Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-479
Employees' Manual, Title 8
Medicaid Appendix

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INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED (ICF/ID) MANUAL TRANSMITTAL NO. 18-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)***, Chapter III, *Provider-Specific Policies*, pages 4, 6, 7, 9, 10, 11, 13, 15, 17, 18, 19, 50 through 54, 56, and 57, revised.

Summary

The ***Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)*** manual is revised to align with current policies, procedures, and terminology.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages in the ***Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)***:

Page	Date
Chapter III	
4, 6, 7, 9, 10	May 1, 2014
11	January 1, 2016
13	May 1, 2014
15, 17-19, 50	January 1, 2016
51, 52	May 1, 2014
53, 54, 56, 57	January 1, 2016

Additional Information

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

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

b. Resident Records

The facility must:

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

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

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

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

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

D. ARRANGEMENTS MADE WITH THE RESIDENT

1. Financial Participation

A resident's payment for care may include any voluntary payments made by family members toward the cost of care. The resident's financial 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.

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

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

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

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

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

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

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

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

The Department determines the member's financial 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.

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

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

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

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

3. Medicare, Veterans, and Similar Benefits

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

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

The following is a suggested format:

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

We have received information that this resident may:

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

Send documentation to:

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

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

4. Resident Care Agreement

Iowa law requires that each person residing in a health care facility be covered by a contract that lists the duties, rights, and obligations of all parties.

The ICF/ID shall enter into an agreement with a Medicaid-eligible resident (or the resident's relative, guardian, or trustee) upon admission to the facility. The *ICF/ID Resident Care Agreement*, form 470-0374, is a three-party contract between the ICF/ID, the resident, and the Department, which will serve to meet this requirement.

The ICF/ID is responsible for the distribution of the form to all parties. One copy of the form is given to the member, one copy is retained in the resident's record at the facility, and is uploaded to the Department's Iowa Medicaid Portal Access (IMPA) system.

E. AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS

Upon proper identification, the Iowa Medicaid Enterprise (IME), the Department's contracted managed care organizations (MCOs), field auditors of the Department of Inspections and Appeals or representatives of the U.S. Department of Health and Human Services shall have the right to audit the following:

- Billings to the Department,
- Receipts of the member's financial participation, and
- Record of the facility to determine proper handling of personal needs funds.

The audit shall ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed.

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

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

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

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

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

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

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

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

Written plans shall be submitted to the following addresses:

Iowa Medicaid Enterprise	Health Facilities Council
Bureau of Medical and LTSS	Iowa Department of Public Health
100 Army Post Road	321 E 12th Street
Des Moines, IA 50315	Des Moines, IA 50319

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

2. License

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

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

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

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

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

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

4. Survey and Certification

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

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

- The facility shall request an application form from the Department.
- The Department shall transmit *Iowa Medicaid – Universal Provider Enrollment Application*, form 470-0254, and a provider manual to the facility. The facility shall complete its portion of the application form and submit it to the Department.
- The Department shall review the application form and retain it until the DIA completes the *Medicare/Medicaid Certification and Transmittal*, CMS-1539. Download a sample of the form at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1539.pdf.

- The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

♦ When certification is recommended, the DIA notifies the Department recommending terms and conditions of a provider agreement.

♦ The Department reviews the certification data and:

- Transmits the provider agreement as recommended, or
- Transmits the provider agreement for a term less than recommended by the DIA or elects not to execute an agreement.

G. MEDICAID ELIGIBILITY

See CHAPTER II. MEMBER ELIGIBILITY for rules regarding Medicaid eligibility.

1. Application Procedure

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

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

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

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

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

2. Continued Stay Reviews

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

3. Eligibility for Services

Contact the Department on, or preferably before, admission of a resident who is expected to be eligible for Medicaid. Also contact the Department when a resident who has been admitted on private pay decides to apply for Medicaid.

The IME reviews ICF/ID admissions and transfers only when documentation is provided which verifies a referral from a case management program. For members enrolled with an MCO, the referral shall be made by the member's case manager assigned by the MCO. For members not enrolled with an MCO, the referral shall be made through the Department's selected case management program.

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

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

- Diagnoses; summaries of present medical; social and, where appropriate, developmental findings; medical and social family history; mental and physical functional capacity; prognoses; range of service needs; and amounts of care required.
- An evaluation of the resources available in the home, family, and community.

- An explicit recommendation with respect to admission (or in the case of persons who make application while in the facility, with respect to continued care in the facility).
- Where it is determined that ICF/ID services are required by a person whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.
- An individual plan for care, which shall include:
  - Diagnosis, symptoms, complaints or complications indicating the need for admission;
  - A description of the functional level of the resident;
  - Written objective;
  - Orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives;
  - Plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.
- Written reports of the evaluation and the written individual plan of care, which shall be delivered to the facility and entered in the resident's record at the time of admission or, in the case of persons already in the facility, immediately upon completion.

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

a. Placement Approved

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

The beginning date of eligibility shall be no more than 90 days before the first day of the month in which application was filed with the Department.

If a Medicaid resident requests transfer or discharge, or there is another person requesting this for the resident, the facility administrator shall promptly notify the Department by means of the *Case Activity Report*, form 470-0042. The facility shall also notify the member's case manager for members enrolled with a managed care organization, or the Department's selected case management provider for members not enrolled with a managed care organization.

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

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

> Mr. S has a monthly member participation of $300. The facility in which Mr. S resides has a per diem rate of $100. In a normal month, Mr. S pays for the first three days of his care ($100 x 3 days = $300) and the state pays for the remainder of the month.
>
> If Mr. S leaves the facility on the third of the month, the facility must make a $100 refund to Mr. S ($300 minus $200 (2 days' care) equals $100). If he leaves the home on the fourth of the month or later, no refund is normally due. An exception could arise if reserve bed days are involved.

2. Closing of Facility

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

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

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

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

3. Department Procedures

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

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

4. Reasons for Discharge or Transfer

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

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

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

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

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

5. Transfer of Residents by Ambulance

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

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

N. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

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

1. ICF/ID Provider Assessment Fee

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

The amount of the provider assessment fee is 5.5 percent of actual paid claims, from all sources, for the facility's preceding quarter.

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

2. Method of Reimbursement

For members not enrolled in an MCO the Medicaid program reimburses ICFs/ID under a cost-related vendor payment system, with a per diem set for each facility. This rate is established on the basis of financial and statistical data submitted by the facility on the *Financial and Statistical Report*, form 470-0030. The financial data submitted by the facility is audited by the accounting firm under contract with the Department.

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

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

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

3. Time Frames for Submitting Claims

Claims for members not enrolled in an MCO can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, only one claim should be submitted per month after the end of the month.

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

The IME generates payments weekly.

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

4. Periods of Service for Which Payment Will Be Authorized

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

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

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

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

c. Payment Rate for Reserved Beds

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

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

d. Payment After Medical Eligibility Denial

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

(1) Grace Days

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

If the facility and case manager reports document that no appropriate, alternate placement is available within a reasonable distance, this grace period may be extended until alternate placement becomes available. Extension of grace days beyond the standard 30 working days is determined by the Bureau of Medical and LTSS.

(2) Continuation of Other Medicaid Services

If the member is determined to no longer meet the requirements for ICF/ID Medicaid coverage, the member's eligibility will be redetermined to see if the person may still be eligible to receive another Medicaid coverage group, if applicable.

If a resident is determined eligible for another Medicaid coverage group, they will continue to receive Medicaid state plan benefits. If a resident has another payment source available to maintain the resident at the ICF/ID, the resident could potentially stay in the ICF/ID but Medicaid would not be covering the stay.

5. Supplementation

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

EXCEPTIONS:

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

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