Iowa Department of Human Services

Agreement for Intermediate Care Facilities for Individuals with an Intellectual Disability Participation in the Medicaid Program

This agreement is between

and the Iowa Department of Human Services.

This agreement covers: beds

In accordance with the provisions of section 1905(17)(c) of the Social Security Act and the Regulations (42 CFR 442.12) the term of your agreement is for a conditional term of full calendar months, beginning , ending , and is subject to the provision that your agreement will automatically terminate , unless it is determined that all deficiencies have been satisfactorily corrected, or determined that you have made substantial effort and progress in correcting such deficiencies.

The Iowa Department of Inspections and Appeals has furnished you results of their latest survey of your facility. The deficiencies listed on that form reflect the State's recent survey evaluation of your compliance with rules and regulations governing care facilities. You have been asked to furnish your plans providing for the correction of deficiencies cited and expected completion dates. Your agreement to continue participation in the Medicaid program is being accepted on the expectation that you will proceed to correct these deficiencies within the expected time frames. A copy of your more recent survey report will be furnished to your local Department of Human Services and will be made available to the public upon request.

Iowa Department of Human Services	
By:	Signature of Owner or Administrator:
Title: Bureau Chief, Policy and Long Term Care Services	Title of Authorized Official:
Date:	Date:

This agreement is enclosed in two copies. Please complete and sign both copies and return one copy to: Iowa Department of Human Services, Bureau of Policy and Long Term Care Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315.

We are also enclosing two copies of form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*. Please complete both copies and retain one copy for your files. Return the other copy **with no documentation attached**. If you have any questions concerning this matter, call 800-338-7909, Option 2.

This Contract, made and entered into this day of , 20 , by and between the Iowa Department of Human Services, hereinafter designated as the Department, and the , a provider of health-related care and services, whose address is as stated above, hereinafter designated as the Facility, Witnesseth:

WHEREAS, persons receiving public assistance payments from the Iowa Department of Human Services and other persons eligible for care under the Medicaid program operating under Title XIX of the Social Security Act, are in need of health-related care and services in the form of Intermediate Care Facility for individuals with an intellectual disability;

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or health care facility providing services under the State Plan for Medicaid;

WHEREAS, acting pursuant to Section 249A of the 1971 Code of Iowa which makes the Iowa Department of Human Services the agency responsible for administering the Medicaid program in Iowa, and authorizes the Iowa Department of Human Services to take all necessary steps for the proper and efficient administration of the Medicaid program;

WHEREAS, the Iowa Department of Human Services is the agency with the authority to certify Intermediate Care Facilities for individuals with an intellectual disability for participation in the Medicaid program;

WHEREAS, to participate in the Medicaid program, the Intermediate Care Facility for individuals with an intellectual disability must: (1) be licensed under the laws of Iowa; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing administrator who holds a current license, or by a qualified intellectual disability professional; and (4) meet on a continuing basis federal standards for participation in Medicaid;

WHEREAS, the Facility hereby has filed an application with the Department to provide ICF/ID care and services to persons eligible under the Medicaid program;

NOW THEREFORE, the aforesaid application is approved by the Department subject to the following stipulations, terms and conditions.

SECTION I

DEFINITIONS

An Intermediate Care Facility for Individuals with an intellectual disability means a health care facility (or distinct part of a health care facility) licensed under Section 135C, of the Code of Iowa that meets all conditions for participation as an Intermediate Care Facility for individuals with an intellectual disability in the Medical Assistance Program Title XIX of the Social Security Act.

SECTION II

RESPONSIBILITIES OF FACILITY

The Facility Agrees:

A. To abide by all pertinent rules and regulations of the Department. Delivery of a copy of said rules and regulations to the Applicant shall constitute due notice and knowledge by the Applicant of said rules and regulations. That said rules and regulations contained in the current Handbook for Intermediate Care Facilities for Individuals with an Intellectual Disability prepared and circulated by the Department are made a part of this agreement. Delivery to the Applicant of new, amended, or revised rules and regulations shall constitute due notice thereof, and the Applicant agrees to abide by said rules and regulations.

B. To provide diagnosis, treatment, and habilitation of individuals with an intellectual or developmental disability, in a protected residential setting, with individualized, ongoing evaluation, planning, 24 hour supervision, and coordination and integration of health and rehabilitative services to help each individual reach his/her maximum functioning level.

C. To accept for payment for supplying the services in "B" above, the Department's vendor payment now in effect, or as hereafter modified.

   1. The Facility will be notified of the amount the resident is to pay on the cost of his/her care. The balance of the allowable payment for care will be paid by the Department directly to the Facility. The total of these amounts shall be accepted as payment in full for the care of the resident, and no additional charges shall be made to the resident or any other source, except as allowed within Medicaid policies and regulations.

   2. If the Facility should receive payment for medical services, benefits, and/or goods, in an amount in excess of that permitted by said law, rules, and regulations; that such excessive payments may be deducted from future payments on behalf of residents otherwise payable to said Facility, and/or recovery of such payments may be made otherwise, at the option and discretion of the Department, in accordance with its rules and regulations pertaining to recoveries or other legal means.

D. To cooperate with state and federal personnel who make periodic inspections, reviews, and audits.

   1. To allow regular medical care reviews of each resident covered under the Medicaid program including an evaluation of the patient's need for the services the Facility provides. Reviews may include private interviews with residents.

   2. To make available to the appropriate state and federal personnel at all reasonable times all necessary records, including, but not limited to, the following:

      a. All medical records necessary for the conduct of resident care reviews;

      b. Records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Medicaid program, including the authority for and the date of administration of such treatment, drugs, or services;

c. Documentation in each resident's record which will enable the Department to verify prior to payment that each charge is due and proper;

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

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

f. Census records shall be prepared and maintained by employees of the health facility to include:

(1) Date – Number of patients beginning each day – Name of patient admitted - Name of patient discharged;

(2) The above information (number 1) shall be provided for the following clients:
(v) ICF/ID
(x) Skilled
(y) Intermediate
(z) Custodial and/or residential

(3) Each category (v), (x), (y), or (z) shall be totaled monthly to indicate:
(a) Number admitted
(b) Number discharged
(c) Number of patient days

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

3. To abide by accounting and billing policies as outlined by the Department:

a. Assuring that any charges made under the Medicaid program will be consistent with efficiency, economy, and quality of care;

b. Assuring that the Facility shall not profiteer on drugs (or other items) for Medicaid patients; nor shall the Facility enter into any agreement with any supplier of drugs (or other items) for rebates or cutbacks for supplies.

4. To provide in writing a plan of correction and timetable of completion acceptable to the Department for each deficiency reported as a result of a Facility survey.

5. Facilities owned by organizations maintaining financial records outside the territorial boundaries of the state of Iowa may, at their option, elect to pay an annual examination fee of $300 for auditing financial records at the home office in lieu of making such records available in the Iowa facility. The examination fee is payable to the Department upon submission of form 470-0030, *Financial and Statistical Report*, for the six-month period, accompanied by a letter requesting that the examination be made at a specified address.

6. The Iowa Department of Human Services can request that a complete audit of the Facility's financial records be performed by an independent certified public accountant and/or a CPA firm. Such circumstances include those where:

   a. The Department has indications of possible fraud or irregularities.

   b. The Department has indications of records being withheld, or the possible falsification of records submitted to the Department.

   The examination will be made to enable the Department to verify costs reflected in the financial reports submitted by the provider, and to determine that payments made to the Facility have been proper, and to ascertain that there has been compliance with the Department's rules and regulations, as well as any agreements between the parties.

   The costs of this special audit shall be borne by the Facility in those instances where the audit verifies that circumstances referred to above do exist. If the audit proves the above referred to circumstances do not exist, the expense shall be borne by the Iowa Department of Human Services.

7. The rules and regulations currently in effect relating to the preparation and submitting of form 470-0030, *Financial and Statistical Report*, shall remain in force. In order to provide for a fair and accurate rate of vendor payment for the period of time between the semi-annual reports, the following conditions shall be affected:

   a. In those instances wherein the fiscal records (including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports) as compiled and maintained by/for the Facility, are not adequately maintained to render a proper per diem rate, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate. Recommendations may be made to the Iowa Department of Human Services that the indicated per diem be reduced by 25% for the ensuing six-month period. If the situation is not remedied on the subsequent form 470-0030, *Financial and Statistical Report*, the Facility shall be suspended and eventually canceled from the ICF/ID program.

   b. In those instances wherein the Facility continues to include as an expense, such item(s) as had in a prior audit been removed by an adjustment in the total audit costs, the auditor shall recommend that the Iowa Department of Human Services reduce the audited per diem by 25% for the ensuing six-month period.

   The conditions as set forth herein shall also apply to the audits conducted by the Division of Audits, Iowa Department of Inspections and Appeals.

E. To comply with the Civil Rights Act of 1964 and any amendments thereto, with Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975. These acts provide that no person in the United States shall, on the grounds of race, color, or national origin (Civil Rights Act), handicap (Rehabilitation Act), or age (Age Discrimination Act), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

F. To respect the observance of religious beliefs of all Medicaid residents.

G. To promptly inform the Department of Human Services county office when a recipient of Medicaid receiving care in the Facility requires social services beyond that range of services the Facility is expected to provide.

H. To promptly inform the Department of Human Services county office when individuals covered under the Medicaid program enter and leave the Facility.

I. To have a licensed administrator acting in accordance with the laws of the state of Iowa and the rules of the Iowa Board of Examiners for Nursing Home Administrators, and/or possessing at least one year administrative experience and meeting Federal requirements as a Qualified intellectual disability Professional.

J. To meet sanitation standards approved by the Department.

K. To immediately notify the Department of any change in its license to operate as an ICF/ID as issued by the licensing agency of the state.

L. To provide the Department with at least 60 days prior notice in the event of termination of participation in said medical program (this pertains to cessation of business, election to no longer be involved in the program, and to transfers of ownership or operation of said business). However, this provision shall not apply in the case where an amendment to the rules of the Department is determined to be unacceptable to the eligible provider who for said reason elects to discontinue participation in the program.

In such event, the eligible provider shall forthwith notify the Department in writing of such intent to discontinue, and the provider and the Department shall forthwith negotiate the termination date. In no event shall said date be longer than 60 days from the effective date of the rule amendment.

M. To provide the Department with the information requested below, and to promptly notify the Department of any changes in it:

1. The name, address, and Social Security number of each person having individual interests in mortgages or other obligations equal to at least $25,000 or 5% of total facility assets;

2. If the facility is a corporation, the names, addresses, and Social Security numbers of each officer and director of the corporation;

3. If the facility is a partnership, the name, address, and Social Security number of each partner;

4. If the facility is a sole proprietorship, the name, address, and Social Security number of the proprietor.

N. To pay the Department all provider assessment fees that become due and owing pursuant to Iowa Code section 249A.21 in a manner and time frame as prescribed by the Department.

O. That none of the foregoing specifics in this Contract shall limit the responsibility of the Applicant to abide by applicable laws, rules, and regulations, either current as they may be amended or subsequently enacted.

SECTION III

RESPONSIBILITIES OF THE MEDICAID AGENCY (DEPARTMENT)

The Department Agrees:

A. To pay for such care and services in the form of vendor payments (in amounts and under conditions determined by the Department) for all persons receiving care who have been determined by the Department to be eligible for such assistance under the Medicaid program.

B. To make such payments in accordance with the applicable laws and as promptly as is feasible after a proper claim is submitted and approved.

C. To withhold payments if necessary because of irregularity from whatever cause, until such irregularity or difference can be adjusted.

D. To make proper adjustment in vendor payments to compensate for either overpayment or underpayment.

E. To give to the Facility reasonable notice of any impending change in its status as a participating Intermediate Care Facility for Intellectual Disability Persons.

F. To notify the Facility of any major changes in Medicaid rules and regulations, and to work with the Facility toward providing the best care available within the limitations of the law and available funding.

G. To provide methods and procedures for review of care and services in accordance with Medicaid standards.

SECTION IV

JOINT RESPONSIBILITIES OF THE MEDICAID AGENCY (DEPARTMENT) AND THE FACILITY

The Department and Facility Mutually Agree:

A. That in the event the federal and/or state laws should be amended or judicially interpreted so as to render the fulfillment of this Contract on the part of either party infeasible or impossible, or if the parties to this Contract should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of Medicaid program participation as the result of amendments of judicial interpretations; then in that event, both the Facility and the Department shall be discharged from further obligation created under the terms of this Contract, except for equitable settlement of the respective debts owed up to the date of termination.

B. That the term of this Contract shall be from the date hereof, or until the federal and/or state government cease to participate in the program, or until the Facility gives 60 days' notice of

termination in writing to the Department or the Department notifies the Facility in writing that it is being terminated from the program.

C. That as the Federal standards for participation are amended, modified, or changed, the Department shall immediately furnish the Facility a copy of any such changes, and that unless the Facility notifies the Department in writing within the 30 days of its non-acceptable of the amendment, modifications, or changes, the Department shall presume acceptance.

D. The effective rate of vendor payments shall be agreed upon by the contracting parties and shall be in effect until adjustment is necessary, as indicated by information submitted by the Facility in the semi-annual form 470-0030, *Financial and Statistical Report*, or until the Federal standards for participation are amended, modified, or changed in such a manner as to dictate an adjustment in the effective rate.

E. That the effective date for vendor payment shall be the date that the ICF/ID attains participation status, as determined by the Department under the Federal standards for participation, and that such determination shall be made a part of this Contract.

F. That this Contract shall not be transferable or assignable.

G. That it is understood that by signing this Contract the Facility and Department accept all of the stipulations in the Contract, and agree to each and every provision therein.

1. Each person having individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of total facility assets.

Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	

If necessary, attach an additional sheet listing the remaining owners.

2. If the Facility is a corporation, the officers of said corporation are:

Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	

The Directors of said corporation are:

Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	

If necessary, attach an additional sheet listing the remaining directors.

3. If the Facility is a partnership, the partners are:

Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	

4. If the Facility is a sole proprietorship, the proprietor is:

Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	
Name	Social Security Number
Address	

To be Completed by the Department:	
Effective Date of Contract	Termination Date of Contract
IOWA DEPARTMENT OF HUMAN SERVICES	
Authorized Signature	Date
Title	

To be Completed by the Facility:	
Name of ICF/ID	
Address	
Authorized Signature	Date
Title	