Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-389
Employees' Manual, Title 8
Medicaid Appendix

June 13, 2014

NURSING FACILITY MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***NURSING FACILITY MANUAL***, Title page, revised; Table of Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (pages 1 through 4), new; pages 1 and 113, new; and the following forms:

470-0369	*Agreement for Nursing Facilities and Skilled Nursing Facilities*, revised
470-0377	*Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*, revised
470-3494	*Nurse Aide Education Program Waiver Request*, unchanged
470-0042	*Case Activity Report*, revised
470-0030	*Financial and Statistical Report*, revised
470-4836	*Nursing Facility Quality Assurance Assessment Calculation Worksheet*, new
470-4829	*Nursing Facility Enhanced Medicaid Payment Report*, new

Summary

The ***NURSING FACILITY MANUAL*** is revised to:

- Reformat and revise the chapters on coverage and limitations and billing and payment to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters. This includes:
  - Removing Chapter E. Information on coverage and limitations is now included in Chapter III. *Provider-Specific Policies*.
  - Removing Chapter F. Billing and payment information and forms are now included in Chapter IV. *Billing Iowa Medicaid*.
- Align with current policies, procedures, and terminology.
- Ensure that current contact information is provided.
- Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make sure that the most recent version of the form is accessible.

Date Effective

Upon receipt.

Material Superseded

This material replaces the entire Chapter E and Chapter F from the ***NURSING FACILITY MANUAL***, which includes the following:

Page	Date
Title page	Undated
Contents (pages 4, 5)	February 1, 1999
Contents (pages 6, 7)	July 1, 1999
Contents (page 8)	July 1, 2000
Chapter E	
1-4	February 1, 1999
5-10 (HCFA-671)	7/95
11 (HCFA-2567L)	Undated
12	February 1, 1999
13, 14 (470-0369)	12/98
15-18 (470-0377)	7/91
19-24	February 1, 1999
25-27 (HCFA-1513)	5-86
28	Undated
29-58	February 1, 1999
59, 60 (470-3494)	3/99
61-63	February 1, 1999
64, 64a	July 1, 2000
65, 66	February 1, 1999
67-82 (MDS 2.0)	September 2000
83-118	February 1, 1999
119, 120 (470-0042)	6/00
121-124	February 1, 1999
125	November 1, 1999
126	July 1, 1999
127-132	February 1, 1999
133	July 1, 1999
134	February 1, 1999
135, 136, 136a	July 1, 2000
137, 138	February 1, 1999
139	July 1, 2000
140-146	February 1, 1999
147 (470-0373)	1/79
148-150	February 1, 1999
151 (470-0041)	2/00
152	July 1, 1999
153	February 1, 1999
154-168, 168a (470-0030)	5/00
169-177	February 1, 1999
178, 178a	July 1, 2000

179-192	February 1, 1999
193, 194, 194a	July 1, 2000
195-202	February 1, 1999
203	July 1, 1999
204-215	February 1, 1999
216	July 1, 1999
217-220	February 1, 1999
Chapter F	
1-4	February 1, 1999
5, 6 (470-0039)	7/97
7, 8	February 1, 1999
9 (Remittance Advice)	6/12/97
10, 11	February 1, 1999
12	July 1, 2000
13 (470-3744)	4/00
14	Undated
15 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at: http://dhs.iowa.gov/sites/default/files/nf.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.

Nursing Facility

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

This chapter outlines the policies and procedures governing nursing facility care, one of the health care services available in Iowa through the Medicaid program. The chapter covers all nursing facilities, whether free-standing nursing homes, distinct parts of hospitals, or nursing facilities which are Medicare-certified.

Nursing facilities wishing to participate in the Medicaid program must comply with federal and state rules and regulations. This chapter sets forth the standards and requirements that are conditions for participation in the Medicaid program.

A. CERTIFICATION PROCEDURES

All nursing facilities must enter into a contractual agreement with the Department that sets forth the terms under which they will participate in the Medicaid program. The steps leading to certification of a nursing facility and issuance of a Medicaid provider agreement are:

- The facility obtains the applicable license from the Health Facilities Division of the Iowa Department of Inspections and Appeals (DIA).
- The facility requests Medicaid application materials from Iowa Medicaid Enterprise (IME), completes the application, and returns it to IME.
- The DIA Division of Health Facilities, under contract to the Department of Human Services (DHS), surveys the facility for compliance with Medicaid certification standards.
- DIA recommends the facility for certification as a nursing facility.
- DHS issues a provider agreement.

The Department office responsible for the nursing facility portion of the program is the Bureau of Long Term Care in the IME.

Facilities may order DHS forms and brochures from Iowa Prison Industries. Facilities may obtain a *Form Order Blank* by calling (800) 432-9163. Completed order forms may be sent to:

Iowa Prison Industries
406 N High St
Anamosa, IA 52205

The following sections give additional information on:

- Certification Survey
- Provider Agreement

1. Certification Survey

All survey procedures must be in accordance with U.S. Department of Health and Human Services publication "Providers Certification State Operations Manual."

New facilities must contact DIA initially. The Health Facilities Division schedules and completes an unannounced survey of the facility, in cooperation with the State Fire Marshal. After the initial survey, DIA schedules the survey.

a. Long Term Care Facility Application for Medicare and Medicaid

Form CMS-671, *Long Term Care Facility Application for Medicare and Medicaid*, collects information regarding the services the facility intends to provide. Click here to view the form online.

Facilities must complete this form:

- At the initial request for Medicaid certification.
- Upon each survey of the facility.

b. Statement of Deficiencies and Plan of Correction

Both the Health Facilities Division and the State Fire Marshal use form CMS-2567, *Statement of Deficiencies and Plan of Correction*, to notify the facility of any deficiencies and ask for a plan for their correction. Click here to view the form online.

The Health Facilities Division evaluates the survey findings and plan of correction and decides whether to recommend the facility for certification as a Medicaid facility.

If the facility is recommended for Medicaid certification, DIA notifies the DHS and makes recommendations about terms and conditions of a provider agreement.

c. Plan of Correction

When a facility is found to be out of compliance, the facility must submit a plan of correction to DIA within 15 calendar days from the date DIA mails the survey results to the provider. (If more time is required, the facility may request an extension from DIA.) DIA must approve this plan before the facility can be recommended for certification in the Medicaid program.

If the survey indicates deficiencies in the areas of American National Standards Institute (ANSI) standards, or environment, the facility must submit a timetable detailing corrective measures. This timetable must detail corrective steps to be taken and when corrections will be accomplished. Time allowed will depend upon the deficiency cited.

The following standards apply in these instances:

- DIA must approve the timetable submitted in the plan of correction.
- During the period allowed for corrections, the facility must be in compliance with existing state fire safety and sanitation codes.
- DIA must survey the facility 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, etc. Continued verification is contingent upon no period of substantial compliance beyond six months.

If the survey indicates deficiencies in the life safety code, the facility must also submit a timetable detailing corrective measures. The State Fire Marshall must review and approve the plan for corrective measures. The State Fire Marshall must recommend approval or denial of life safety code waivers.

The Centers for Medicare and Medicaid Services (CMS) has the final decision on life safety code waivers and any timetables submitted for correction.

2. Provider Agreement

a. Agreement for Nursing Facilities and Skilled Nursing Facilities

DIA must recommend a facility for certification as a nursing facility before a provider agreement may be issued. The effective date of a provider agreement may not be earlier than the date of certification.

Agreements between the Department and the facility are not time-limited. Provider agreements remain in effect until the facility changes owners or is no longer certified by DIA.

Click here to view the *Agreement for Nursing Facilities and Skilled Nursing Facilities*, form 470-0369.

A transfer of ownership or operation terminates the participation agreement. A new owner or operator must establish that the facility meets the conditions for participation and must enter into a new agreement.

b. Nondiscrimination Compliance Review

Facilities should complete form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*, at the time of enrollment in the Medicaid program and periodically thereafter.

Click here to view the *Nondiscrimination Compliance Review*, form 470-0377.

When it becomes necessary for the Department to cancel 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.

B. PHYSICAL ENVIRONMENT

All facilities that provide nursing facility care and also provide other types of care must set aside a distinct or identifiable part for the provision of the nursing facility care. It must be clearly identified and licensed by DIA.

Iowa Department of Human Services

AGREEMENT FOR NURSING FACILITIES AND SKILLED NURSING FACILITIES

This agreement is between:

( )

here referred to as "the facility," and the Iowa Department of Human Services, here referred to as "the Department."

This agreement covers facility services provided to eligible residents in Medicaid-certified beds and is effective .

As a provider in the Iowa Medicaid Program, the facility agrees and assures that:

1. The facility will maintain admission, discharge, fiscal and other records necessary to document services the facility furnished to recipients for at least five years.

2. The facility will afford the Department and the United States Department of Health and Human Services, through their authorized representatives, the right to review facility records and substantiate claims submitted for payment under the program. The Department will hold information in facility records confidential.

3. The allowable charges determined in accordance with the policy of the Department will be the full and complete payment for the services provided. Except for the amount of client participation, the facility will make no additional charges to residents or family members or any other person for any supplies or services required for the care of the resident.

   If any additional payment is received or will be received from any other sources, the facility will deduct that amount from the amount paid by the Department. Any overpayment made by the Department shall be promptly returned to the Department. No Medicaid resident or responsible party shall be charged for items not specifically requested by the resident or responsible party.

4. Payment and satisfaction of claims will be from federal and state funds. Any false claims, statements, and documents or concealment of a material fact may be prosecuted under applicable federal and state laws.

5. The facility will notify the Department 60 days before a planned change of ownership.

6. This agreement may be terminated under the following conditions:

   a. By the facility by giving 30 days notice to the Department of intent to terminate participation, or

   b. By the Department by giving 30 days notice to the facility:

      - After it has been determined that the facility is not in substantial compliance with the provisions of this agreement, or
      - When the facility's state license or certification has been terminated or suspended by the regulatory authority, or
      - For any other reason as provided by 441 Iowa Administrative Code 79.2(249A), "Sanctions Against Provider of Care."

7. The facility will not deny service on the basis of race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability.

8. The facility will comply with the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975, as amended; and the Americans with Disabilities Act of 1990.

9. The facility will provide residents with advance directive material as required by law.

10. The facility will abide by all policy and procedures as explained in the Iowa Administrative Code, the Medicaid Provider Manual for Nursing Facilities or Medicaid Skilled Nursing Facility Manual, and supplemental policy material distributed by the Department.

Authorized Signature of Provider	Authorized Signature of Department
Title	Chief, Bureau of Long Term Care
Date	Date

Instructions:

Please complete and sign both copies and return one copy to: Robert Schlueter, Iowa Medicaid Enterprise, Provider Services Unit, PO Box 36450, Des Moines, Iowa 50315.

We are also enclosing two copies of form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*. Please complete both copies and retain one copy for your files. Return the other copy WITH NO DOCUMENTATION ATTACHED. If you have any questions concerning this matter, call 515-725-1396.

NONDISCRIMINATION COMPLIANCE REVIEW

The Department of Human Services has the responsibility for ensuring that Medicaid providers are in compliance with Title VI of the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 as amended; and the Age Discrimination Act of 1975, as amended.

Identifying Information

Facility Name	County	Phone ( )
Address		
Legal Auspices: ❑ Proprietary ❑ Nonprofit ❑ Governmental		Provider No.
Number of Beds _____ NF _____ Skilled _____Other Total_____		

Documentation to support the information you provide on this form must be available for inspection at the facility.

Yes No **A. Admission Policies**

❑ ❑ 1. Does your facility have an admissions policy prohibiting discrimination based on race, color, age, national origin, or disability (mental or physical)?

❑ ❑ 2. If such a policy has been adopted, is it in writing and posted?

❑ ❑ 3. Have the following been notified in writing of the facility's policy on nondiscrimination:
Note: If you answer no to any of the items, explain in Section G.

❑ ❑ Community
❑ ❑ Employees
❑ ❑ Residents
❑ ❑ Attending physicians

❑ ❑ 4. Is admission to your facility limited to membership in a defined group, e.g. fraternal organization, religious denomination, corporate employee, etc.?

If so, explain:_____

_____

5. Specify major referral sources for new admissions: _____

_____

6. What approximate percentage of your geographic service area population consists of racial minorities? _____%

B. Analysis of Residents Admitted During the Previous 12-Month Period

		RACIAL/ETHNIC GROUP IDENTIFICATION					With Disabilities	Age	
	Total	White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.		Age 40+	39 or less
Men									
Women									
Total									

C. Type of Room Assignment

Number of residents in:	White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.	With Disabilities
Single room or in room alone						
Semiprivate or ward room with **no** minority people						
Semiprivate or ward room with **only** minority people						
Semiprivate or ward room with mixed racial/ethnic groups						
Total						

D. General Availability of Facilities and Services

Yes No

❑ ❑ 1. Are all services and facilities available to and used by all residents without regard to race, color, age, national origin, or disability?

❑ ❑ 2. Can any licensed physician or therapist visit or treat a patient who is residing in this facility, regardless of race, color, age, national origin or disability of the patient or practitioner?

❑ ❑ 3. Has any qualified person within a disability been denied admission or excluded from participation in any applicable services or programs because the facility is structurally inaccessible? (If so, describe in Section G and state your plan for correction.)

❑ ❑ 4. Have persons with disabilities (or organizations representing them) assisted in identifying potential barriers to optimal participation by persons with disabilities in facility programs? (Please describe in Section G.)

❑ ❑ 5. Providers with fewer than 15 employees may refer persons with disabilities to an accessible provider only if no means other than a significant alteration in existing facilities is available. Do you have a procedure which is followed to ensure that referrals are made under this condition?

❑ ❑ 6. Do you have a method of determining where services may be provided at alternate accessible sites in a nondiscriminatory manner?

❑ ❑ 7. When assessing a person's eligibility for your programs and services, you use the same procedures for disabled and non disabled?

Yes No

❑ ❑ 8. Are appropriate services provided by your facility to persons with disabilities regardless of the nature of their disability?

❑ ❑ 9. Do you admit or treat alcohol or drug abusers in your programs or services on a nondiscriminatory basis?

❑ ❑ 10. Is there an effective means of communication for persons with hearing impairments receiving care in your facility?

❑ ❑ 11. Are auxiliary aids for persons with disabilities, including those with visual and hearing impairments, used to ensure equal benefit from services?

❑ ❑ 12. Has your staff been informed of the auxiliary aids which are available for service to persons who are disabled?

❑ ❑ 13. Does your facility have a written policy concerning hiring of bilingual employees to match bilingual characteristics of the population?

❑ ❑ 14. Does your facility have a written policy and procedure prohibiting discrimination in employment based on race, color, national origin, religion, sex, age, creed, and disability? If not, describe why in Section G.

E. Current Employment Breakdown

Staff Positions	White		Black		Hispanic		Amer. Ind. Alas. Nat.		Asian/ P.I.		With Disabilities	Age 40+	39 or less
	M	F	M	F	M	F	M	F	M	F			
Administrative													
RN/LPNs													
Nurses Aides													
Dietary													
Housekeeping & Maintenance													
Laundry													
Beauticians & Barbers													
Activities & Social Serv.													
Therapists & Consultants													
Other													
Other													
Total													

F. Grievance

Yes No

❑ ❑ 1. Does your facility have a written grievance policy and procedure prohibiting discrimination in the delivery of services to residents based on race, color, national origin, age, or disability?

2. Has your facility received a complaint of discrimination based on:
If so, describe in Section G.

Services to Residents:				Treatment of Employees:		
Yes	Number	No		Yes	Number	No
			a. Race			
			b.. Color			
			c. Religion			
			d. Creed			
			e. Sex			
			f. National Origin			
			g. Disability			
			h. Age			
			i. Other			

❑ ❑ 3. Is documentation maintained by your facility which can substantiate the nondiscriminatory practices on the basis of race, color, national origin, age, or disability? At the time of an on-site compliance review, documentation must be made available to the state's authorized reviewer.

G. Additional Information (Attach additional sheets, if necessary.)

CERTIFICATION

I CERTIFY THAT THE INFORMATION FURNISHED IN THIS CIVIL RIGHTS REVIEW REPRESENTS ACCURATELY THE POLICIES, PRACTICES, AND CURRENT STATUS OF THIS FACILITY.

Signature of Person Completing Form	Date
Authorized Signature - Administrator	Date

The distinct part must be identifiable as a unit, such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It must consist of all beds and related facilities in the unit where payment is being made for nursing facility services.

The distinct part must meet all requirements for a nursing facility. Hospitals participating as nursing facilities must meet all of the same conditions applicable to free-standing nursing facilities.

The facility must:

- Be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.
- Provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public.
- Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
- Provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.
- Provide adequate and comfortable lighting levels in all areas.
- Provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, must maintain a temperature range of 71 to 81 degrees Fahrenheit.
- Provide for the maintenance of comfortable sound levels.
- Maintain an effective pest control program so that the facility is free of pests and rodents.

The following sections explain the requirements for:

- Space and Equipment
- Resident Rooms
- Fire Safety

1. Space and Equipment

The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

The facility must provide one or more rooms designated for residents' dining and activities. These rooms must:

- Be well lighted.
- Be well ventilated, with nonsmoking areas identified.
- Be adequately furnished.
- Have sufficient space to accommodate all activities.

The facility must ensure that the residents' environment remains as free of accident hazards as possible. The facility must equip corridors with firmly secured handrails on each side.

The nurse's station must be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

An emergency electrical power system must supply power when the normal electrical supply is interrupted that is adequate at least for:

- Lighting at all entrances and exits.
- Equipment to maintain the fire detection, alarm, and extinguishing systems.
- Life-support systems.

When life-support systems that are used have no nonelectrical backup, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) located on the premises.

The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

2. Resident Rooms

Resident rooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. Facilities must provide a safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

Each resident room must be equipped with or located adjacent to toilet facilities unless DIA grants a waiver. Additionally, each resident room must be equipped with or located adjacent to bathing facilities.

Bedrooms must:

- Accommodate no more than four residents.
- Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single-resident rooms.
- Have direct access to an exit corridor.
- Be designed or equipped to ensure full visual privacy for each resident. In facilities initially certified after March 31, 1992, each bed (except in private rooms) must have ceiling-suspended curtains that extend around the bed, to provide total visual privacy in combination with adjacent walls and curtains.
- Have at least one window to the outside.
- Have a floor at or above grade level.

The facility must provide each resident with:

- A separate bed of proper size and height for the convenience of the resident.
- A clean, comfortable mattress.
- Bedding that is appropriate to the weather and climate, clean, and in good condition.
- Functional furniture appropriate to the resident's needs.
- Adequate storage facilities for the resident's personal effects, including individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

DIA may permit variations in requirements specified for rooms and furnishings in individual cases. To obtain a variance, the facility must demonstrate in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

3. Fire Safety

Except as provided below, the facility must meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

A facility that on October 26, 1982, complied with or without waivers with the requirements of the 1967, 1973, or 1981 edition of the Life Safety Code is considered to meet this requirement, as long as the facility continues to remain in compliance with those editions of the Code.

A facility that on May 8, 1988, complied with or without waivers with the 1981 or 1985 edition of the Life Safety Code is considered to meet this requirement, as long as the facility continues to remain in compliance with that edition of the Code.

Medicaid nursing facilities and Medicaid distinct-part nursing facility providers may request a waiver of Life Safety Code requirements in accordance with subsection 1919(d)(2)(B)(i) of the Social Security Act. DIA sends these requests to the CMS Regional Office for review and approval.

C. ADMINISTRATION

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

The facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes. The facility must also comply with accepted professional standards and principles that apply to professionals providing services in such a facility.

In addition to compliance with these rules, facilities must meet the applicable provisions of other regulations of the U.S. Department of Health and Human Services. These include, but are not limited to, regulations pertaining to:

- Nondiscrimination on the basis of race, color, national origin, age, or disability.
- Protection of human subjects of research.
- Fraud and abuse.

Although these regulations are not in themselves considered requirements under DHS rules, their violation may result in the termination or suspension of payment, or the refusal to grant or continue payment with federal funds.

The following sections detail requirements for:

- Policies and Procedures
- Facility Records

1. Policies and Procedures

The facility must have written policies and procedures that govern all areas of service provided by the facility. These documents must be available to staff, residents, their families or legal representatives, and the public.

Policies must describe the way in which services will be provided, directly or under written agreement. The facility must establish and maintain identical policies and practices regarding the provision of services for all persons regardless of source of payment. See also PROVISION OF SERVICES.

Facility policies must describe:

- The care of residents in emergencies.
- The care of residents when acutely ill, mentally or emotionally disturbed, or difficult to manage.
- The protection afforded residents' property rights and monies.
- Arrangements for residents to receive visitors and for residents to make outside visits. See also RESIDENT RIGHTS.

Facility policy must include procedures for transferring the resident when the facility can no longer meet the resident's needs. See also TRANSFER AND DISCHARGE.

The following sections describe the requirements for policies and procedures on:

- Nondiscrimination
- Facility Admissions Policy
- Notice of Resident Rights and Services
- Staff Treatment of Residents
- Infection Control
- Disaster and Emergency Preparedness

a. Nondiscrimination

The facility must:

- Adopt written statements that explain the facility's nondiscrimination policies and practices.
- Keep these policies current.
- Include these policies in any publication of staff regulations or public information brochures.
- Periodically review the policies with employees.

Where appropriate, the facility must provide copies of these statements to its residents, employees, attending physicians and other contractors providing services to residents.

b. Facility Admissions Policy

The facility's policies must describe the categories of residents accepted and not accepted. The facility must use its referral sources in a manner that ensures an equal opportunity for admission without regard to a person's race, color, or national origin, in relation to the population of the potential service area.

The facility must admit all residents without discrimination and must not make inquiries regarding race, color, or national origin before admission. Admission must not be restricted to members of any group or order that discriminates.

Facilities must:

- Apply policies regarding deposits, extension of credit, and other financial matters uniformly and without regard to race.
- Make information regarding the price and availability of accommodations uniformly available to all without regard to race, color, or national origin.

The facility must not require a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay in the facility. The facility may require a person who has legal access to a resident's income or resources to sign a contract to provide facility payment from the resident's income or resources, without incurring personal financial liability.

A facility must not require residents or potential residents to waive their rights to Medicare or Medicaid. A facility must not require oral or written assurance that residents or potential residents are not eligible for Medicare benefits or will not apply for them.

For a Medicaid-eligible person, the facility must not charge, solicit, accept, or receive any gift, money, donation, or other consideration in addition to the Medicaid payment as a precondition of admission, expedited admission, or continued stay in the facility.

A facility may solicit, accept, or receive a charitable, religious or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

The facility must give proper notice of the availability and cost of services to residents. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirements.

The state is not required to offer additional services on behalf of a resident other than services defined in this manual as included in the term "nursing facility services." A facility may charge a Medicaid-eligible resident for other items and services that the resident has requested and received, so long as:

- Notice requirements are met, and
- The facility does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

c. Notice of Resident Rights and Services

The facility must inform the resident of the resident's rights and all rules governing resident conduct and responsibilities during the stay in the facility. This information must be given both orally and in writing in a language that the resident understands. Residents must acknowledge receipt of this information and any amendments to it in writing.

Before or upon admission, and periodically during the resident's stay, the facility must inform each resident of:

- The services available in the facility, and
- Charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

At the time of admission, or when the resident becomes eligible for Medicaid, the facility must inform the resident in writing of the items and services included in nursing facility services under the Medicaid program for which the resident may not be charged.

The facility must also inform the resident in writing of those other items and services that the facility offers for which the resident may be charged, and the amount of charges for those services. The facility must also inform the resident when it makes changes to these items and services.

Before or upon admission and during the resident's stay, the facility must furnish a written description of legal rights that includes:

- A description of the manner of protecting personal funds.
- A statement that the resident may file a complaint with DIA concerning resident abuse, neglect, or misappropriation of the resident's property in the facility.

- A description of the requirements and procedures for establishing eligibility for Medicaid. This includes the right to request an assessment which:
  - Determines the extent of a couple's nonexempt resources at the time of institutionalization, and
  - Attributes to the community spouse an equitable share of resources that cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

The facility must provide residents and applicants for admission with oral and written information about:

- How to apply for and use Medicare and Medicaid benefits, and
- How to receive refunds for previous payments covered by these benefits.

The facility must display written information about this prominently in the facility. The facility must also provide the resident with the pamphlet *"Medicaid for People in Nursing Homes and Other Care Facilities,"* Comm. 52. See MEDICAID ELIGIBILITY for information about this and other publications that are available for this purpose.

Also at the time of admission, the nursing facility must provide written information to each resident that explains the resident's rights under state law to make decisions concerning medical care, including:

- The right to accept or refuse medical or surgical treatment, and
- The right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

"Advance directive" means written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

The nursing facility must:

- Document in the resident's medical record whether or not the resident has executed an advance directive.
- Ensure compliance with requirements of state law regarding advance directives.
- Provide for education for staff and the community on issues concerning advance directives.

The nursing facility must not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive. (Under Iowa law, a nursing facility may object to implementing an advance directive on the basis of conscience.)

d. Staff Treatment of Residents

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of residents, and misappropriation of resident property. Facility staff must not use verbal, mental, sexual, or physical abuse (including corporal punishment), or involuntary seclusion of residents.

The facility must not employ persons who:

- Have been found guilty by a court of law of abusing, neglecting, or mistreating people, or
- Have had a finding entered into the state Nurse Aide Registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property.

The facility must report to the state Nurse Aide Registry or licensing authorities any knowledge it has of court action against an employee that indicates unfitness for service as a nurse aide or other nursing facility staff.

The facility must ensure that the following are reported immediately to the administrator of the facility or to other officials (including DIA) in accordance with state law through established procedures:

- All alleged violations involving mistreatment; neglect or abuse, including injuries of unknown source.
- Misappropriation of resident property.

The facility must have evidence that all alleged violations are thoroughly investigated. The facility must prevent further abuse while the investigation is in process.

Within five working days of the incident, facility staff must report the results of all investigations to the administrator or the administrator's designated representative or to other officials (including DIA) in accordance with state law. If the alleged violation is verified, the facility must take appropriate corrective action.

e. Infection Control

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents live and to help prevent the development and transmission of disease and infection.

Under the facility's infection control program, it must investigate, control, and prevent infections in the facility. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

The program must determine what procedures, such as isolation, should be applied to an individual resident. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

The facility must maintain a record of incidents and corrective actions related to infections.

f. Disaster and Emergency Preparedness

The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

2. Facility Records

At a minimum, the nursing facility should maintain the following records:

- All records required by the Department of Public Health and DIA, including:
  - Resident or patient records
  - Incident records
  - Death records
  - Patient activities program records
  - Financial and statistical records
- All records required by 441 IAC Chapters 79 and 81, and in the provider agreement for nursing facilities, including:
  - Medical records.
  - Records of all treatments, drugs, and services for which Medicaid payment has been or will be made, including the authority for the treatment, drugs, or services and the date of administration.
  - Documentation in each patient's record that will enable the Department to verify that each charge is proper.
  - Financial records maintained in the standard, specified form including the facility's most recent *Financial and Statistical Report*.
- Records required by federal regulations, including:
  - Resident accounts
  - In-service education records
  - Inspection reports pertaining to conformity with federal, state, and local laws
  - Resident personal records
  - Resident medical records
  - Disaster-preparedness reports

Facilities must maintain records uniformly without discrimination for all residents. Identification by race, color, and national origin on records is not considered to be discriminatory. Facilities may use such identification to demonstrate compliance with Title VI.

Upon an oral or written request, the resident or the resident's legal representative has the right to access all records pertaining to the resident within 24 hours, including clinical records.

After receipt of the records for inspection, the resident or representative has the right to purchase photocopies of the records or any portions of them upon request. The resident must give two working days' advance notice to the facility. The facility may charge a cost for copies, not to exceed the community standard.

Facilities must retain resident personal records for a minimum of five years after death or discharge. Records not pertaining to individual residents must also be retained in the facility for a minimum of five years. All records must be retained within the nursing facility upon change of ownership.

a. Clinical Records

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. The records must be complete, accurately documented, readily accessible, and systematically organized. The clinical record must contain:

- Sufficient information to identify the resident.
- A record of the resident's assessments.
- The plan of care and services provided.
- The results of any preadmission screening or resident review conducted by the state and record of all interventions provided as a result.
- Progress notes.
- Nurses' notes.
- Physician orders.

- Procedure, laboratory, or test orders and results.
- Physical therapy, occupational therapy, and speech therapy notes.
- Medication administration records.
- *Case Activity Reports*.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

- Law for transfer to another health care institution.
- Third-party payment contract.
- The resident.

The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

b. Accounting for Residents' Personal Funds

The facility must establish and maintain a system that ensures a full, complete, and separate accounting of each resident's personal funds entrusted to the facility on the resident's behalf.

Accounting must be according to generally accepted accounting principles. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The facility must purchase a surety bond or otherwise provide assurance satisfactory to DIA and DHS to ensure the security of all personal funds of residents deposited with the facility.

Nursing facilities do not have the option of refusing to handle a resident's personal allowance funds if requested to do so. However, residents may elect to handle their own funds if they wish.

Facilities must maintain two types of accounts to handle resident personal allowance funds:

- Maintain a resident's personal funds that do not exceed $50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.
- Deposit any residents' personal funds in excess of $50 in an interest-bearing account that:
  - Is separate from any of the facility's operating accounts, and
  - Credits all interest earned on the resident's funds to that account.

In pooled accounts, there must be a separate accounting for each resident's share. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

Notify each resident who receives Medicaid benefits when the amount in the account reaches $200 less than the SSI resource limit for one person. Notify residents that they may lose eligibility for Medicaid or for SSI if the amount of the account, in addition to the resident's other nonexempt resources, reaches the SSI resource limit for one person.

Within 30 days after a resident's death, convey the resident's funds and a final accounting of those funds to the person or probate jurisdiction administering the resident's estate.

Obtain a receipt from the next of kin or the resident's guardian before releasing the balance of the deceased resident's personal needs funds and any money derived from the sale of property or possessions.

If the resident has no guardian, any funds left in the personal needs account reverts to DHS. In the event that an estate is opened, the Department must turn the funds over to the estate.

D. STAFF

The facility must employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation. Professional staff must be licensed, certified or registered in accordance with applicable state laws.

If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility.

Arrangements or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

The governing body appoints the administrator. The administrator must be licensed by the state and must be responsible for management of the facility.

The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

The following sections explain requirements for:

- Nurses
- Nurse Aides
- Nurse Aide Training and Competence Evaluation Programs (NATCEP)
- Dietary Staff
- Consultant Pharmacist
- Social Worker
- Activities Staff

1. Nurses

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Except when waived, the facility must designate a registered nurse to serve as the director of nursing on a full-time basis. Except when waived, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Except when waived, the facility must use the services of a registered nurse for at least eight consecutive hours per day, seven days a week. Except when waived, the facility must provide services by sufficient numbers of licensed nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

A facility may request a waiver from these requirements. A waiver may be granted if the following conditions are met:

- The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, including offering wages at the community prevailing rate for nursing facilities, to recruit appropriate personnel.
- DIA determines that a waiver of the requirement will not endanger the health or safety of facility residents.
- DIA finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility. This type of waiver is subject to annual review by DIA.

In granting or renewing a waiver, DIA may require a facility to use other qualified, licensed personnel.

DIA must provide notice of the waiver granted to the state long-term care ombudsman in the Department of Aging and to the state's agency for protection and advocacy for persons with disabilities.

The nursing facility that is granted a personnel waiver must notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

2. Nurse Aides

The facility must provide services by sufficient numbers of other nursing personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

"Nurse aide" means any person providing nursing or nursing-related services to residents in a facility who is not a:

- Licensed health professional.
- Registered dietitian.
- Person who volunteers to provide services without pay.

"Licensed health professional" means a:

- Physician
- Physician assistant
- Nurse practitioner
- Physical, speech, or occupational therapy assistant
- Registered or licensed professional nurse
- Licensed or certified social worker

The facility must ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Nurse aides may provide care only in those skill areas in which they have received training and have demonstrated competence. Before employment or within four months after employment, all nurse aides must pass a state-approved competency evaluation. See Nurse Aide Training and Competency Evaluation Programs for requirements.

The following sections explain requirements for:

- Demonstration of Competency
- Nurse Aide Registry Verification
- Registration Rights and Responsibilities
- In-Service Training and Performance Review

a. Demonstration of Competency

A facility must not use any person working in the facility as a nurse aide for more than four months (on a permanent, temporary, per diem, leased, or other basis) unless that person is competent to provide nursing and nursing-related services. The person must either:

- Have completed a state-approved training and competency evaluation program, or
- Have completed a state-approved competency evaluation, or
- Have been deemed or determined competent by DIA.

A facility may employ a person who does not meet these requirements as a nurse aide for less than four months if the person:

- Is a permanent employee, and
- Is in a state-approved nurse aide training and competency evaluation program.

When a person has not performed paid nursing or nursing-related services for a continuous period of 24 consecutive months since the most recent completion of a training and competency evaluation program, the facility must require the person to complete a new training and competency evaluation program or pass the competency evaluation again.

(A person may be employed as a nurse aide in a nursing facility, skilled nursing facility, certified or licensed hospital, federally certified home health agency, hospice, ICF/ID, or NF/MI to meet this employment requirement.)

No nurse aide who is employed by a facility, or who has received an offer of employment from a facility, on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program. This includes any fees for textbooks or other required course materials.

A facility must reimburse the nurse aide for costs incurred in completing the program when a person whose training costs were not covered by a facility becomes employed by the facility or receives an offer of employment from the facility within 12 months after completing the program.

The facility must reimburse the aide on a pro rata basis during the period in which the facility employs the person as a nurse aide. The formula for paying the nurse aide on a prorated basis is as follows:

- Add all costs incurred by the aide for the course, books, and tests.
- Divide this total by 12 to prorate the costs over a one-year period and establish a monthly rate.

Reimburse the aide at the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.

b. Nurse Aide Registry Verification

Facility staff must contact the Nurse Aide Registry before any person is hired as a nurse aide to determine if the person:

- Is on the Registry.
- Has completed an approved training course.
- Has passed the competency test.
- Has any founded abuse reports on the Registry record.

A facility must check with all state nurse aide registries it has reason to believe contain information on an individual before using that individual as a nurse aide.

To obtain information, facility staffs need the nurse aide's social security number and the last four digits of the facility license number.

The facility must ensure that the name of each person employed as a nurse aide in a Medicaid-certified facility in Iowa is submitted to the Nurse Aide Registry.

Within 30 days of when a nurse aide is hired and when a nurse aide's employment ends, the facility must complete form 427-0497, *Nurse Aide Employment Status Report*. This form may be obtained from and must be sent to the Nurse Aide Registry.

All information retained by the Nurse Aide Registry must be available to the public. This includes the name and social security number of the nurse aide, founded abuse reports, and a brief statement from the nurse aide, if available, disputing the findings of abuse. Other information collected will be kept for statistical purposes.

c. Registration Rights and Responsibilities

Persons employed as nurse aides must complete form 427-0496, *Nurse Aide Registry Application*, within the first 30 days of employment. A certified nurse aide who is not employed may also apply for inclusion on the Registry by submitting form 427-0496. This form may be obtained by calling or writing the Nurse Aide Registry.

Information will not be placed on the Registry until the nurse aide has successfully completed a competency evaluation. When the Registry has received and entered the required training and testing information, the Registry will send the nurse aide a letter that includes all the information the Registry has on the nurse aide.

A nurse aide may obtain a copy of the information on the Registry by writing or calling the Nurse Aide Registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, and date of birth.

When there is an allegation of abuse against a nurse aide, DIA will investigate the allegation. When DIA finds an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing.

The nurse aide must have 30 days to request a hearing. The request must be in writing and must be sent to the Nurse Aide Registry. The hearing must be held according to the appeals rules of the Department of Inspection and Appeals.

Information will not be placed on the Registry until an abuse allegation has been founded. If the nurse aide fails to appeal, the Nurse Aide Registry will include a notation after 30 days that the nurse aide has a founded abuse report on record.

If the nurse aide appeals, the notation must be made when all appeals are exhausted, if the final decision indicates the nurse aide performed an abusive act.

d. In-Service Training and Performance Review

The facility must provide 12 hours of in-service training each year to ensure that persons used as nurse aides are competent to perform services as nurse aides. Each nurse aide must receive and be compensated for 12 hours of in-service training each year.

Training may be offered for groups or individuals. Training for individuals may be performed on the unit as long as it is directed toward specific skill improvement, is provided by trained staff, and includes a return demonstration recorded on a checklist. In-service education must include training for persons providing nursing and nursing-related services to residents with cognitive impairments.

The facility must:

- Provide regular performance review to ensure that persons used as nurse aides are competent to perform services as nurse aides.
- Determine the format and content of the performance evaluation.
- Conduct an evaluation of each aide's work performance at least annually.
- Keep a record of the performance evaluation in the aide's personnel file.

3. Nurse Aide Training and Competency Evaluation Programs

The Department has designated DIA to approve required nurse aide training and testing programs. Before the DIA approves a nurse aide training and competency evaluation program (NATCEP), the DIA determines whether the program meets the requirements described in this section. The DIA also reviews the programs in the course of all facility surveys.

The following sections describe:

- Approval Process
- General Requirements
- Requirements for Instructors
- Requirements for Curriculum
- Requirements for Records and Reports
- Requirements for Competency Evaluations
- Exceptions to Facility Ineligibility

a. Approval Process

Facilities must submit applications to the DIA before a new program begins and every two years thereafter on form 427–0517, *Application for Nurse Aide Training*.

Within 90 days of the date of a request or receipt of additional information from the requester, the DIA will:

- Advise the requester whether or not the program has been approved; or
- Request additional information from the requesting entity.

The DIA will grant approval of a NATCEP for a period no longer than two years. When there are substantive changes made to a program within the two-year period, the program must notify the DIA, and the DIA will review that program.

Except as provided under Exceptions to Facility Ineligibility, the DIA will not approve a NATCEP offered by or in a facility which, in the previous two years:

- Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or
- Has been subject to an extended or partial extended survey; or
- Has been assessed a civil money penalty of not less than $5,000; or
- Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or
- Pursuant to state action, was closed or had its residents transferred; or
- Has been terminated from participation in the Medicaid or Medicare program; or
- Has been denied Medicaid payment.

The DIA will withdraw approval of a NATCEP offered by or in a facility when one of these events occurs.

The DIA may withdraw approval of a NATCEP if the DIA determines that any of the requirements for approval are not met. The DIA will withdraw approval of a NATCEP if the entity providing the program refuses to permit unannounced visits by the DIA.

If the DIA withdraws approval of a NATCEP, the DIA will notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started the program will be allowed to complete the course.

To secure approval for a competency evaluation program, submit a copy of the evaluation plan and procedures to DIA. The DIA will make a decision within 90 days of receipt of the application. If approval is denied, the DIA notification will include the reason for not giving approval and the applicable rule citation.

b. General Requirements

For a NATCEP to be approved by the DIA, it must, at a minimum:

- Consist of no less than 75 clock hours of training including at least:
  - 15 hours of laboratory experience.
  - 30 hours of classroom instruction.
  - 30 hours of supervised clinical training.
- Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor.
- Ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.
- Contain information regarding competency evaluation through written or oral and skills testing.

The first 16 hours of classroom instruction must occur before the nurse aide has resident contact. “Supervised clinical training” means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

The classroom must have appropriate equipment, be of adequate size, and not interfere with resident activities.

c. Requirements for Instructors

The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience. At least one year of this experience must be in the provision of long-term care facility services.

Instructors must be registered nurses and must have completed a course in teaching adults or have experience teaching adults or supervising nurse aides. Other personnel from the health professions may supplement the instructor. Supplemental personnel must have at least one year of experience in their fields.

The ratio of qualified trainers to students must not exceed one instructor for every ten students in the clinical setting.

In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

d. Requirements for Curriculum

The curriculum of the nurse aide training program must include:

- At least a total of 16 hours of training in the following areas before any direct contact with a resident:
  - Communication and interpersonal skills
  - Infection control
  - Safety and emergency procedures including the Heimlich maneuver
  - Promoting residents' independence
  - Respecting residents' rights
- Basic nursing skills:
  - Taking and recording vital signs
  - Measuring and recording height and weight

- Caring for the residents' environment
- Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor
- Caring for residents when death is imminent

♦ Personal care skills, including, but not limited to:

- Bathing
- Grooming, including mouth care
- Dressing
- Toileting
- Assisting with eating and hydration
- Proper feeding techniques
- Skin care
- Transfers, positioning, and turning

♦ Mental health and social service needs:

- Modifying aide's behavior in response to residents' behavior
- Awareness of developmental tasks associated with the aging process
- How to respond to resident behavior
- Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity
- Using the resident's family as a source of emotional support

♦ Care of cognitively impaired residents:

- Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others)
- Communicating with cognitively impaired residents
- Understanding the behavior of cognitively impaired residents
- Appropriate responses to the behavior of cognitively impaired residents
- Methods of reducing the effects of cognitive impairments

- Basic restorative services:
  - Training the resident in self-care according to the resident's ability
  - Use of assistive devices in transferring, ambulation, eating, and dressing
  - Maintenance of range of motion
  - Proper turning and positioning in bed and chair
  - Bowel and bladder training
  - Care and use of prosthetic and orthotic devices
- Residents' rights:
  - Providing privacy and maintenance of confidentiality
  - Promoting the residents' rights to make personal choices to accommodate their needs
  - Giving assistance in resolving grievances and disputes
  - Providing needed assistance in getting to and participating in resident and family groups and other activities
  - Maintaining care and security of residents' personal possessions
  - Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff
  - Avoiding the need for restraints in accordance with current professional standards

e. Requirements for Records and Reports

Nurse aide education programs approved by the DIA must:

- Keep a list of faculty members and their qualifications available for review.
- Complete a lesson plan for each unit which includes behavioral objectives, a topic outline, and student activities and experiences.

- Notify the DIA:
  - Of dates of classroom and clinical sessions and location of classrooms and clinical practice sites before each course begins.
  - If a scheduled course is canceled.
  - When a facility or other training entity will no longer be offering nurse aide training courses.
  - Whenever the person coordinating the training program is hired or terminates employment.
- Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
- Provide the student evidence of having successfully completed the course within 30 days of the last class period.

f. Requirements for Competency Evaluation

The competency examination must be administered and evaluated only by an entity approved by the DIA. The administering entity cannot be a skilled nursing facility that participates in Medicare or a nursing facility that participates in Medicaid.

A competency evaluation program must contain a written or oral portion and a skills demonstration portion. The program must allow an aide to choose between a written and oral examination. The person responsible for administering a competency evaluation must provide secure storage of the evaluation instruments when they are not being administered or processed.

The written or oral portion of the competency evaluation must:

- Address each of the course requirements listed in Requirements for Curriculum.
- Be tested for reliability and validity using a nationally recognized standard as determined by the Department of Education.
- Be developed from a pool of test questions, only a portion of which is used in any one examination.

- Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.
- Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.
- If oral, be read from a prepared text in a neutral manner.

The skills demonstration evaluation must consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in Requirements for Curriculum.

The skills demonstration part of the evaluation must be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide. It must be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

At the nurse aide's option, the competency evaluation may be conducted at the facility in which the nurse aide is or will be employed, unless the facility is prohibited from being a competency evaluation site.

The DIA may permit the competency evaluation to be proctored by facility personnel if the DIA finds that the procedure adopted by the facility ensures that the competency evaluation program:

- Is secure from tampering.
- Is standardized and scored by a testing, educational, or other organization approved by the DIA.
- Requires no scoring by facility personnel.

The DIA will retract the right to proctor nurse aide competency evaluations from facilities in which the DIA finds any evidence of impropriety, including evidence of tampering by facility staff.

A score of 70 percent or above is passing for both the written and oral and skills demonstration parts of the test. The competency testing entity must:

- Inform the nurse aide of the test score within 30 calendar days of the completion of the test.
- Inform the Nurse Aide Registry of the nurse aide's scores within 20 calendar days after the test is administered.

If the person does not complete the evaluation satisfactorily, the person must be advised in writing within ten working days after the test is scored:

- Of the areas which the person did not pass.
- That the person has three opportunities to take the evaluation.

Each person has three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course must be taken or retaken before the test can be taken again.

g. Exceptions to Facility Ineligibility

When a facility is ineligible to offer an approved nurse aide training and competency evaluation program, the DIA may grant an exception for 75-hour nurse aide training courses offered in (but not by) the facility under the following conditions:

- The facility submits a request to the DIA (*Nurse Aide Education Program Waiver Request*, form 470-3494) for a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility. Click here to view the form online.
- The 75-hour nurse aide training is offered in a facility by an approved NATCEP.
- No other NATCEP program is offered within 30 minutes travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.
- The facility is in substantial compliance with the federal requirements related to nursing care and services.
- The facility is not designated by DIA as a poor performing facility.
- Employees of the facility do not function as instructors for the program unless specifically approved by DIA.
- The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for assuring that program requirements are met.
- The NATCEP submits to the DIA an evaluation indicating that an adequate teaching and learning environment exists for conducting the course.

Iowa Department of Human Services

NURSE AIDE EDUCATION PROGRAM WAIVER REQUEST

Section I - Completed by Facility Requesting the Waiver

LTC Facility Requesting the Waiver		
Address		Phone ( )
City	State	Zip

Reason for Waiver Request:

- ❑ No other approved nurse aide training program within a reasonable distance from the facility. (Reasonable distance is defined as 30 minutes travel time each way from the facility.)
- ❑ Classes not currently being offered at an approved site within a reasonable distance.
- ❑ Classes within a reasonable distance are not offered during time frames to meet student and facility needs. Please specify:

_____

_____

_____

_____

_____

_____

_____

_____

List all NATCEP approved training sites contacted for course availability. Specify date of next course, distance and travel time to each site contacted.

NATCEP Program	Individual Contacted	Training Site	Course Date	Travel Time

Facility Administrator's Signature	Date

Section II - Completed by NATCEP Course Sponsor

Course Sponsor		
Address		Phone ( )
City	State	Zip

Course NATCEP Program Coordinator's Name	RN/License No.
Course Instructor (if different than program coordinator listed above)	RN/License No.

Is the instructor an employee of the facility? ❑ Yes ❑ No

Course Start Date _____ Course Completion Date _____

Describe the evaluation process used to determine an adequate teaching/learning environment exists for conducting a course. An evaluation should address adequacy of classroom, availability of equipment and oversight of the clinical component of the course.

Describe how the course will be evaluated and how the evaluation process will be used to improve future courses.

At the completion of each course the NATCEP course instructor and students must submit the course evaluations to the Department of Inspections and Appeals, Division of Health Facilities.

RN Program Coordinator Signature _____ Date _____

- The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.
- Upon completion of the course, the program instructor and students submit an evaluation of the course to the DIA.

4. Dietary Staff

The facility must employ a qualified dietitian either full-time, part-time or on a consultant basis. If a qualified dietitian is not employed full time, the facility must designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is licensed by the Iowa Board of Dietetic Examiners.

The facility must employ sufficient support personnel competent to carry out the functions of the dietary services.

5. Consultant Pharmacist

The facility must employ or obtain the services of a licensed pharmacist who:

- Provides consultation on all aspects of the provision of pharmacy services in the facility.
- Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

The licensed pharmacist must provide:

- Consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals.
- Monthly drug regimen review reports.

The consultant's visits must be scheduled to be of sufficient duration and at a time convenient to:

- Work with nursing staff on the resident care plan.
- Consult with the administrator and others on developing and implementing policies and procedures.
- Plan in-service training and staff development for employees.

A facility that does not employ a licensed pharmacist must have formal arrangements with a licensed pharmacist. These arrangements must include separate written contracts for pharmaceutical vendor services and consultant pharmacist services.

The facility must provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation must be available for review in the facility.

6. Social Worker

A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is a person who meets both of the following criteria:

- A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling, or psychology.
- One year of supervised social work experience in a health care setting working directly with people.

7. Activities Staff

The activities program must be directed by a qualified professional who meets one of the following criteria:

- Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on October 1, 1990, or
- Has two years of experience in a social or recreational program within the last five years, one of which was full time in a patient activities program in a health care setting, or
- Is a qualified occupational therapist or occupational therapy assistant, or
- Has completed a training course approved by the state.

E. PROVISION OF SERVICES

Residents must be admitted only under the order of a physician. The facility must accept only those residents whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. Admission of residents to the facility must be determined by:

- Assessment of the resident's medical, health, and social situation.
- Adequacy of physical facilities and equipment for meeting the needs of the resident in a safe and effective manner.
- Adequacy and suitability of the facility personnel and resources to provide the services.
- Comparative benefit of nursing care in relation to care by a hospital or provided in a home- and community-based setting.

The facility must provide and each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Services must be provided in accordance with the resident's assessment and care plan.

The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

The following sections explain requirements for:

- Resident Assessment (MDS)
- Preadmission Screening and Resident Review
- Comprehensive Care Plans
- Physician Services
- Nursing Services
- Dietary Services
- Pharmacy Services
- Social Services and Activities
- Specialized Rehabilitative Services
- Laboratory Services
- Radiology and Other Diagnostic Services
- Dental, Vision, and Hearing Services
- Quality Assessment and Assurance

1. Resident Assessment (MDS)

Before admission you must conduct an assessment of each person seeking nursing facility placement. Gather assessment information similar to the data in the *Minimum Data Set* (MDS) resident assessment tool. The purpose of this assessment is:

- To identify those people who may be able to be served by home- and community-based services, and
- To provide education, assistance, or referral for these services.

Upon admission and periodically, you must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability. You must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.

Make a comprehensive assessment of a resident's needs based on the *Minimum Data Set* (MDS) specified by DIA. The assessment describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

Conduct assessments within 14 calendar days after admission or readmission, except for readmissions in which there is no significant change in the resident's physical or mental condition. Coordinate assessments with preadmission screening to the maximum extent practicable to avoid duplicative testing and effort.

Also complete assessments within 14 calendar days after there has been a significant change in the resident's physical or mental condition. Examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment. Always assess residents at least once every 12 months.

The comprehensive assessment must include at least the following:

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision

- Mood and behavior patterns
- Psychosocial well-being
- Physical functioning and structural problems
- Continence
- Disease diagnoses and health conditions
- Dental and nutritional status
- Skin condition
- Activity pursuit
- Medications
- Special treatments and procedures
- Discharge potential
- Documentation of summary information regarding the additional assessment performed through the resident assessment protocols
- Documentation of participation in assessment
- Additional specification relating to resident status as required in Section S of the MDS

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. Include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. A registered nurse must sign and certify that the assessment is completed.

A person who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment.

A person who willfully and knowingly causes another person to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.

If the Department determines that there has been a knowing and willful certification of false statements, the Department may require that resident assessments be conducted and certified by persons who are independent of the facility. (See Requirement of Independent Assessors, for more information.)

Automated Data Processing Requirement

Within seven days after completing a resident's assessment, enter the resident's assessment information into a computerized format for transmission to the state. This format must:

- Conform to standard record layouts and data dictionaries.
- Pass edits that ensure accurate and consistent coding of the minimum data set (MDS).

On at least a monthly basis, input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month. Transmit MDS data in the format specified by CMS. Include the following:

- Admission assessment
- Annual assessment
- Significant correction of prior full assessment
- Significant correction of prior quarterly assessment
- Quarterly review
- A subset of items upon a resident's transfer, reentry, discharge, and death
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment

Do not release information that is resident-identifiable to the public. Release information that is resident-identifiable to an agent only under a contract where the agent agrees not to use or disclose the information except to the extent the facility itself may do so.

Click here to access details regarding Version 3.0 of the MDS, as detailed by CMS.

2. Preadmission Screening and Resident Review

Preadmission Screening and Resident Review (PASRR) is a federally required process to ensure that individuals with intellectual disabilities or mental illness are appropriately screened, evaluated, placed in nursing facilities when appropriate; and if placed in a nursing facility, are receiving all services necessary to meet the resident's needs.

Every person entering a Medicaid-certified nursing facility must undergo a Level I screening for mental illness or intellectual disability before admission, regardless of the source of payment. Individuals who are identified by a Level I screening as potentially having a mental illness or intellectual disability must then undergo a more extensive Level II evaluation which determines whether the person's needs can be met in the nursing facility setting and whether any specialized services may be needed.

For full details of preadmission screening procedures, please reference the PASRR and Level of Care Screening Procedures for Long-Term Care Services manual.

Click here to view the vendor-managed PASRR website.

3. Comprehensive Care Plans

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs identified in the comprehensive assessment.

The plan of care must deal with the relationship of items or services ordered to be provided (or withheld) to the facility's responsibility for fulfilling other requirements in these rules.

The plan must be developed:

- Within seven days after an interdisciplinary team completes the comprehensive assessment.
- With the participation of the resident and the resident's family or legal representative, to the extent practicable.

The interdisciplinary team must include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

The services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care. The plan must be reviewed periodically and must be revised by a team of qualified persons after each assessment.

4. Physician Services

A physician must personally approve in writing a recommendation that a person be admitted to a facility. Each resident must remain under the care of a physician.

The facility must:

- Ensure that the medical care of each resident is supervised by a physician.
- Ensure that another physician supervises the medical care of residents when their attending physician is unavailable.
- Provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

A physician must see all nursing facility residents at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than ten days after the date the visit was required. All required physician visits must be made by the physician personally.

The physician must:

- Review the resident's total program of care, including medications and treatments, at each visit.
- Write, sign, and date progress notes at each visit.
- Sign and date all orders.

NOTE: Any required physician task in a nursing facility may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician, except where prohibited by state law. This includes tasks which the rules specify must be performed personally by the physician.

5. Nursing Services

Based on the comprehensive assessment of a resident, the facility must ensure that:

- A resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom, transfer and ambulate, toilet, eat, and use speech, language or other functional communication systems.
- A resident is given the appropriate treatment and services to maintain or improve the resident's abilities to perform activities of daily living.
- A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
- Each resident receives adequate supervision and assistive devices to prevent accidents.
- A resident who enters the facility without a limited range of motion does not experience reduction in range of motion, unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.
- A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.
- A resident who is incontinent of bladder receives the appropriate treatment and services to:
  - Restore as much normal bladder functioning as possible.
  - Prevent urinary tract infections.

- A resident who enters the facility without an indwelling catheter is not catheterized, unless the resident's clinical condition demonstrates that catheterization was necessary.
- A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable.
- A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
- A resident who has been able to eat enough alone or with assistance is not fed by nasogastric tube, unless the resident's clinical condition demonstrates that use of a nasogastric tube was unavoidable.
- A resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore normal feeding functions if possible.

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

The facility must ensure that residents receive proper treatment and care for the following services:

- Injections
- Parenteral and enteral fluids
- Colostomy, ureterostomy or ileostomy care
- Tracheostomy care
- Tracheal suctioning
- Respiratory care
- Foot care
- Prostheses

6. Dietary Services

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that this is not possible.

The facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. Therapeutic diets must be prescribed by the attending physician. The facility must provide special eating equipment and utensils for residents who need them.

Menus must be prepared in advance and be followed. The menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day.

The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

The facility must procure food from sources approved or considered satisfactory by federal, state or local authorities. The facility must store, prepare, distribute and serve food under sanitary conditions and must dispose of garbage and refuse properly.

Each resident must receive and the facility must provide food prepared by methods that conserve nutritive value, flavor, and appearances. The food must be palatable, attractive, and at the proper temperature. Food must be prepared in a form designed to meet individual needs. Substitutes of similar nutritive value must be offered to residents who refuse food served.

7. Pharmacy Services

A facility must provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

The facility must label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date, when applicable.

In accordance with state and federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of l976 and other drugs subject to abuse. (This is not required when the facility uses single-unit-package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.)

A licensed pharmacist must review the drug regimen of each resident at least once a month. The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose, including duplicate drug therapy, or
- For excessive duration, or
- Without adequate monitoring, or
- Without adequate indications for its use, or
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued, or
- Any combinations of the reasons above.

The facility must ensure that residents who have not used antipsychotic drugs are not given these drugs, unless antipsychotic drug therapy is necessary to treat a specific condition, as diagnosed and documented in the clinical record.

Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

The facility must ensure that it is free of significant medication error rates and that residents are free of any significant medication error rates of five percent or greater.

8. Social Services and Activities

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

The facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

9. Specialized Rehabilitative Services

If specialized rehabilitative services are required in the resident's comprehensive plan of care, the facility must provide these services or obtain them from an outside provider of specialized rehabilitative services. This includes services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy.

10. Laboratory Services

The facility must provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

If the facility does not provide laboratory services on site, it must have an agreement to obtain these services only from a laboratory that meets federal requirements or from a physician's office.

If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved or licensed to test specimens in the appropriate specialties or subspecialties of service.

If the facility provides its own laboratory services, the services must meet the conditions for coverage of the services furnished by laboratories. If the facility provides blood bank and transfusion services, it must meet the requirements for laboratories.

The facility must provide or obtain laboratory services only when ordered by the attending physician. The facility must assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. The facility must promptly notify the attending physician of the findings and must file signed and dated reports of clinical laboratory services in the resident's clinical record.

11. Radiology and Other Diagnostic Services

The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier approved to provide these services under Medicare.

The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician. The facility must assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

The facility must promptly notify the attending physician of the findings and file signed and dated reports of x-ray and other diagnostic services in the resident's clinical record.

12. Dental, Vision, and Hearing Services

The facility must provide or obtain from an outside resource routine dental services (to the extent covered under Medicaid) and emergency dental services to meet the needs of each resident.

The facility must assist residents in obtaining routine and 24-hour emergency dental care. The facility must promptly refer residents with lost or damaged dentures to a dentist. If necessary, the facility must assist the resident in making appointments and arranging for transportation to and from the dentist's office.

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must assist a resident in making appointments with:

- A medical practitioner specializing in the treatment of vision or hearing impairment.
- A professional specializing in the provision of vision or hearing assistive devices.

The facility must also assist residents in arranging for transportation to and from the office of these providers, if necessary.

13. Quality Assessment and Assurance

A facility must maintain a quality assessment and assurance committee consisting of:

- The director of nursing services,
- A physician designated by the facility, and
- At least three other members of the facility's staff.

The quality assessment and assurance committee must:

- Meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
- Develop and implement appropriate plans of action to correct identified quality deficiencies.

The state or the Department of Health and Human Services may not require disclosure of the records of the committee, except as the disclosure relates to the compliance of the committee with these requirements.

F. RESIDENT RIGHTS

A facility must protect and promote the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to:

- Be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.
- Exercise rights as a resident of the facility and as a citizen of the United States.
- Be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

When the resident is adjudged incompetent under state law, the resident's rights are exercised by the person appointed under state law to act on the resident's behalf.

When a resident has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

The facility must post the names, addresses, and telephone number of all pertinent state member advocacy groups. This includes the state survey and certification agency, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit, as follows:

State Survey and Certification Agency:
Iowa Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
Phone: (515) 281-4115

State Ombudsman Program:
Iowa Department on Aging
State Long-Term Care Ombudsman
Jessie M. Parker Building
510 E 12th Street, Suite 2
Des Moines, IA 50319-9025
Phone: (866) 236-1430

Protection and Advocacy Agency:
Disability Rights IOWA
400 East Court Avenue Suite 300
Des Moines, IA 50309
Phone: (515) 278-2502

Medicaid Fraud Control Unit:
Iowa Department of Inspections and Appeals
Medicaid Fraud Control Unit
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
Phone: (515) 281-7102

The following sections cover policies on:

- Nondiscrimination
- Free Choice of Treatment
- Freedom of Association
- Privacy and Confidentiality
- Personal Property and Funds
- Grievances

1. Nondiscrimination

Compliance with Title VI of the Civil Rights Act of 1964 is a condition of participation for the Medicaid program. Facilities must not discriminate on the basis of race, color, or national origin.

All referrals under Medicaid must be made on a nondiscriminatory basis. The facility must effectively convey to the community, to hospitals, and other referral sources, its nondiscriminatory policy and the nature and extent of services available.

Compliance with Title VI requires adherence to the policies and practices outlined under Facility Admissions Policy. Where there is a significant variation between the racial or ethnic composition of the resident census and available population census data for the potential service area, the facility has a responsibility to determine the reason for the variation and take whatever action may be necessary to correct any discrimination.

Residents' privileges and care services, such as medical and dental care, nursing, laboratory services, pharmacy, physical, occupational and recreational therapies, social services, volunteer services, dietary service, and housekeeping services must be provided on a nondiscriminatory basis. Physical facilities, including lounges, dining facilities, lavatories and beauty and barber shops, must be provided and used without discrimination.

Rules of courtesy must be uniformly applied without regard to race, color, or national origin in all situations, including face-to-face contact and written records and communications. Assignment of staff to residents must not be governed by the race, color, or national origin of either resident or staff.

Residents must be assigned to rooms, wards, floors, sections, buildings and other areas without regard to race, color, or national origin. Room assignments must result in a degree of multiracial occupancy of multi-bed accommodations which reflects the proportion of minority use of the facility.

Residents must not be asked whether they are willing to share accommodations with persons of a different race, color, or national origin. Requests from residents for transfer to other rooms in the same class of accommodations must not be honored if based on racial or ethnic considerations.

Exceptions may be made only if the attending physician or facility administrator certifies in writing that there are valid medical reasons or special compelling circumstances in the individual case. However, such certifications may not be used to permit segregation as a routine practice in the facility.

Privileges of attending residents in the nursing facility must be granted to physicians and other health professionals without discrimination. Nursing facility referrals, including but not limited to, referrals to other facilities and care programs must be made in a manner which does not result in discrimination.

2. Free Choice of Treatment

Residents have the right to choose a personal attending physician. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for the resident's care.

Unless adjudged incompetent or otherwise found to be incapacitated under the state law, the resident has the right to participate in planning care and treatment or changes in care and treatment.

The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition. Residents have the right to refuse treatment and to refuse to participate in experimental research.

Residents have the right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be in a place readily accessible to residents.

Residents have the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. A facility must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is:

- An accident involving the resident which results in injury and has the potential for requiring physician intervention,
- A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications),
- A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or
- A decision to transfer or discharge the resident from the facility.

Except in a medical emergency, the facility must also notify the resident's physician and the resident's legal representative or interested family member within 24 hours of one of these events. In an emergency, notification must be made immediately.

A resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe. Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Residents have the right to choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care. The resident may make choices about aspects of life in the facility that is significant to the resident.

Residents have the right to refuse to perform services for the facility or to perform services for the facility if the resident chooses. The facility must document the resident's need or desire for work in the plan of care and specify in the plan the nature of the services performed and whether the services are voluntary.

Compensation for paid services must be at or above prevailing rates, and the resident must agree to the work arrangement described in the plan of care.

3. Freedom of Association

A married couple has the right to share a room when both spouses live in the same facility and both consent to the arrangement. The facility must promptly notify the resident and the resident's legal representative or interested family member, if known, when there is a change in room or roommate assignment.

A person has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate a resident from the distinct part of the facility that is a skilled nursing facility to a part of the facility that is not a skilled nursing facility or vice versa. A resident's exercise of this right does not affect the resident's eligibility or entitlement to Medicaid benefits.

Residents have the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Residents have the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage, and writing implements at the resident's own expense.

Residents have the right to receive visitors. The facility must allow access to the resident for the visitors at any reasonable hour. The facility must provide immediate access to any resident by immediate family, relatives, or others who are visiting with the consent of the resident. Access must be subject to the resident's right to deny or withdraw consent at any time.

The resident also has the right to immediate access to:

- The resident's individual physician.
- Any representative of the state or the U.S. Department of Health and Human Services.
- The state long-term care ombudsman and the agency responsible for the protection and advocacy system for persons with disabilities.

The facility must provide reasonable access to the resident for any entity or person that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

4. Privacy and Confidentiality

Residents have the right to personal privacy and confidentiality of personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room.

The resident may approve or refuse the release of personal and clinical records to any person outside the facility, except when the resident is transferred to another health care institution or record release is required by law. Residents have the right to inspect and purchase photocopies of all records pertaining to the resident upon written request and 24 hours' notice to the facility.

5. Personal Property and Funds

Residents have the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Residents have the right to manage their own financial affairs. The facility may not require residents to deposit their personal funds with the facility. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility.

6. Grievances

Residents have the right to voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

Residents may participate in resident and family groups. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

G. MEDICAID ELIGIBILITY

As noted under Notice of Resident Rights and Services, facilities are required to make information about Medicare and Medicaid benefits available to residents. Department publications about Medicaid which can be used for this purpose include:

- Comm. 20, *Your Guide to Medicaid*
- Comm. 28, *Medicaid for SSI-Related Persons*
- Comm. 30, *Medicaid for the Medically Needy*
- Comm. 52, *Medicaid for People in Nursing Homes and Care Other Facilities*
- Comm. 72, *Protection of Your Resources and Income*

These publications are available from Iowa Prison Industries at Anamosa. See CERTIFICATION PROCEDURES for information on placing orders.

Financial eligibility for Medicaid is determined by the county DHS offices under rules established by the Department. See Chapter II for more information. No payments will be made for nursing facility care of persons found to be financially ineligible for Medicaid.

Decisions on approval of the level of care are made for the Department by the IME Medical Services Unit. When placement has final medical and financial approval of the Department, payment will be authorized retroactive to the date of the resident's admission to the nursing facility, if appropriate.

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

The following sections cover:

- Attribution of Resources
- Application Procedures
- Medical Approval
- Requirements to Submit a *Case Activity Report*
- Residential Financial Participation
- Periods of Service for Which Payment Is Authorized
- Continued Stay Reviews

1. Attribution of Resources

The Medicare Catastrophic Coverage Act of 1988 contains "spousal impoverishment" provisions. They require the Department determine the attribution of a married couple's resources to the institutionalized spouse and to the community spouse at the beginning of the continuous period of institutionalization.

The attribution is intended to protect an amount of resources for the community spouse, so that the community spouse will not become impoverished through spending all of the couple's resources for care of the institutionalized spouse.

When one spouse enters a medical institution expecting to stay at least 30 days, the Department will "attribute" their resources to each spouse. Only the resources attributed to the institutionalized spouse are considered in determining initial eligibility.

An attribution of resources is always completed for the month that one spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days when there is a community spouse. Attribution of resources will also be completed for estranged couples.

The Department initiates the attribution of resources when:

- Either spouse requests that the Department determine the attribution of resources at the beginning of the person's continuous stay in a medical institution. This request must be accompanied by form 470-2577, *Resources Upon Entry to Medical Facility*, and necessary documentation.
- The institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant must also complete form 470-2577 and provide necessary documentation.

The attribution of resources must be completed at the time of original entry of the spouse. Attribution at the time of entry is easier for both the couple and the agency, as verification of resources is more accessible. The resources must be evaluated as of the first moment of the first day of the month to determine their accountability or exclusion.

All resources owned by either spouse must be considered in the attribution, except for some resources, such as the home. The amount to attribute does not depend on which spouse owns the resource.

One-half of the documented resources of both the institutionalized and community spouses at the time of the spouse's entry to a medical institution is attributed to each spouse. However, the Department sets a minimum and maximum community spouse resource allowance.

The maximum limit is indexed annually with the Consumer Price Index. When the limit increases, the resources are assessed to determine if the revised maximum will be attributed the community spouse (unless the institutionalized spouse is already eligible).

2. Application Procedures

Facilities should advise persons needing help with the costs of medical care to contact the Department office in the county where they live (or where they will live when they enter the nursing facility).

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 nursing facility providing monthly income is not in excess of 300% of SSI income limits and resources are within SSI limits.

Eligibility for these people requires a 30-consecutive-day period of residence in a medical institution, such as a hospital or nursing facility. A resident may have been in more than one facility or needed more than one level of care, but must have been in a medical institution for the 30-day period. Residents whose death occurs during the 30-day period meet this requirement if there was continuous residency.

The Department redetermines ongoing eligibility for Medicaid 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 Social Security Administration.

All information regarding the case should be sent to the DHS Centralized Facility Eligibility Unit as soon as possible in order to effect prompt approval of the application.

3. Medical Approval

IME Medical Services Unit makes the decision as to medical necessity for nursing care and sends the validation information to IME. IME matches it with financial eligibility data received from the Department.

Facilities must contact the IME Medical Services Unit on, or preferably before, admission of a resident who is expected to be financially eligible for Medicaid. Facilities also must contact IME Medical Services Unit when a resident who has been admitted on private pay decides to apply for Medicaid.

When placement of a nursing facility resident is not approved for medical reasons, IME Medical Services Unit notifies the facility and the resident in writing.

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.

4. Requirements to Submit a *Case Activity Report*, Form 470-0042

Form 470-0042, *Case Activity Report*, is used to ensure prompt and accurate reporting on activities of individual Medicaid members that occur at the nursing facility. When a resident is enrolled under hospice, the facility is responsible for sending the *Case Activity Report* to the Department. Click here to view the form online.

Iowa Department of Human Services

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: ☐ Nursing facility ☐ Skilled nursing facility ☐ Swingbed ☐ ICF/ID ☐ PMIC ☐ Hospice ☐ PACE ☐ RCF ☐ 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: ☐ IME Medical Services ☐ Medicare ☐ Managed care ☐ Utilization Board ☐ Out-of-state skilled preapproval	Effective Date

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? ☐ No ☐ Yes, see dates:	Expected dates of Medicare coverage _____ through _____

5. Discharge Data

Date of Discharge _____ Last Month in Facility (for residents who transfer to another facility or level of care): _____ Days in facility _____ Reserve bed days _____ Non-covered days _____ Total billing days on claim to fiscal agent	Reason for Discharge ☐ Died ☐ Hospital stay (less than 10 days, form is not required) ☐ Transferred to another facility Name _____ Level of care, if known _____ ☐ 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.

Form Instructions

Complete the *Case Activity Report* and submit it to the DHS Centralized Facility Eligibility Unit when:

- A current resident applies for Medicaid.
- A Medicaid-eligible resident:
  - Enters the facility.
  - Changes level of care.
  - Is discharged from facility.
  - Dies.

When a Medicaid applicant or member enters the facility, complete Sections 1 through 3 and, if applicable, Section 4. When a Medicaid applicant or member dies, complete Sections 1 and 5. Detailed instructions are given on the back of the form.

NOTE: Facilities no longer should send a *Case Activity Report* when a member enters or returns from the hospital or therapeutic leave to the same level of care. A discharge for the *Case Activity Report* does not mean someone who is transferred to the hospital with an expectation to return, even though they exceed the bed hold days for the month.

Within two business days of the action, mail or fax a copy to the DHS Centralized Facility Eligibility Unit. Keep a copy in the member record.

Section 1. Member Data: Section 1 contains resident-specific information. Use the member's first name, middle initial, and the last name as it appears on the *Medical Assistance Eligibility Card*. The "Date Entered Facility" is the date the resident entered the facility for the first time, or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility and the person filling out the form (either the administrator or designee). Your provider number must match the level of care indicated in Section 3. The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and sent to the county DHS office.

Section 3. Level of Care: Section 3 lists the level of care (ICF, skilled, etc.) the "Effective Date" as determined by the IME Medical Services Unit, Medicare, or the managed care contractor.

Section 4. Medicare Information for Either Skilled Patients or Hospice Patients in Facilities: Section 4 reflects Medicare coverage that may be applicable when a skilled resident is in a skilled nursing facility.

Section 5. Discharge Data: Fill out section 5 when a resident leaves the facility or dies. The income maintenance worker needs the information to calculate client participation for a partial month.

Provide information under "Last Month in Facility" only if the resident transfers to another facility or living arrangement (but not home).

5. Resident Financial Participation

Upon admission to the nursing facility or Medicaid approval, make any necessary arrangements for financial participation by the resident with a Medicaid-eligible person (or relatives, guardians, or trustees).

Vendor payments for nursing facility care are made to participating nursing facilities to supplement the resident's income. The resident keeps $50 of income for personal needs (plus a possible diversion for health insurance). The balance of income is applied to the cost of nursing facility care. It is the responsibility of the nursing facility to collect financial participation from the resident.

Sometimes diversion of the resident's income is allowed to a spouse who is not in the nursing facility. Such a diversion is allowed to bring the gross income of the spouse up to the SSI payment level for one person. If there is a spouse at home with dependent children under age 18, a diversion is allowed in the amount necessary to bring the gross income up to FIP standards for a family of the same size.

For member participation, the facility and the hospice must jointly determine who will collect the money. The contract between the nursing facility and the hospice provider must include a statement defining who is to collect the member participation.

6. Personal Needs Allowance

All Medicaid residents of a nursing facility have a small monthly 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.

The personal needs allowance is as its name suggests: an allotment of money provided for the resident to spend on personal needs and articles as the resident wishes. No Medicaid resident or responsible party must 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.

The resident should be the person who spends the money, and should be encouraged to see the money as personal funds. If the resident is unable to manage funds, the guardian should then use the allowance to meet the personal needs of the resident.

The personal needs allowance is one method of improving the quality of life for people needing a nursing facility living situation. The money can serve as a way for residents to maintain control over a segment of their personal life and environment and to individualize themselves in an institutional setting.

7. Periods of Service for Which Payment Is Authorized

Payment for care in a nursing facility is authorized as long as the resident is certified as medically needing that level of care and is otherwise eligible for Medicaid. Medicaid members must be in Medicaid-certified beds in order to receive payment from Medicaid.

If only a distinct part of the total facility has been certified as a nursing facility, Medicaid payment may be approved only for residents who occupy beds in the certified part of the facility. The facility cannot 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.

When a resident becomes eligible for Medicaid payments for facility care, the facility must accept Medicaid rates effective when the resident's Medicaid eligibility begins. When the beginning Medicaid eligibility date is a future month, the facility must accept the Medicaid rate effective the first of that future month.

A facility must refund any payment received from a resident or family member for any period of time when the resident is eligible for Medicaid. Any refund owing must be made no later than 15 days after the facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's member participation for a month of Medicaid eligibility from the refund of the amount paid.

Payment is made for the day of admission but not the day of discharge or death. No payment will be made for care of persons entering and leaving the facility the same day. Days of absence with no Medicaid payment are billed as non-covered days. Facilities must maintain documentation on all reserve bed days for audit purposes.

a. Absence from Facility for Visits

The facility will be paid to hold the bed while the resident is visiting away from the facility for a period not to exceed 18 days in any calendar year. These 18 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 18.

Additional days will be allowed if the resident's physician recommends in the plan of care that additional days would be rehabilitative. The physician's recommendation should be available at the facility for audits. Visit days cannot be used to extend payment for hospital stays.

b. Absence from the Facility for Hospitalization

Effective December 1, 2009, no payment is made for reserve bed days for either hospital leave or therapeutic leave.

No payments are made to reserve a bed in a facility to which a resident intends to transfer. No payment is made to reserve a bed while a member is at the skilled or ICF/ID level of care or at a state mental health institute.

8. Continued Stay Reviews

Continued stay reviews for medical approval are the responsibility of the IME Medical Services Unit. The purpose is to determine if the resident continues to need the nursing care.

H. TRANSFER AND DISCHARGE

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. The administrator and staff must assist the resident in planning for transfer or discharge through development of a discharge plan.

Transfer and discharge includes movement of a resident to a bed outside of the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

The following sections explain requirements for:

- Hospital Transfer Agreement
- Notice of Bed-Hold Policy and Readmission
- Allowable Reasons for Transfer and Discharge
- Notice Requirements for Transfer and Discharge
- Discharge Summary
- Administrative Procedures

1. Hospital Transfer Agreement

The facility must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. The agreement must reasonably ensure:

- Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
- Medical and other information needed for care and treatment of residents will be exchanged between the institutions.

When the transferring facility deems it appropriate, information for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital must also be transferred.

The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

2. Notice of Bed-Hold Policy and Readmission

A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the Medicaid bed-hold period is readmitted to the facility.

If the resident requires the services of the facility and is eligible for Medicaid nursing facility services, the resident must be readmitted immediately upon the first availability of a bed in a semiprivate room.

Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility must provide written information to the resident and a family member or legal representative. The information must specify:

- The duration of the Medicaid bed-hold policy during which the resident is permitted to return and resume residence in the facility.
- The facility's policy about bed-hold periods.

At the time of a resident's transfer for hospitalization or therapeutic leave, the nursing facility must again provide this written notice to the resident and a family member or legal representative.

3. Allowable Reasons for Transfer or Discharge

The facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

- The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility.
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
- The safety of persons in the facility is endangered.
- The health of persons in the facility would otherwise be endangered.
- After reasonable and appropriate notice, the resident has failed to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charge under Medicaid.
- The facility ceases to operate.

Except when the transfer is due to the closing of the facility, the facility must document the reason for the transfer in the resident's clinical record. The reasons for transfer or discharge must be recorded before the resident is moved.

When the transfer is due to the resident's health improving or failing, the documentation must be made by the resident's physician. When the transfer is due to endangerment of other residents, the documentation must be made by a physician.

4. Notice Requirements for Transfer or Discharge

Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move. The notice must be in writing and in a language and manner the resident and family member may understand.

The facility must make the notice at least 30 days before the resident is transferred or discharged. **EXCEPTION:** Notice must be made as soon as practicable before transfer or discharge when:

- The safety of persons in the facility would be endangered.
- The health of persons in the facility would be endangered.
- The resident's health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident's urgent medical needs.
- A resident has not lived in the facility for 30 days.

The written notice must include:

- The reason for transfer or discharge.
- The effective date of transfer or discharge.
- The location to which the resident is transferred or discharged.
- A statement that the resident has the right to appeal the action to the Department.
- The name, address, and telephone number of the state long-term care ombudsman.
- The mailing address and telephone number of the agency responsible for the protection and advocacy of disabled or mentally ill persons, for residents with mental illness or a disability.

When a public assistance member requests transfer or discharge, or another person requests this for the member, the administrator must promptly notify the Department's county office. This must be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

A facility that plans on closing must notify the Department at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid must be approved by the Department.

5. Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes:

- A recapitulation of the resident's stay.
- A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.
- A post-discharge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

When a resident is transferred to another facility, transfer information must be summarized from the facility's records in a copy to accompany the resident. This information must include:

- A diagnosis.
- Activities of daily living information.
- Transfer orders, a nursing care plan.
- The physician's order for care.
- The resident care review team assessment.
- The resident's personal records (including the personal needs fund record when applicable).

6. Administrative Procedures

If a Medicaid member requests transfer or discharge, or there is another person requesting this for the resident, the nursing home administrator must promptly notify the Department by means of 470-0042, *Case Activity Report*. See Requirements to Submit a *Case Activity Report*, form 470-0042, for additional details.

This should be done within two days of the action. This will allow the Department enough time to complete the necessary paperwork, ensuring a smooth discharge or transfer for the resident.

When the Department receives a *Case Activity Report* stating that a resident has been discharged (through death, return to own home, etc.), the income maintenance worker closes the Medicaid nursing facility case through the eligibility system. This information is forwarded to the Departments' central office. (See Resident Financial Participation for additional details.)

The facility must refund any unused member participation. See Schedule A-1 of the *Financial and Statistical Report* for more information. When a resident is transferred to another Medicaid facility, the income maintenance worker enters the necessary information concerning the transfer.

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.

The following sections explain policies on:

- Transfer of Residents by Ambulance
- Transfer of Personal Needs Funds After Death of Resident

a. Transfer of Residents by Ambulance

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

When a resident is transferred by ambulance, the ambulance provider can bill Medicaid through their usual claim submission process. If the ambulance provider cannot directly bill Medicaid, a worker from the Department county office will provide IME with the information necessary to process the claim and authorize IME to make payment. Close coordination between the IME, county offices, and facilities is required in all emergency situations.

b. Transfer of Personal Needs Funds After Death of Resident

Upon a member's death, a receipt must be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds.

In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds must revert to the Department. In the event that an estate is opened, the Department must turn the funds over to the estate.

I. BASIS OF PAYMENT

Non-state-owned nursing facilities and hospital-based nursing facilities that are Medicare-certified and provide the skilled level of care are reimbursed based on a modified price-based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index.

The following sections explain:

- Rate Determination
- Allowable Costs for Facility Payment
- Use of Resources Available to the Resident
- Facility Cost Report and Instructions
- Capital Cost Per Diem Instant Relief
- Quality Assurance Assessment Fee

1. Rate Determination

a. Calculate Per Diem Costs

For purposes of calculating the modified price-based reimbursement rate, facility costs are divided into two components:

- The "direct care component" is the portion attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
- The "non-direct care component" is the portion attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

Each nursing facility's per diem allowable direct care and non-direct care cost shall be established.

Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period.

However, for non-state-owned nursing facilities for purposes of calculating the per diem cost for administrative, environmental and property expenses, total patient days are the greater of the actual inpatient days or 85 percent of the facility's licensed capacity. For facilities falling below 85 percent occupancy, all costs not related to patient care services are divided by 85 percent of the facility's licensed capacity.

Effective July 1, 2001, and every second year thereafter, total reported allowable costs shall be adjusted by an inflation factor from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

Inflation shall be adjusted quarterly to ensure that state appropriations are not exceeded. This inflation adjustment can also effect the median calculations as new normalized direct care per diems and non-direct care per diems are affected.

b. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001 – 12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

Example calculation of per diem costs and cost normalization:

Direct Care Costs		
Direct Care Costs (inflation adjusted)	$	375,000
Actual Patient Days	÷	10,000
Average Direct Care Costs	$	37.50
Facility Average Case-Mix Index (CMI)	÷	0.9800
A. Normalized Direct Care Costs	$	38.27

c. Calculate Patient-Day-Weighted Medians

For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low-to-high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low-to-high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated, using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period, adjusted as described above.

d. Calculate Excess Payment Allowance

The nursing facility excess payment allowance is calculated as follows:

- For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero percent times the difference of the following (if greater than zero):
  - The direct care patient-day-weighted median times 95 percent times the provider's Medicaid average case-mix index, minus
  - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid average case-mix index.

  In no case shall the excess payment allowance exceed ten percent times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

- For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to zero percent times the difference of the following (if greater than zero):
  - The non-direct care patient-day-weighted median times 96 percent, minus
  - A provider's allowable per patient day non-direct care cost.

  In no case shall the excess payment allowance exceed eight percent times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Calculate Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted quarterly to account for changes in the provider's Medicaid average case-mix index, plus a potential excess payment allowance and a capital cost per diem relief add-on for qualifying nursing facilities, not to exceed an overall rate component limit.

The direct care and non-direct care rate components are calculated as follows:

- The direct care component is equal to the provider's normalized allowable per patient day costs times the provider's Medicaid average case-mix index plus the allowed excess payment allowance.

  For Medicare-certified hospital-based nursing facilities, the component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid average case-mix index.

  For non-state-owned nursing facilities not located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid average case-mix index.

  For non-state-owned nursing facilities located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day-weighted median times 120 percent times the wage index factor times the provider's Medicaid average case-mix index.

- The non-direct care component is equal to the provider's allowable per patient day costs plus the allowed excess payment allowance. For Medicare-certified hospital-based nursing facilities the component limit is the non-direct care Medicare-certified hospital-based patient-day-weighted median times 110 percent. The component limit for non-state-owned nursing facilities is the non-direct care non-state-owned nursing facility patient-day-weighted median times 110 percent.

f. State-Owned Nursing Facilities and Special Population Nursing Facilities

"Special population nursing facility" refers to a nursing facility that serves the following populations:

- 100 percent of the residents served are aged 21 and under and require the skilled level of care
- 70 percent of the residents served require the skilled level of care for neurological disorders

State-owned nursing facilities and special population nursing facilities receive Medicaid payment rates that are updated annually with new cost report data. State-owned and specialty population nursing facilities are required to complete a financial and statistical report approved by the Department.

Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given services or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on the Medicaid reimbursement rate is equal to the sum of the following:

- The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 120 percent
- The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 110 percent

g. Payment to New Facility or New Construction

The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components.

After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility's average Medicaid case-mix index. A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year.

Following the completion of the new facility's first fiscal year, rates will be established in accordance with the modified price-based case-mix reimbursement methodology described above. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

h. Payment to Existing Facility Sold to New Owner

An existing facility with a new owner shall continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year.

Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the Department's accounting firm of the date its fiscal year will end.

i. Ventilator Incentive

A special rate to care for ventilator-dependent patients is paid to a facility if the patient meets the requirements for skilled and ventilator care. The reimbursement rate is equal to the following:

- The Medicare-certified hospital-based nursing facility direct care patient-day-weighted median times 120 percent times the provider's Medicaid average case mix index, plus
- The Medicare-certified hospital-based nursing facility non-direct care rate patient-day-weighted median times 110 percent.

j. Case Mix Index Calculation

The Resource Utilization Groups (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility.

Standard Version 5.12b case-mix indices developed by CMS are the basis for calculating the average case-mix index and are used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate.

Each resident in the facility with a completed and submitted assessment is assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index.

From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year, based on the last day of each calendar quarter.

- The facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices.
- The Medicaid-average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payer source on the last day of the calendar quarter.

Assessments that cannot be classified to a RUG-III group due to errors are excluded from both average case-mix index calculations.

k. Payment Rate for Reserved Beds

Medicaid payments for reserved days are made at the rate of zero percent of the actual per diem rate, but not to exceed the maximum rate.

l. Out-of-State Care

Payment may be made for care of Iowa residents in nursing facilities in states which border Iowa. These facilities must be enrolled as an Iowa Medicaid nursing facility provider in order to receive payments through the Medicaid program.

Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit plus the non-direct care rate limit, whichever is lower.

Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit plus the non-direct care rate component limit if one of the following criteria is met:

- The placement is recommended because:
  - Moving the resident back to Iowa would endanger the resident's health,
  - Services are not readily available in Iowa, or
  - The out-of-state placement is cost-effective.
- The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence subject to the Iowa special population maximum rate, if not participating in the Medicaid program in their state, they shall be reimbursed if one of the following criteria is met:

- The placement is recommended because:
  - Moving the resident back to Iowa would endanger the resident's health,
  - Services are not readily available in Iowa, or
  - The out-of-state placement is cost-effective.
- The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.
- The out-of-state placement is cost-effective.

2. Allowable Costs for Facility Payment

Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following:

- Federal and state income taxes are not allowed as reimbursable costs.
- Fees paid to directors and nonworking officers' salaries are not allowed as reimbursable costs.
- Bad debts are not an allowable expense.

- Charity allowances and courtesy allowances are not an allowable expense.
- Personal travel and entertainment are not allowable as reimbursable costs. Expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal costs shall be prorated. Amounts that appear to be excessive may be limited after consideration of the specific circumstances:
  - Commuter travel by the owners, owner-administrators, administrator, nursing director or any other employee from private residence to facility and return to residence is not an allowable cost.
  - The expense of one car or one van or both designated for use in transporting patients is an allowable cost.
  - Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption from public transit coordination requirements after receipt from the Iowa Department of Transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.
  - Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.
  - Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.
  - Travel for which a patient must pay is not an allowable expense.
  - Allowable expenses in sub-bullets 2 through 4 above are limited to six percent of total administrative expense.
- Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.
- Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

- A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. Adjustments may be necessary to provide compensation as an expense for non-salaried working proprietors and partners.

  Members of religious orders serving under an agreement with their administrative office are allowed salaries paid to persons performing comparable services. When the facility provides maintenance to these persons, the value of these benefits is deducted from the amount otherwise allowed for a person not receiving maintenance.

  - Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

    On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor based on the latest CMS Total Skilled Nursing Facility Market Basket Index published before July 1.

  - The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

  - The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. People involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community, not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Ownership is defined as an interest of 5 percent or more.

- Management fees shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.
- Depreciation may be included as a patient cost based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made.
- Necessary and proper interest on both current and capital indebtedness is an allowable cost. Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

  Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

  When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in previous years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.
- Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

  "Related" means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies. Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

Charges by the supplier are allowable costs when the facility demonstrates by convincing evidence that:

- The supplying organization is a bona fide separate organization.
- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.
- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions.
- The charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

♦ When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility plus the landlord's other expenses. The landlord must be willing to provide documentation of these costs for rental arrangements.

♦ Depreciation, interest, and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the state health planning process.

♦ Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

3. Use of Resources Available to the Resident

Medicaid payments for nursing facility care are made to supplement the resident's income. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the cost of nursing facility care. The facility is responsible for collecting the resident's financial participation.

a. Medicare, Veterans, and Similar Benefits

All medical resources available to the resident must be used. Such resources include:

- Private health or accident insurance carried by the resident or by others on the resident's behalf, and
- Services reasonably available through other publicly supported programs, such as Medicare, Veterans Administration, Vocational Rehabilitation, etc.

When a facility receives information that not all resources available to a resident are being used, the facility should inform the Department in writing. Following is a suggested format:

> We have received information that this resident may:
>
> - Be eligible for veteran's benefits.
> - Have other potential resources to pay for nursing care as described below.
> - Not be eligible for Medicaid because.

b. Client Participation

All of a resident's income in excess of authorized exemptions is applied toward the cost of nursing care. This includes interest earned on the resident's personal needs funds.

A nursing facility may not charge more client participation for Medicaid-eligible members than the maximum monthly allowable payment for the facility. When the Department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the member the increased amount for the retroactive period.

Client participation begins with the first month of admission as a Medicaid resident in the following instances:

- Residents leaving the facility for hospitalization or to a skilled level of care who remain on the Medicaid program and later return to the nursing facility.
- Medicaid-eligible persons transferring from residential care to nursing facility care.
- Residents changing from private pay status to Medicaid status while residing in a nursing facility.
- Residents transferring from an out-of-state nursing facility to an Iowa facility.

A resident who has moved from an independent living arrangement to a nursing facility may have limited first-month client participation due to maintenance or living expenses connected with the previous living arrangement. The Department determines how much of the resident's income may be protected to defray expenses and how much is available for first-month client participation.

If a resident transfers from one nursing facility to another during a month, any remaining financial participation must be taken to the new facility and applied to the cost of care at that facility.

Present policy concerning reserve bed days has the result of changing financial participation in some cases when residents are absent from the facility (see Payment Rate for Reserved Beds). Administrators should ensure that the correct amount of financial participation is collected, particularly in cases where the resident may transfer from the facility.

The amount of ongoing financial participation is available through the IMPA system (see Resident Financial Participation).

c. Refund of Unused Client Participation

When a resident leaves the nursing facility 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 Social Security income of $630. His only allowable deduction is for personal needs, so he has $580 to apply towards the cost of his care in the facility ($630 minus $50 personal allowance).
>
> The nursing facility in which Mr. S lives has a per diem rate of $75. In a normal month, Mr. S pays for the first eight days of his care ($75 x 8 days = $600) and the state pays for the remainder of the month.
>
> If Mr. S leaves the nursing facility on the 6th of the month, the facility must make a $205 refund to Mr. S ($580 minus $375 (5 days care) = $205). If he leaves the home on the 9th of the month or later, no refund would normally be due. (An exception could arise if reserve bed days are involved.)

4. Facility Cost Report and Instructions

The *Financial and Statistical Report* is designed to provide information concerning costs of providing care to residents of the following types of facilities:

- Nursing facilities (NFs) participating in the Medicaid program
- Intermediate care facilities for the intellectually disabled (ICF/IDs) participating in the Medicaid program
- Residential care facilities (RCFs) participating in the State Supplementary Assistance program
- Residential care facilities for the intellectually disabled (RCF/IDs) participating in the State Supplementary Assistance program
- Assisted living facilities

Nursing facilities are required to submit the report no later than five months after their fiscal year end. Facilities must furnish all information called for in the Schedules, unless they can show that it is not applicable to their operation.

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 (81/2" 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	
☐ State	☐ Church Operated	☐ Individual	☐ Corporation
☐ County	☐ Church Related	☐ Partnership	☐ "S" Corporation
☐ Other	☐ Other Non-Profit		

[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. ☐ Yes ☐ No

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	Patient Days in Reporting Period		Medicaid Utilization Col 5/4	Percent Occupancy Col 4/3	Number of Admissions	Number of Discharges
		Start of Period	End of Period		Total	Medicaid				
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
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	

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**						

IOWA FINANCIAL AND STATISTICAL REPORT

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: Medicaid Residents (5)	Resident Days during Period: Total Residents (6)	Monthly Rental Rate: Medicaid Residents (7)		Monthly Rental Rate: Non-Medicaid Residents (8)	
271	Type A		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
272	Type B		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
273	Type C		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
274	Type D		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
275	Type E		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
276	Type F		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
277	Type G		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
278	Type H		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
279	Type I		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
280	Type J		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	

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: Medicaid Residents (5)	Resident Days during Period: Total Residents (6)	Monthly Rental Rate: Medicaid Residents (7)		Monthly Rental Rate: Non-Medicaid Residents (8)	
281	Type A		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
282	Type B		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
283	Type C		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
284	Type D		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
285	Type E		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
286	Type F		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
287	Type G		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
288	Type H		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
289	Type I		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	
290	Type J		One-bedroom							
			Two-bedroom				Room		Room	
			Efficiency				Board		Board	

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:	431				
Depreciation	432				
Amortization	433				
Interest	434				
Property tax	435				
Other	436				
Return on Equity	437				
Reduction - IF Column 1 < Column 2	438				
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 Sch A. (2)	Adjustment of Expenses Sch. B (3)	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)
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**

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? ☐ Yes ☐ No
2. Does the lease contain an option to purchase the leased property? ☐ Yes ☐ No

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		

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		0.00

		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%

Nursing Only	0%

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

SUPPORTING SCHEDULE (1)

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	Competed
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	Competed
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 Department sends out notifications of due dates from where *Financial and Statistical Report* may be retrieved from the DHS website. A letter of notification is forwarded to each participating facility before the end of each reporting period.

- Click here to view the form online.
- Click here to view instructions to complete the form. In these instructions, both of these programs are referred to as "public assistance" programs. Persons whose care is paid for in part by one of these programs are called "public assistance residents."

If you change fiscal years, you must notify the Department 60 days in advance of the change. A facility may not change fiscal years more often than every two years. If you change your fiscal year within two years, you must submit cost reports on the previous fiscal year schedule until you meet the two-year limit.

Base the financial information on the audited financial statements, if applicable. Adjustments converting reported amounts to the accrual basis of accounting are required if the records are maintained on another accounting basis.

Submit the report electronically to the Department no later than five months after the close of each reporting period. Forward the original certification page with an original signature to:

Iowa Medicaid Enterprise
Provider Cost Audit and Rate Setting Unit
PO Box 36450
Des Moines IA 50315

Failure to submit the report within the three-month period will reduce the payment to 75 percent of the current rate. This reduced rate will be paid for no longer than five months. After that, no further payments under Medicaid will be made if the report is not submitted.

Facilities must maintain the *Financial and Statistical Report* and all financial and statistical records to support the cost reports for a minimum of five years. Facilities are required to make these reports and records available to authorized representatives or agents of the Department and of the U.S. Department of Health and Human Services, upon request.

5. Capital Cost Per Diem Instant Relief Add-On and Enhanced Non-Direct Care Rate Component Limit

For rates effective October 1, 2007, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations.

A "complete replacement" means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

"Major renovations" means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds $1.5 million. The $1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service.

When the property costs of an asset have been included in a facility's financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the $1.5 million threshold.

"New construction" means the construction of a new nursing facility that does not replace an existing licensed and certified facility and requires the provider to obtain a certificate of need pursuant to Iowa Code Chapter 125, Division VI.

Two types of additional reimbursement are available:

- The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit.
- The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit. The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care component limit, or both, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

- Rectification of a violation of life safety code requirements, or
- Providing home- and community-based waiver program services.

A facility with an eligible project must also meet the following requirements:

- The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the most current financial and statistical report.
- The facility meets the pay-for-performance criteria set forth for regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.
- The facility has documented active participation in a quality of care program.
- The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

In addition, a facility with an eligible project for the purpose of providing home- and community-based waiver program services must also meet the following requirements:

- Services shall be provided in an underserved area, which may include a rural area.
- Services shall be provided on the direct site of the facility but not as a nursing facility service.
- Services shall meet all federal and state requirements for Medicaid reimbursement.
- Services shall include one or more of the following:
  - Adult day care as defined by 441 IAC 78.37(1)
  - Consumer-Directed Attendant Care (CDAC) provided in an assisted living setting as defined by 441 IAC 78.37(15)
  - Day habilitation as defined by 441 IAC 78.41(14)

- Home-delivered meals as defined by 441 IAC 78.37(8)
- Personal emergency response as defined by 441 IAC 78.37(2)
- Respite as defined by 441 IAC 78.37(6)

a. Submission of Request for Capital Cost Per Diem Instant Relief Add-On

A facility shall submit a written request for the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit to:

Iowa Medicaid Enterprise
Attn: Provider Cost Audit and Rate Setting Unit
100 Army Post Rd
Des Moines, IA 50315

A qualifying facility may request one or both types of additional reimbursement.

A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

b. Content of Request for Capital Cost Per Diem Instant Relief Add-On

A facility's request for the capital cost per diem instant relief add-on shall include:

- A description of the project for which the add-on is requested, including a list of goals for the project and a timeline of the project that spans the life of the project.
- Documentation that the facility meets the applicable qualifications in Capital Cost Per Diem Instant Relief Add-On and Enhanced Non-Direct Care Rate Component Limit.

- The period during which the add-on is requested (no more than two years).
- Whether the facility is also requesting the enhanced non-direct care rate component limit.
- A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule.

  Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule and that schedule shall include the amount of the depreciation expense for removed assets that is included in the current reimbursement rate.
- If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project shall be submitted including the following:
  - The estimated date the assets will be placed into service;
  - The total estimated depreciable value of the assets;
  - The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
  - The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.
  - Separately identify any assets that are used to provide non-nursing facility services only.
  - Any cost of the project furnished by a related party or organization must be reported as set forth above for "Items furnished by related organizations."
- The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.
- If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

- If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.
- A copy of the facility's allocation methodology used to allocate allowable costs between nursing facility services and non-nursing facility services.

c. Content of Request for Enhanced Non-Direct Care Rate Component Limit

A facility's request for the enhanced non-direct care rate component limit shall include:

- A description of the project for which the enhanced component limit is requested, including a list of goals for the project and a timeline of the project that spans the life of the project.
- Documentation that the facility meets the qualifications in Capital Cost Per Diem Instant Relief Add-On and Enhanced Non-Direct Care Rate Component Limit.
- Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

d. Calculating Cost Per Diem Instant Relief Add-On

The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for nursing facility services for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual nursing facility total patient days.

- Nursing facility total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.
- The annual estimated property costs for nursing facility services is calculated as the total annual estimated property costs less estimated annual property costs for non-nursing facility services.

- The total annual estimated property costs for the project is calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.
- A reconciliation between the estimated amounts and actual amounts shall be completed as described in Reconciliation of Capital Cost Per Diem Instant Relief Add-On.

e. Effective Dates for Cost Per Diem Instant Relief Add-On

A capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit.

f. Allowable Term for Capital Cost Per Diem Instant Relief Add-On

The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biannual rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biannual rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

g. Reconciliation of Capital Cost Per Diem Instant Relief Add-On

During the period in which the capital cost per diem instant relief add-on is granted, the IME shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit. The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate.

All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

h. Effective Date of Enhanced Non-Direct Care Rate Component Limit

An enhanced non-direct care rate component limit shall be effective:

- With a capital cost per diem instant relief add-on (if requested at the same time); or
- Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

i. Allowable Term for Enhanced Non-Direct Care Rate Component Limit

The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years.

If the non-direct care rate component limit amount changes during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

j. Ongoing Conditions

Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the IME is temporary. Additional reimbursement shall be immediately terminated if:

- The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
- The facility does not make reasonable progress on any plans required for initial qualification; or
- The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or enhanced non-direct care rate component.

k. Change of Ownership

Following a change in ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted to the sold nursing facility shall continue under the new owner. Future reimbursement rates shall be determined pursuant to 441 IAC 81.6(15) and 81.6(16).

6. Quality Assurance Assessment Fee

The reimbursement methodology for nursing facilities shall also be modified to provide a quality assurance assessment pass-through rate and a quality assurance assessment rate add-on, pursuant to Iowa Code Chapter 249L.

The quality assurance assessment is effective April 1, 2010, and shall be paid on a quarterly basis due to the Department no later than 30 days following the end of each quarter.

The following are the amount of the assessments:

- $1.00 per non-Medicare patient day if licensed beds are less than or equal to 46
- $1.00 per non-Medicare patient day for nursing facilities designated as a continuing care retirement center (CCRC) per the Iowa Insurance Division
- $1.00 per non-Medicare patient day for nursing facilities with annual Iowa Medicaid patient days of 26,500 or greater
- $5.26 per non-Medicare patient day for all other nursing facilities

The following nursing facilities shall not be excluded from paying the quality assurance assessment:

- Nursing facilities operated by the state
- Non-state government-owned or government-operated nursing facilities
- Distinct-part skilled nursing unit or a swing-bed unit operated by a hospital

The facility shall use the *Nursing Facility Quality Assurance Assessment Calculation Worksheet*, form 470-4836, to calculate the quarterly assessment amount due and submit the form and payment to the Department no later than 30 days following the end of each calendar quarter. Click here to view the form online.

The quarterly assessment amount due shall be calculated by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level, as described above.

If the Department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the Department shall notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such payment or refund shall be due or refunded within 30 days of the issuance of the notice.

A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

For facilities certified to participate in the Medicaid program, the Department shall deduct the quarterly amount due from Medicaid payments to the facility if the quality assurance assessment amount due has not been received by the Department by the last day of the month in which the payment is due. The Department shall also withhold an amount equal to the penalty owed from any payment due.

The nursing facility quality assurance assessment paid to the Department shall be not be an allowable cost for cost reporting and audit purposes but shall be an allowable cost in determining reimbursement.

NURSING FACILITY QUALITY ASSURANCE ASSESSMENT
CALCULATION WORKSHEET

This form should be completed by health facilities licensed under Iowa Code 135C.1 that are free-standing facilities, or are operated by a hospital licensed pursuant to Iowa Code Chapter 135B. Nursing facilities operated by the state, non-state government-owned or government-operated nursing facilites or distinct-part skilled nursing units and swing-bed units operated by a hospital do not have to complete this form.

NPI Number			
Name of Facility		**Employer I.D. Number**	
Mailing Address			
Street or P. O. Box	**City**	**State**	**Zip**
Physical Address (If Different)			
Street	**City**	**State**	**Zip**

Type of Control ☐ **Proprietary** ☐ **Non-Profit** ☐ **Government**

Is Facility registered as a Continuing Care Retirement Community (CCRC)? ☐ **Yes** ☐ **No**

Did facility status as a CCRC change since the last quarterly assessment calculation was filed? ☐ **Yes** ☐ **No**

If Yes: Effective date facility became registered: **Effective date facility registration terminated:**

Quarter of Report

☐ **January 1 - March 31** ☐ **April 1 - June 30** ☐ **July 1 - September 30** ☐ **October 1 - December 31**

Statistical Data

Beds at Beginning of Period | Beds at End of Period

If there was a change in the number of beds, please submit documentation with the completed form to the address identified below.

	Current Quarter	Prior Period Adjustment	Total
A. Total Medicaid Days for Reporting Period - In-House			0
B. Total Medicare Days for Reporting Period - Part A and Part C			0
C. Hospice Days			0
D. Total Other Days for Reporting Period - Private Pay, Insurance, VA, & HMO			0
E. Total Leave Days (Paid or Unpaid)			0

Calculation of Quality Assurance Assessment Amount

F. Patient days used for calculation (A and D from above)	0
G. Quality assurance assessment fee per bed day (See Instructions)	
H. Total quality assurance assessment owed to Iowa Medicaid (F* G)	$ -

This Form and Check are due no later than 30 Days after the quarter end

Make Check Payable and Mail to:
Iowa Medicaid Enterprise
PO Box 310280
Des Moines, IA 50331-0280

CERTIFICATION STATEMENT

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to nursing facility patient care. I understand that this information is submitted for the purpose of calculating the quality assessment under SF 476, and the ultimate collection of the quality assessment will be based upon the information contained herein. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

Name of Authorized Person	**Title/Position**	**Telephone Number**
Signature of Authorized Person	**Date**	**Address of Authorized Person**
Name of Preparer	**Title/Position**	**Telephone Number of Preparer**
Signature of Preparer	**Date**	**Address of Preparer**

NURSING FACILITY ENHANCED MEDICAID PAYMENT REPORT

This form should be completed by health facilities licensed under Iowa Code 135C.1 that are free-standing facilities, or are operated by a hospital licensed pursuant to Iowa Code Chapter 135B. Nursing facilities operated by the state, non-state government-owned or government-operated nursing facilities or distinct-part skilled nursing units and swing-bed units operated by a hospital do not have to complete this form.

NPI Number			
Name of Facility		**Employer I.D. Number**	
Mailing Address			
Street or P. O. Box	**City**	**State**	**Zip**
Physical Address (If Different)			
Street	**City**	**State**	**Zip**
Type of Control	● **Proprietary**	● **Non-Profit**	● **Government**
Is Facility registered as a Continuing Care Retirement Community (CCRC)?		● **Yes**	● **No**
Date of Report	Beginning	Ending	

Section 1: Reconciliation Of Quality Assurance Assessment Fee		
Statistical Information		
Line No.	Type of Day	
1	Total Medicaid days	
2	Total Medicare days	
3	Hospice Days	
4	Total Other Days	
5	Total patient days	0

6	Licensed beds during period	
7	Total bed days during period	0
8	Average occupancy during period	#DIV/0!
9	Average Medicaid utilization during period	#DIV/0!

Quality Assurance Assessment Fee Remitted		
Line No.	**Amounts reported in this section should agree with amounts from Quarterly Form 470-4836**	
10	Quality assurance assessment fee per bed day	

11	Quality assurance assessment fee paid for 1st quarter	
12	Quality assurance assessment fee paid for 2nd quarter	
13	Quality assurance assessment fee paid for 3rd quarter	
14	Quality assurance assessment fee paid for 4th quarter	
15	Total quality assurance assessment fee paid for period	$0.00

Quality Assurance Assessment Pass-through and Rate Add-on Payments Received		
Line No.		
16	Quality assurance assessment payments received for 1st quarter	
17	Quality assurance assessment payments received for 2nd quarter	
18	Quality assurance assessment payments received for 3rd quarter	
19	Quality assurance assessment payments received for 4th quarter	
20	Quality assurance assessment payments received for period	$0.00

Calculation of Enhanced Medicaid Payment Received and Spending Requirements		
Line No.	**Enhanced Medicaid payment is the amount of payments received over amount remitted**	
21	Amount of Enhanced Medicaid Payment	$0.00
22	Amount of Enhanced Medicaid Payment to be expended on behalf of all employees (60%)	$0.00
23	Amount of Enhanced Medicaid Payment to be expended on behalf of CNAs (35%)	$0.00

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 information. 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.

Name of Authorized Person	**Title/Position**	**Telephone Number**
Signature of Authorized Person	**Date**	**Address of Authorized Person**
Name of Preparer	**Title/Position**	**Telephone Number of Preparer**
Signature of Preparer	**Date**	**Address of Preparer**

NURSING FACILITY ENHANCED MEDICAID PAYMENT REPORT

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

Section 2: Demonstration of Wage and Employment Cost Change for the Period				
Any costs in this section MUST have a descriptive narrative in Section 3				
Line No.	Description	Increases for CNA wages and costs	Increases for other employee wages and costs	Total Increases for wages and costs
1	Wage increases			$0.00
2	Bonuses and other wage adjustments			$0.00
3	Changes to staffing patterns			$0.00
4	Vacation, holiday and sick pay - PTO or leave benefits			$0.00
5	Benefit programs - group health, group life, retirement			$0.00
6	Education programs and advancement opportunities			$0.00
7	Tuition reimbursement programs			$0.00
8	Other costs			$0.00
9	Total increases in wages and costs	$0.00	$0.00	$0.00

Test of Required Increases		
CNA		
Required amount to be expended on behalf of CNAs		$0.00
Actual amount expended on behalf of CNAs		$0.00
Test Met		TRUE

All Employees		
Required amount to be expended on behalf of all employees		$0.00
Actual amount expended on behalf of all employees		$0.00
Test Met		TRUE

Section 3: Narrative
All costs from Section 2 MUST have a descriptive narrative

If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment, no less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers and no less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the Department demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on.

Use of the Pass-Through and Add-On

As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the Department on the *Nursing Facility Medicaid Enhanced Payment Report*, form 470-4829, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. Click here to view the form online.

If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

- No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined.
- No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment

J. AUDITS, SANCTIONS, AND APPEALS

This section covers the following topics:

- Audit of *Financial and Statistical Report*
- Audit of Billing and Handling Resident Funds
- Interest Charges for Credit Balance
- Fines for Notification of Time or Date of a Survey
- Fines for Falsification of a Resident Assessment
- Requirements of Independent Assessors
- Sanctions for Failure to Meet Participation Requirements
- Appeals

1. Audit of *Financial and Statistical Report*

Upon proper identification, authorized state or federal representatives have the right to audit the general financial records of a facility, using generally accepted auditing procedures. This audit determines if expenses reported on the *Financial and Statistical Report* are reasonable and proper according to Medicaid rules. Click here to view the form online.

The audits may be done in an on-site visit either:

- To the facility,
- To the facility's central accounting office, or
- To offices of the facility's agents.

When a proper per diem rate cannot be determined through generally accepted and customary auditing procedures, the auditor will examine and adjust the report to arrive at what appears to be an acceptable rate. The auditor then recommends to DHS that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period.

If the situation is not remedied on the subsequent *Financial and Statistical Report*, the facility will be suspended and eventually canceled from the Medicaid program.

When a facility continues to include as an item of cost an item which was removed in a previous audit by an adjustment in the total audited costs, the auditor may recommend to the Department that the per diem be reduced to 75 percent of the current payment rate for the following six-month period. After considering the seriousness of the exception, the Department may make this reduction. Facilities will be informed in writing of Department actions.

2. Audit of Billing and Handling Resident Funds

Upon proper identification, field auditors of the state of Iowa or representatives of the Department of Health and Human Services have the right to audit:

- Billings to DHS and receipts of financial participation to ensure that:
  - The facility is not receiving payment in excess of the contractual agreement.
  - All other aspects of the contractual agreement are being followed.
- Records of the facility to determine proper handling of personal needs funds.

On the auditor's recommendation, the Department will request repayment of sums inappropriately billed to the Department or collected from the resident. The facility must make repayment 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 will not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding will continue until the entire refund is recovered.

If the audit results indicate significant problems, a facility may be referred to the attorney general's office for whatever action is appropriate.

When the fiscal records (including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices and audit reports, as compiled by or for the facility) are not adequately maintained to render a proper per diem rate, the auditor will:

- Examine and adjust the report to arrive at what appears to be an acceptable rate.
- Recommend to the Department that the indicated per diem be reduced by 25 percent for the next reporting period.

If the situation is not remedied on the next *Financial and Statistical Report*, the facility will be suspended and eventually canceled from participation in the program.

When the facility continues to include an item of expense which had been removed from an earlier report, the auditor will recommend that the Department reduce the audited per diem by 25 percent for the next reporting period.

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

If a facility has a credit balance due the Department for more than 60 days, interest will be also due to the Department.

3. Interest Charge for Credit Balance

When a facility has a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance, the Department will charge interest at 10 percent per year on each overpayment. The interest begins to accrue retroactively to the first full month that the provider had a credit balance over $500.

Agreement to repay must be made with the IME Revenue Collections Unit.

4. Fine for Notification of Time or Date of Survey

Any person who notifies a nursing facility or causes a nursing facility to be notified of the time or date on which a survey is scheduled to be conducted, is subject to a fine not to exceed $2,000.

5. Fine for Falsification of a Resident Assessment

A person who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each falsified assessment.

A person who willfully and knowingly causes another person to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each falsified assessment. These fines are administratively assessed by DIA.

In determining the monetary amount of the penalty, the DIA may consider evidence of the circumstances surrounding the violation. This includes, but is not limited to, the following factors:

- The number of assessments willingly and knowingly falsified.
- The history of the person who falsifies an assessment or causes an assessment to be falsified.
- The areas of assessment falsified.
- The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- The relationship of the falsification of assessment to falsification of other records at the time of the visit.

Notice of a fine imposed for falsification of assessments or causing another person to falsify an assessment will be served upon the person personally or by certified mail.

Notice of intent to formally contest the fine must be given to DIA in writing. The notice must be postmarked within 20 working days after receipt of the notification of the fine.

An administrative hearing will be conducted pursuant to state law and DIA rules. A person who has exhausted all administrative remedies and is aggrieved by the final action of the DIA may petition for judicial review.

6. Requirement of Independent Assessors

If DIA determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the DIA may require that resident assessments be conducted and certified by persons independent of the facility who are approved by the state.

Criteria used to determine the need for independent assessors include:

- The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- The facility's response to the falsification of or causing resident assessments to be falsified.
- The method used to prepare facility staff to do resident assessments.
- The number of persons involved in the falsification.
- The number of falsified resident assessments.
- The extent of harm to residents caused by the falsifications.

The DIA will specify the length of time that these independent assessments will be conducted and when they will begin. This determination is based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

Written notice of the requirement to obtain independent assessments will be sent to the facility by certified mail or personal services. The notice will include:

- The date independent assessors are to begin assessments.
- Information on how independent assessors are to be approved.
- The anticipated length of time independent assessors will be needed.

The persons or agency chosen by the facility to conduct the independent assessments must be approved by the DIA before conducting any assessments. The approval will be based on the ability of the person or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred will be the responsibility of the facility.

Independent assessors must be used until all residents assessed by the disciplines involved have been reassessed by the independent assessor. The facility must submit a plan to the DIA for completing its own assessments. The DIA will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

A written request to appeal the requirement for independent assessors must be postmarked or personally served to the DIA within five working days after receipt of the notice requiring independent assessors.

A request to appeal stays the effective date of the requirement for independent assessments pending a final agency decision. An evidentiary hearing will be held pursuant to DIA rules no later than 15 working days after receipt of the appeal.

The written decision will be rendered no later than ten working days after the hearing. The decision rendered is a proposed decision which may be appealed to the director of the DIA. Final agency action may be appealed to the courts.

7. Sanctions for Failure to Meet Participation Requirements

If DIA finds that a facility does not meet a requirement for participation in the program, it may impose one or more of the following remedies:

- Directed plan of correction. (Category 1)
- Directed in-service training. (Category 1)
- State monitoring of facility operations. (Category 1)
- Denial of Medicaid payment for all new admissions. (Category 2)
- Assessment of a civil money penalty of $50 to $3,000 per day. (Category 2)
- Appointment of temporary management. (Category 3)
- Termination of the facility's participation in the Medicaid program. (Category 3)
- Assessment of civil money penalties of $3,050 to $10,000 per day. (Category 3)

In an emergency situation, the DIA may transfer residents and close the facility.

To select the appropriate remedy to apply to a facility with deficiencies, the DIA determines the seriousness of the deficiencies by considering:

- Whether a facility's deficiencies constitute:
  - No actual harm, with a potential for minimal harm.
  - No actual harm, with a potential for more than minimal harm but not immediate jeopardy.
  - Actual harm that is not immediate jeopardy.
  - Immediate jeopardy to resident health or safety.
- Whether the deficiencies:
  - Are isolated.
  - Constitute a pattern.
  - Are widespread.
- The relationship of the one deficiency to other deficiencies resulting in noncompliance.
- The facility's previous history of noncompliance in general and specifically with reference to the cited deficiencies.

The DIA will apply one or more of the remedies in Category 1 when:

- There are isolated deficiencies that constitute no actual harm, with a potential for more than minimal harm but not immediate jeopardy; or
- There is a pattern of deficiencies that constitutes no actual harm, with a potential for more than minimal harm but not immediate jeopardy.

The DIA will apply one or more of the remedies in Category 2 when:

- There are widespread deficiencies that constitute no actual harm, with a potential for more than minimal harm but not immediate jeopardy; or
- There are one or more deficiencies that constitute actual harm that is not immediate jeopardy.

Except when the facility is in substantial compliance, the DIA may apply one or more of the remedies in Category 1 or Category 2 to any deficiency.

The DIA will apply one or more of the remedies in Category 3 when there are one or more deficiencies that constitute immediate jeopardy to resident health and safety. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the DIA may impose temporary management in addition to Category 2 remedies.

The facility must submit a plan of correction for deficiencies unless there are only isolated deficiencies that constitute no actual harm and have potential for minimum harm only. The DIA must approve the facility's plan regardless of which remedies are applied.

If a facility fails to come into compliance with any requirement within three months after it is found out of compliance with that requirement, payment will be denied for any person admitted to the facility after three months.

If the DIA finds on three consecutive standard surveys that a facility has provided substandard quality of care:

- Payment will be denied for all new admissions.
- Regular on-site monitoring of the facility's compliance with the program requirements. The monitoring will continue until the facility has established that it is in and will remain in compliance.

The following sections give more information on:

- Definitions of Substandard Care and Immediate Jeopardy
- State Monitoring
- Denial of Payment for New Admissions
- Temporary Management
- Termination of Medicaid Certification

a. Definitions of Substandard Care and Immediate Jeopardy

For purposes of any sanction to be imposed, "substandard care" means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either:

- Immediate jeopardy to resident health or safety;
- A pattern of or widespread actual harm that is not immediate jeopardy; or
- A widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

"Immediate jeopardy" means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. This includes, but is not limited to, the following:

- Situations or practices that constitute a serious fire hazard or emergency situation, such as:
  - Inadequate or faulty emergency power and lighting.
  - Electrical wiring that presents an immediate fire hazard.
  - Blocked or obstructed stairways, hallways and exits which prevent egress in the event of an emergency.
  - Widespread failure to enforce smoking restrictions.
  - Failure to maintain required fire protection systems in an operating condition.
  - Failure to maintain the integrity of fire and smoke barriers, such as removal of stairway doors and major unprotected openings in corridor walls.
- Widespread insect or rodent infestation indicative of food contamination or the possible spread of contagion.
- Failure to use adequate infection control procedures.
- Widespread patterns of resident abuse or poor resident care, including:
  - Instances of malnutrition or dehydration that are unrelated to the resident's condition and are a result of poor resident care.
  - A pattern of negligence by staff with the result that residents are often left lying in urine, feces or other waste.
  - Use of physical or chemical restraints in excess of that which is ordered by a physician.

- Drug or pharmaceutical hazards that directly affect resident health and safety, such as:
  - Widespread drug errors, mishandling of drugs or other resident related pharmacy problems.
  - Failure to provide medications as prescribed.
  - Failure to monitor drugs as evidenced by lack of ordered laboratory work, failure to take vital signs as indicated by drug regimen, and lack of other nursing monitoring practices.
- Gross mishandling of drugs, such as leaving drug trays unattended and available to residents and visitors.
- Administration of drugs by unqualified staff.
- Administration of experimental drugs without the informed consent of the resident or responsible party.
- Inadequate procedures for procurement, safekeeping, and transfusion of blood and blood products that could jeopardize resident health and safety.
- Excessive hot or cold temperatures in resident care areas of the facility to the extent that residents are experiencing signs of hyperthermia or hypothermia, when the nursing facility does not have a short-term and effective plan for ameliorating these temperatures.

b. State Monitoring

DIA will designate a DIA employee or contractor as a monitor for any facility which has been found on three consecutive standard surveys to have provided substandard quality of care. Monitors will continue until the facility has demonstrated that it is in compliance and will remain in compliance with the law.

DIA may also designate monitors in:

- Facilities that have failed to come into compliance with any requirement within three months after they are found to be out of compliance.
- A facility that has corrected deficiencies, but verification of continued compliance is needed.
- Any facility when the state has reason to question that facility's compliance.

Monitors must be persons who have knowledge related to the deficiencies cited. Monitors must not have any financial interest in the facility or any affiliate and must not be related to the licensee, the manager, or any employee of the facility.

The DIA will inform the facility of the appointment of a monitor before the date monitoring begins. When the DIA designates a monitor, the DIA will develop a monitoring plan that is related to the type of deficiencies. The plan will:

- Include who is designated as the monitor.
- Include the frequency and duration of visits by the monitor, as well as a schedule of written reports. A copy of these reports will be sent to the facility.
- Be reviewed weekly by the DIA or at the recommendation of the monitor.
- Have a designated time frame for correction of deficiencies.

The monitor oversees the correction of deficiencies at the facility site and protects the facility's residents from harm. Monitors are responsible for observing the facility's operations and efforts to come into compliance. The monitor must have access to the facility 24 hours a day, seven days a week. Monitors will report the results of those observations to the DIA.

If the monitor reports little or no progress on the part of the facility in correcting the deficiencies within the designated time, the DIA may take alternative or additional action.

c. Denial of Payment for New Admissions

DHS will deny payment for newly admitted Medicaid residents when:

- The facility has failed to correct deficiencies within 90 days after the survey identifying noncompliance.
- DIA has cited the facility with substandard care on the last three consecutive standard surveys.

A deficiency statement issued by the DIA will include information that failure to correct deficiencies within three months will result in denial of payment for new admissions. The time period for correction begins three days after the deficiency statement is mailed.

DHS may also deny payment for new Medicaid admissions in the case of physical plan emergencies or insufficient staff.

"New admission" means the admission into a facility of a Medicaid resident who has never been in the facility or, if previously admitted, has been discharged or has voluntarily left the facility. The term does not include the following:

- Persons who were in the facility before the effective date of the sanction, but who were discharged on or after that date.
- Persons who were in the facility before the effective date of the sanction but became eligible for Medicaid on or after the date.
- Persons who were in the facility before the effective date of the sanction but who left the facility for a temporary absence, regardless of whether their departure occurred before or after the effective date of the sanction. Upon their return they are not considered new admissions.

When the DIA finds that the facility has failed to correct a deficiency, the facility may appeal the decision to deny payment for new admissions of Medicaid residents in writing to the DIA within ten working days after receipt of the notice. The appeal does not stay the denial of payment.

The administrative hearing will be held and the decision rendered within 30 days after the DIA receives the request for a hearing.

When the Department has denied payment for new admissions, it will notify IME Medical Services Unit.

The notice will also be posted in the facility. Anyone calling the facility regarding an admission must be notified the facility has been denied payment for new Medicaid admissions.

d. Temporary Management

DIA may appoint a temporary manager when there is immediate jeopardy to resident health or safety or when there are widespread deficiencies that cause actual harm.

The person appointed to serve as a temporary manager must:

- Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the DIA.
- Not have been found guilty of misconduct by any licensing board or professional society in any state.
- Have no financial ownership interest in the facility, nor have an immediate family member with ownership in the facility.
- Not currently serve as a member of the staff of the facility nor have served within the past two years.

The temporary manager has the authority to oversee the operation of the facility and to ensure the health and safety of the facility's residents. The temporary manager must:

- Make at least monthly reports to the court and the DIA regarding progress made by the facility in making corrections of the deficiencies.
- Spend sufficient time in the facility to mitigate the circumstances which resulted in the appointment of the temporary manager.
- Develop a written plan for correcting the deficiencies which were the basis for appointing a temporary manager.

The facility is responsible for paying the salary of the temporary manager. The salary shall be at least equivalent to the sum of the following:

- The prevailing salary paid by providers for positions of this type in the facility's geographic area.
- Additional costs the provider reasonably has incurred by the person who had been in an employment relationship.
- Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement, up to the maximum per diem for state employees.

If the facility fails to relinquish authority to the temporary manager, the facility's Medicaid provider agreement will be terminated. This includes failure to pay the temporary manager's salary.

The temporary management will not be terminated until the DIA has determined that the facility has the management capacity to ensure continued compliance with all requirements of the program.

The licensee must send a written request to terminate the temporary manager to the DIA, the temporary manager, and any other parties to the action. The request must include:

- A statement of any changes the licensee proposes to make in the operation or management to ensure continued compliance with requirements.
- The reasons why the licensee believes it has management capacity to ensure continued compliance.

e. Termination of Medicaid Certification

If a facility's participation is terminated under Medicare, DHS will take steps to terminate the facility's participation under Medicaid.

When decertification is contemplated as a result of survey findings, DIA sends a notice to the facility which:

- Advises the facility of its rights to due process and the expected schedule for termination action.
- States that the deficiency must be corrected and the correction verified by the DIA to suspend the termination.

When the DIA finds upon survey that a facility is not in compliance with one or more conditions of participation or coverage, and the cited deficiencies limit the capacity of the facility to furnish adequate level or quality of care, termination procedures must be completed within 90 days.

No later than 15 days following the survey date, the DIA will notify the facility in writing of cited deficiencies and of recommended termination from the Medicaid program, to be effective within 90 days from the date of the survey.

When the facility has made a credible allegation of compliance, DIA will conduct a revisit to determine whether compliance or acceptable progress has been achieved. DIA may conduct a second visit between the 46 and 90 days.

CMS will send an official termination notice to the facility no later than the seventieth day after the date of survey. Termination will take effect on the ninetieth day following the survey date, if compliance has not been achieved.

When the DIA finds upon survey that a facility poses an immediate and serious threat to patients, termination procedures will be completed within 23 calendar days.

No later than two working days following the survey date, DIA will notify the facility by telegram or overnight express of the facility's deficiencies and termination from the Medicaid program.

CMS will notify the facility by of the proposed termination action no later than the fifth working day following the survey date.

The termination will take effect no later than the twenty-third calendar day following the date of the survey, unless compliance has been met or the threat has been removed. The facility may appeal the decision in accordance with Department procedures.

When the threat has been removed, but deficiencies exist, the DIA may grant the facility up to 67 more days to correct the deficiencies, or 90 days total.

If the Department cancels or denies further Medicaid participation due to a survey, federal financial participation may continue for 30 days beyond the date if an extension is necessary to ensure the orderly transfer of residents.

8. Appeals

Any person or facility wishing to appeal a Departmental action or decision must do so within 30 days of notification of the action or decision. Appeals should be directed to the office taking the action.

Facilities may obtain information concerning appeals by contacting:

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

When DHS takes decertification action for reasons unrelated to the survey report, the appeal is filed with DHS. The hearing is held by DIA, but the final decision is issued by DHS.

K. 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.

Refer to Chapter IV. *Billing Iowa Medicaid*, for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/all-iv.pdf