of operation. The accounting firm under contract with the Department will perform an on-site audit of facility costs.

Based on the audited cost report, a rate will be established for the facility. This rate will be the facility's base rate until rebasing of facility costs occurs. The reimbursement rate for the second six months cost report is subject to the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.



(4) Subsequent Reports

After the second six months of operation and in order to bring the facility reporting cycle to a June 30 reporting period, facilities must submit cost reports based on the following:

- ◆ Facilities receiving initial certification between July 1 and December 31 shall submit three successive six-month cost reports covering the first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.
- ◆ Facilities receiving initial certification between January 1 and June 30 shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

The reimbursement rate for all subsequent cost reports is the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

c. Payment to New Owner

An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established. The facility shall submit one report for the period of July 1 to June 30. A new base rate will not be established because of a change in ownership.

d. Payment to Existing Facilities

The following reimbursement limits apply to all non-state owned ICFs/ID:

- ◆ The facility's cost report covering the period from January 1, 1992, to June 30, 1992, is used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually covering the 12 months from July 1 to June 30.



- ◆ The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, is calculated using the method in place before July 1, 1992, including inflation and incentive factors.
- ◆ The reimbursement rate is the lower of the actual allowable per diem rate, the maximum allowable base rate, or the maximum allowable cost ceiling.

State-owned ICFs/ID shall submit semiannual cost reports. They receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index, all urban consumers, U.S. city average.

e. Rate Determination

(1) Business Startup and Organization Costs

The costs incurred during the period of developing a provider's ability to furnish patient care services are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example:

- ◆ Administrative and program staff salaries,
- ◆ Heat, gas and electricity,
- ◆ Taxes, insurance, mortgage and other interest,
- ◆ Employee training costs,
- ◆ Repairs and maintenance, and
- ◆ Housekeeping.

Any other costs that are properly identifiable as organization costs or capitalized as construction costs must be appropriately classified as such.

Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the cost of future periods of operation. Organization costs must be amortized over a five-year period.



Allowable organization costs include, but are not limited to:

- ◆ Legal fees incurred in establishing the corporation or other organization, such as:
 - ◆ Drafting the corporate charter and bylaws
 - Legal agreement
 - Minutes of organization meetings
 - Terms of original stock certificates
- ◆ Necessary accounting fees,
- ◆ Expenses of temporary directors and organizational meetings of directors and stockholders, and
- ◆ Fees paid to states for incorporation.

The following types of costs are not considered allowable organization costs:

- ◆ Costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, and accountant's or lawyer's fees;
- ◆ Costs of qualifying the issues with the appropriate state or federal authorities; and
- ◆ Stamp taxes.

(2) Administrative Costs

Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the following:

- ◆ Administrative salaries
- ◆ Accounting costs
- ◆ Clerical costs
- ◆ Data processing
- ◆ Personnel department
- ◆ Management fees
- ◆ Home office and other organizational costs
- ◆ Office supplies and postage
- ◆ Indirect business expense



(3) Actual Allowable Cost Per Diem

The actual allowable cost for ICFs/ID shall be the actual audited reported cost plus the inflation factor and may include an incentive factor.

For community-based ICFs/ID, an additional occupancy factor is used in determining the actual per diem rate for the facility. Typically the per diem is arrived at by dividing the actual allowable reported costs by total patient days during the reporting period.

Total patient days for purposes of rate determination shall be actual inpatient days or 80 percent of the licensed capacity of the facility, whichever is greater.

(4) Inflation Factor

The inflation factor is equal to the lesser of the percentage increase of the Consumer Price Index for all urban consumers, U.S. city average, or the average percentage increase of actual costs from the prior year, of "Unaudited Compilation of Various Costs and Statistical Data." The inflation factor is applied to the first six months and all subsequent cost reports submitted by a new ICF/ID and the annual cost reports for the existing ICFs/ID.

(5) Incentive Factor

An incentive factor for new facilities is applied to the first six-month cost report files ending June 30 after a base rate has been established. The incentive factor for existing ICFs/ID is applied annually.

Facilities with a per diem cost percentage increase of less than the percentage increase of the Consumer Price Index are given their actual percentage increase plus one-half the difference of the Consumer Price Index less their actual percentage increase. This percentage difference times the actual per diem cost for the annual period just completed is the incentive factor.



Facilities whose annual per diem cost decreased from the previous year are given one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. One-half of the percentage increase of the Consumer Price Index times the actual per diem cost for the annual period just completed is the incentive factor.

(6) Maximum Allowable Base Rate

The maximum allowable base rate for the first annual period is determined by taking the per diem rate calculated for new facilities for the base period and then multiplying it by the Consumer Price Index and adding it to the base rate. The maximum allowable base rate for each period thereafter (until rebasing) is calculated by increasing the previous year's maximum allowable base by the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average.

Facility rates will be rebased using the cost report for the year covering state fiscal year 1996 and will subsequently be rebased each four years. The Department will consider allowing special rate adjustments between rebasing cycles if:

- ◆ An increase in the minimum wage occurs.
- ◆ A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- ◆ A decision is made by a facility to serve a significantly different resident population or to otherwise make a dramatic change in program structure. (Documentation and verification will be required.)
- ◆ A facility increases or decreases licensed bed capacity by 20 percent or more.



(7) Maximum Allowable Cost Ceiling

The maximum allowable cost ceiling is set at the eightieth percentile of all participating community-based Iowa ICFs/ID based on the "Unaudited Compilation of Various Costs and Statistical Data." The eightieth percentile maximum rate is adjusted July 1 of each year. The state hospital-schools are not included in the compilation of facility costs.

(8) Reimbursement Rate (Payment Rate)

The reimbursement rate is the lower of the actual allowable per diem rate, the maximum allowable based rate, or the maximum allowable cost ceiling.

f. Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, only one claim should be submitted per month after the end of the month.

Payment will be made for covered services when the IME receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

The IME generates payments weekly and mails checks every Wednesday.

3. Periods of Service for Which Payment Will Be Authorized

Payment for care in an ICF/ID is authorized to begin on the date that the resident is certified as medically needing that level of care and is otherwise financially eligible for Medicaid. It can continue as long as both of these criteria are met and the resident remains in care.

If only a distinct part of the total facility has been certified as an ICF/ID, payment may be approved through the Medicaid program only for residents who occupy beds in the certified part of the facility. The facility shall not submit claims to the state nor request authorizations from the Department for residents who do not receive care in the certified part of the facility.



Payment for care in an ICF/ID is made on a per diem basis for the portion of the month the resident is in the facility. Payment is made for the day of admission but not the day of discharge or death. No payment shall be made for care of persons entering and leaving the facility the same day. If there is excess resident participation because the resident leaves the facility early in the month, the facility must refund the excess to the resident.

Under certain conditions, a facility may receive Medicaid payments for days that a resident is absent for visits or hospitalization. The facility shall report all resident absences to the county office using the [Case Activity Report, form 470-0042](#).

a. Absence for Hospitalization

Payment will be approved to hold the bed while the resident is hospitalized (not in a skilled bed) for a period not to exceed ten days in a calendar month, as long as the resident intends to return to the facility. However, if the person enters a mental health institute, this provision no longer applies. Payment will not be made for over ten days per month.

For example:

A resident enters the hospital on September 21 and is discharged on October 14. The resident then reenters the hospital on October 18 and is discharged October 31.

For the first hospitalization, Medicaid pays to hold the bed for the 10-day period of September 21 through 30. The 10 days renews in October.

In the second month, Medicaid pays to reserve the bed for the period of October 1 through 10 (10 days). The periods of October 11 through 14 and October 18 through 31 are not covered due to the 10-day limit in any one month.

NOTE: Payment for reserving a bed is made only when a resident was admitted before the absence. No payments are made to reserve a bed in a facility to which a resident intends to transfer.



b. Absence for Visits

Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. These days may be taken at any time. There is no restriction as to the amount of days taken in any one month or on any one visit, as long as the days taken in the calendar year do not exceed 30. Visit days shall not be used to extend payment for hospital stays. The resident must intend to return to the facility.

Additional days may be approved for special programs of evaluation, treatment, or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

c. Payment Rate for Reserved Beds

Medicaid payments for reserved bed days in an ICF/ID of over 15 beds are made at the rate of 80 percent of the allowable audited cost (facility costs plus any added factors). Facilities with 15 or fewer beds are reimbursed at 95 percent of the allowable audited cost for reserved bed days.

Since the reserved bed payment rate has the result of changing the financial participation in some cases, administrators must ensure that the correct amount of financial participation is collected. This is particularly important where a resident leaves the facility and is due a refund on financial participation previously collected.

d. Payment After Medical Eligibility Denial

The Department is bound by medical review determinations performed by the IME Medical Services Unit. The Department is not authorized to pay for ICF/ID services provided to persons who do not satisfy the medical necessity criteria, even if the person is financially eligible. However, in certain cases, the Department continues limited Medicaid coverage after the IME Medical Services Unit eligibility denial.



(1) Grace Days

Financially eligible persons who are (or would be) new admissions to an ICF/ID and are medically denied by the IME Medical Services Unit are not eligible for ICF/ID service payment from Medicaid. Medicaid members in ICFs/ID who receive “continued stay” medical denials may be eligible for a grace-day period of up to 30 working days in order to make alternate arrangements for the member.

If the facility and county service worker reports document that no appropriate, alternate placement is available within a reasonable distance, this grace period may be extended until alternate placement becomes available. Extension of grace days beyond the standard 30 working days is a joint determination of the Bureau of Long-Term Care and the IME Medical Services Unit liaison personnel.

(2) Continuation of Other Medicaid Services

Even if the IME Medical Services Unit has denied a Medicaid member for ICF/ID service, the person may still be eligible to receive other Medicaid services if the person would be eligible for SSI if still at home.

Presuming that some other payment source is available to maintain the SSI-eligible resident at the ICF/ID, other covered medical services can be reimbursed through other Medicaid vendors, such as physicians, pharmacies, medical appliance dealers, etc.

ICF/ID residents who would not be eligible for SSI if still in their own homes may be ineligible for Medicaid if they are medically denied by the IME Medical Services Unit, or they may be eligible for partial Medicaid benefits.

4. Supplementation

Medicaid rules prohibit supplementation of the Medicaid payment for care in an ICF/ID. Only the amount of resident participation may be billed to the resident. No supplementation of the state payment shall be made by any person. Practices such as charging residents or their families extra money for a private room are considered to be supplementation and are not permissible, even if the payment is offered voluntarily.



EXCEPTIONS:

- ◆ A resident, the family, or friends shall be allowed to pay a facility to reserve a resident's bed beyond the maximum number of reserve bed days that the Department pays or allows to be paid from resident participation. When a resident is not discharged, payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate.

However, facilities which discharge a resident after the date the state discontinues payment may make arrangements with the resident or family to hold the bed at whatever rate is agreed upon by both parties. Facilities must make arrangements with residents or their families to reserve beds in advance of the date when the reserve bed days run out and the resident is billed for the bed.

- ◆ There are cases when a family member or other interested person wishes to make an ongoing voluntary contribution toward the cost of care of a Medicaid resident. Such payments shall not be considered as supplementation, so long as they increase the resident's member participation and are not over and above the payment made by the state for care or the resident.

The [Voluntary Contribution Agreement, form 470-0373](#), may be used to implement such a voluntary contribution.

Voluntary Contribution Agreement

1. I _____, agree to contribute \$ _____ monthly toward the care of _____, a Medicaid resident of _____, a health care facility located in _____. This contribution will be furnished to the facility no later than the _____ day of each month. I understand that this contribution is completely voluntary. I am making it with the understanding that I may terminate or change the amount of contribution at any time I so desire. If I decide to terminate or change the amount of my contribution, I will notify the facility of my intentions.

Name	Date
Address	

2. I understand that the voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the basic cost of the care of the resident designated and that if such contribution ceases, or changes in amount, the local office of the Department of Human Services will be promptly notified.

Administrator or Representative	Date
Facility	
Address	

3. I understand that the amount of voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the care of the resident named until notified otherwise. Upon notification of any change in the amount of contribution, such information will be promptly forwarded to the Quality Assurance Section of the Department of Human Services and, if applicable, a new letter of Agreement will be initiated.

Department of Human Services Representative	Date
Local Office	