HUMAN SERVICES DEPARTMENT[441]

Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 82

"Intermediate Care Facilities for Persons with an Intellectual Disability"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A

State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A and 42 CFR 483

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

November 7, 2024
10 a.m.

Microsoft Teams
Meeting ID: 295 147 282 130
Passcode: jm6rgf

Public Comment

Any interested person may submit written comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

HUMAN SERVICES DEPARTMENT[441]

This proposed chapter provides operational and reimbursement rules for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). These rules and the underlying federal regulations allow the Department to hold providers accountable and help ensure quality care for resident members on Medicaid.

Analysis of Impact

1. Persons affected by the proposed rulemaking:

- Classes of persons that will bear the costs of the proposed rulemaking:

There are no costs associated with this rulemaking.

- Classes of persons that will benefit from the proposed rulemaking:

Owners and operators of ICF/ID and individuals residing in an ICF/ID will benefit.

2. Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:

- Quantitative description of impact:

The impact is the reduction of redundant language in the chapter.

- Qualitative description of impact:

Iowa currently has 74 facilities that are licensed as ICF/ID. These rules and the underlying federal regulations allow the Department to hold providers accountable, help ensure quality care for resident members on Medicaid, and provide operational and reimbursement rules for ICF/ID.

3. Costs to the State:

- Implementation and enforcement costs borne by the agency or any other agency:

There will be no new costs to the agency to enforce the chapter since no rate changes or system changes will occur.

- Anticipated effect on state revenues:

No effect on state revenues is anticipated.

4. Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:

The chapter is needed to provide information on reimbursement and quality standards for ICF/ID in Iowa. Without regulation, quality of care and the health and well-being of residents could suffer.

5. Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:

Rulemaking is necessary to guide quality of care and provide consistency.

6. Alternative methods considered by the agency:

- Description of any alternative methods that were seriously considered by the agency:

None were considered.

- Reasons why alternative methods were rejected in favor of the proposed rulemaking:

This type of information, in conjunction with the federal regulations, is appropriate to be contained in administrative rules.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.

- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

There is no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 82 and adopt the following **new** chapter in lieu thereof:

CHAPTER 82

INTERMEDIATE CARE FACILITIES FOR PERSONS

WITH AN INTELLECTUAL DISABILITY

441—82.1(249A) Definitions.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental

Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009 as amended to August 1, 2024; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermediate care facility for persons with medical complexity" means an intermediate care facility for persons with an intellectual disability that provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

This rule is intended to implement Iowa Code section 249A.12.

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections, appeals, and licensing pursuant to 481—Chapter 64. The facility shall meet the following conditions of participation.

82.2(1) *Governing body and management—disclosure of ownership.* The facility shall supply to the licensing agency full and complete information, and promptly report any changes that would affect the current accuracy of the information, as to identify:

a. Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

b. Each officer and director of the corporation if the facility is organized as a corporation.

c. Each partner if the facility is organized as a partnership.

82.2(2) *Client protections.* The facility shall ensure the rights of all clients in accordance with 42 CFR 483.420 as amended to August 1, 2024.

82.2(3) *Facility staffing.* The facility shall provide adequate, qualified professional staffing in accordance with 42 CFR 483.430 as amended to August 1, 2024.

82.2(4) *Active treatment services.* Each client shall receive a continuous active treatment program in accordance with 42 CFR 483.440 as amended to August 1, 2024.

82.2(5) *Client behavior and facility practices.* Each facility shall establish and maintain standards for client behavior and facility practices in accordance with 42 CFR 483.450 as amended to August 1, 2024.

82.2(6) *Health care services.* Each facility shall establish and maintain standards for health care services in accordance with 42 CFR 483.460 as amended to August 1, 2024.

82.2(7) *Physical environment.* Each facility shall establish and maintain standards for the physical environment in accordance with 42 CFR 483.470 as amended to August 1, 2024.

82.2(8) *Dietetic services.* Each facility shall establish and maintain standards for dietary services in accordance with 42 CFR 483.480 as amended to August 1, 2024.

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

This rule is intended to implement Iowa Code section 249A.12.

441—82.4(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a financial and statistical report to the department. These reports shall be based on the following rules.

82.4(1) *Failure to maintain records.* Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.4(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.4(3) *Submission of reports.* The facility's cost report shall be received by the department no later than September 30 each year except as described in subrule 82.4(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.4(3)*"c."*

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the department.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.4(4) *Payment at new rate.* When a new rate is established, payment at the new rate will be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments will be included in the payment the third month after the receipt of the report.

82.4(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses pertaining to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.4(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.4(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.4(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.4(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.4(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services that include room, board, nursing services, and such services as supervision, feeding, incontinence, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.4(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. 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.

e. 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. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation are unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, are required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.4(3)*"c."*

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) 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 $1,926 per month plus $20.53 per month per licensed bed capacity for each bed over 60, not

to exceed $2,852 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 will be increased or decreased by the inflation factor applied to facility rates.

(5) 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.

(6) 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. Persons 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. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.4(11)*"e"*(4) through 82.4(11)*"e"*(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit will be adjusted by the percentage of total costs of the

entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs are allowed only to the extent they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation 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's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition), may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment will be made. For change of ownership, refer to subrule 82.4(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) 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.

(5) 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.

(6) 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 prior 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.

i. 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.

(1) 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.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that 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; that the services, facilities, or supplies are those that 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; and that the charge to the facility is in line with the charge for 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, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

(1) When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report is the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return is defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

(2) When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report is limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

(3) The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility that supplies transportation services as defined in Iowa Code section 324A.1(1) shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, will result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Reserved.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.4(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion but terminates with respect to the leased portion.

b. No increase in the value of the property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property are not allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest,

and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

82.4(13) *Assessed fee.* The fee assessed pursuant to 441—Chapter 36 is not an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.4(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.4(14) *Payment to new facility.* A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, is subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility will be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate will be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year. The state hospital schools are be included in the compilation of facility costs. The beginning rates for a new facility will be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the

Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

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

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

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

1. Allowable organization costs. Allowable organization costs include but are not limited to legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

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

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(3) All facilities shall comply with the requirements of subrule 82.4(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.4(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate will be established for the facility. This rate will be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities will be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities that complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.4(14)*"d,"* will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates will be subject to the prevailing maximum rate.

82.4(15) *Payment to new owner.* An existing facility with a new owner will continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.4(16). The facility may submit a report for the period of July 1 through June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.4(16) *Payment to existing facilities.* The following reimbursement limits apply to all non-state-owned ICFs/ID:

a. Each facility shall file a cost report covering the period from January 1, 1992, through June 30, 1992. This cost report will be used to establish a reimbursement rate to be paid to the facility and will be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 through June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, through June 30, 1992, will be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, through June 30, 1992, cost report will become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.4(14)*"d."*

d. Facilities that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year will receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

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

(1) Administrator wages.

(2) Business office wages.

(3) Advertising and marketing wages.

(4) Employer's taxes (administrative).

(5) Group/life and retirement benefits (administrative staff).

(6) Workers' compensation insurance (administrative staff).

(7) Employment advertising and recruitment (administrative staff).

(8) Criminal record checks (administrative staff).

(9) Education and training (administrative staff).

(10) Office supplies (administrative staff).

(11) Telephone.

(12) Equipment rental.

(13) Home office costs.

(14) Management fees.

(15) Accounting fees.

(16) Professional organization dues.

(17) Licensing fees.

(18) Information technology expenses.

(19) Legal fees—direct patient-care-related.

(20) Legal fees—other.

(21) Working capital interest.

(22) General liability insurance.

(23) Travel, entertainment and auto expenses.

(24) Advertising and public relations.

(25) Other.

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

(1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs that necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes that necessitate the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation are inpatient days as determined in subrule 82.4(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate will be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase that will not exceed the percentage change in the Consumer Price Index.

h. State-owned ICFs/ID shall submit semiannual cost reports and will receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

82.4(17) *Wage add-on factor.* A wage add-on factor of $8.86 per day for community-based ICFs/ID will be included in rates effective July 1, 2022, and after, not subject to the maximum allowable cost ceiling in paragraph 82.4(14)*"e,"* until rates are established using the cost reports for the period ending June 30, 2023.

a. In accordance with 2022 Iowa Acts, House File 2578, section 31, the entire wage add-on factor will be used for wages and associated costs specific to wages, benefits, and required withholding of direct support professionals and frontline management.

b. The wage add-on factor of $8.86 per day will be added to the maximum allowable base rate in subparagraph 82.4(14)*"d"*(1) until the next rebase using cost reports for the period ending June 30, 2024.

c. The wage add-on factor of $8.86 per day will be added to the maximum allowable cost ceiling, eightieth percentile of costs of all participating facilities in paragraph 82.4(14)*"e,"* until the eightieth percentile maximum is established using the December 31, 2023, compilation for rates effective beginning July 1, 2024.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

441—82.5(249A) Eligibility for services.

82.5(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.5(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required

by an individual whose needs might be met through the use of alternative services that are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.5(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility will continue as long as a valid need for the care exists.

This rule is intended to implement Iowa Code section 249A.12.

441—82.6(249A) Initial approval for ICF/ID care.

82.6(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program will:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.6(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department will:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.6(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.6(3) *Approval of level of care.* Medicaid payment will be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the department.

82.6(4) *Appeal rights.* Notice of adverse action and right to appeal will be given in accordance with 441—Chapter 7 and rule 441—16.3(17A).

This rule is intended to implement Iowa Code section 249A.12.

441—82.7(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay will be made according to procedures established by the department. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the client's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

441—82.8(249A) Arrangements with residents.

82.8(1) *Resident care agreement.* The ICF/ID Resident Care Agreement shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.8(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.8(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections, appeals, and licensing and will meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections, appeals, and licensing representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department will turn the funds over to the member's estate.

82.8(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

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

b. Providing adequate storage facilities for the resident's personal effects.

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

This rule is intended to implement Iowa Code section 249A.12.

441—82.9(249A) Discharge and transfer.

82.9(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.9(2) *Case activity report.* A case activity report shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.9(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.9(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.9(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

441—82.10(249A) Records.

82.10(1) *Content.* The facility shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act (as amended to August 1, 2024).

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records, which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.10(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.10(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.11(249A) Payment procedures.

82.11(1) *Method of payment.* Facilities will be reimbursed under a cost-related vendor payment program. A per diem rate will be established based on information submitted according to rule 441—82.4(249A).

82.11(2) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.11(3) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person. However, the resident or the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over ten days on a hospital stay. When the resident is not discharged from the facility, the payments will not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

This rule is intended to implement Iowa Code section 249A.12.

441—82.12(249A) Billing procedures. Claims for service for clients not enrolled with a managed care organization must be sent to the department after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through the department's electronic clearinghouse.

82.12(1) A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

82.12(2) Adjustments to claims may be made electronically as provided for by the department.

This rule is intended to implement Iowa Code section 249A.12.

441—82.13(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Audits.

82.14(1) *Audits of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the financial and statistical report are reasonable and proper according to the rules set forth in 441—82.4(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent financial and statistical report, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.14(2) *Auditing of proper billing and handling of patient funds.*

a. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals, and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.8(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation that would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph *"d,"* 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 requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

441—82.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.15(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.56(249A).

82.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds will be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

441—82.16(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month will receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.