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For Human Services use only:

General Letter No. 8-AP-446
Employees' Manual, Title 8
Medicaid Appendix

May 13, 2016

INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED (ICF/ID) MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED (ICF/ID)***, Chapter III, *Provider-Specific Policies*, Contents (page 3), revised; pages 8, 11, 12, 15 through 19, 25, 33, 38, 41, 42, 43, 50, and 53 through 58, revised.

Summary

The ***INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED MANUAL*** is revised to:

- ◆ Align with current IA Health Link policies, procedures, and terminology.
- ◆ Update links due to the Department's new website.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the ***INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED MANUAL***:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 3)	May 1, 2014
8, 11, 12, 15-19, 25, 33,	May 1, 2014
38, 41-43, 50, 53-64	

Additional Information

The new provider manual can be found at:
<http://dhs.iowa.gov/sites/default/files/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.



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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.

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.



E. AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS

Upon proper identification, the Iowa Medicaid Enterprise (IME), the Department's contracted managed care organizations (MCOs), 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, the IME, the Department's contracted MCOs, 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 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. Download a sample of the form at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1539.pdf>.



- ◆ 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 revisit 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 revisit 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 performed at least yearly. Their purpose is to determine if the resident continues to need the ICF/ID level of care. For members not enrolled with an MCO, continued stay reviews are the responsibility of the IME. For members enrolled with an MCO, the MCO will review the member's need for continued stay. For any review by an MCO which indicates a change in the member's level of care, the MCO will submit documentation of the change to the IME and the IME will make a final determination.

3. Eligibility for Services

Contact the Department on, or preferably before, admission of a resident who is expected to be financially eligible for Medicaid. Also contact the Department 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. For members enrolled with an MCO, the referral shall be made by the member's case manager assigned by the MCO. For members not enrolled with an MCO, the referral shall be made through the Department's selected 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. Members enrolled in an MCO must also obtain authorization from the MCO. 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.



- ◆ 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, and the resident's case manager for those members enrolled with an MCO, 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, case managers, 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.



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 regarding 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.



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. For those members enrolled with a managed care organization, the client's case manager shall participate as appropriate and allowed by the member. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

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.



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, older adult) 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. For members enrolled with an MCO, the member's case manager is assigned by the MCO.

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.

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.

The facility shall 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.

The facility shall 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.



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](#). The facility shall also notify the member's case manager for members enrolled with a managed care organization, or the Department's selected case management provider for members not enrolled with a managed care organization.

This should be done in sufficient time to permit the case manager 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) equals } \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, the Department's contracted MCOs with which the facility is enrolled, 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.



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.

2. Method of Reimbursement

For members not enrolled in an MCO 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.

State owned ICF/ID facilities will be reimbursed at 100% of allowable costs. Non-state owned ICF/ID facilities will be reimbursed at the lower of:

- ◆ Their current cost plus inflation;
- ◆ The 80th percentile; or
- ◆ The maximum allowable base rate

For members enrolled in an MCO, reimbursement will be at a rate negotiated between the facility and the MCO, which shall not be lower than the provider-specific per diem rate in effect on July 1, 2015.

3. Time Frames for Submitting Claims

Claims for members not enrolled in an MCO 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.

Claims for members enrolled in an MCO must be submitted to the MCO in accordance with their billing procedures.

4. 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 case manager 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 determined by the Bureau of Long-Term Care.



(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.

5. 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.



Iowa
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- ◆ 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 of the resident.

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