ARC 0994C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4 and 2001 Iowa Acts, chapter 192, section 4(6), the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 81, "Nursing Facilities," Iowa Administrative Code.

The purpose of these amendments is to provide clarification for the treatment of prescription drugs, X-ray, lab, and related-party compensation in the setting of rates for nursing facilities (NFs). The amendments also clarify the Department's treatment of legal, accounting, consulting and other professional fees, including association dues, management fees, penalties and fines, and therapy expenses. These amendments change what is required to be submitted to the Department with the cost report, change the timing for submission of the cost report, better define the timing for submitting an amended cost report, and clarify the Department's position regarding the penalty period for late submission of cost reports. This rule making also includes an amendment to elaborate on Medicaid's ability to recoup outstanding debts of facilities whose ownership changes and includes changes to language in the rules to reflect current operations of the Iowa Medicaid Enterprise.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0789C** on June 12, 2013. The Department received a number of comments from four persons on these amendments. The comments received by the Department are compiled as follows:

General comments on professional fees: There were two comments on professional fees. In the first comment, there was a question about inclusion of costs associated with professional fees, including association dues, penalties and fines that do not directly impact the quality of care and thus are items that should not be funded by taxpayers. The second comment was a request to add specificity to the cost reports specifically with regard to fees paid to trade associations, to attorneys, to accountants, and to consultants.

Department response: Professional fees for attorneys, accountants, and other professionals may be a valid administrative cost of doing business for any type of health care provider, and appropriate professional fees are factored into the reimbursement rate for many types of providers, including nursing facilities. There is a limit on the amount of non-direct costs, including on administrative costs, for which a provider may receive payment.

Professional fees are currently all reported on one line in the cost report; however, the cost report also includes optional supplemental schedules which many providers use to provide further detail about these costs. Additionally, the amendment to subrule 81.6(3) in Item 7 of this rule making includes new requirements for facilities to submit a working trial balance which corresponds to the data on the cost report. This change will allow for review of the types of costs that go into a specific line, including the different accounts that are added together to be reported on Line 14. Facilities that accept Medicare payment will also be required to submit a copy of their Medicare cost report, and facilities with audited financial statements will be required to submit those as well. These requirements will provide the Department with ample information for reviewing nursing facility cost reports.

The Department plans to convene a stakeholder group in the second half of 2013 to discuss possible revisions to the cost report form and will invite representatives of both the Iowa Caregivers Association and the nursing facility associations to participate. It is anticipated that any revisions to the cost report which result from stakeholder discussions will not require further rule making.

General comments on legal fees: There was one comment in this area, which stated that the current rule allows for legal fees to be submitted regardless of whether the nursing home prevails on the matter for which the fees are changed. In addition, the comment stated that the rule does not specify how "reasonableness" of legal fee claims will be measured.

Department response: The amendments increase the limitations on legal expenses that may be allowed in a facility's rate calculation. Under the current rule, litigation costs could be allowable even

if the facility does not prevail in the matter; however, under these amendments, litigation costs will only be allowable after a case is decided and will then only be allowable if the facility prevails on the disputed issue, regardless of whether the facility is the plaintiff or defendant or whether the issue is heard in a criminal or administrative proceeding. The term "reasonable" is widely used in both statutes and rules to represent what is appropriate under usual or ordinary circumstances. In reviewing cost reports, the Department considers a reasonable cost as one which would be paid by a prudent, cost-conscious buyer. As such, reasonable legal fees may vary depending upon the nature of the work; for example, legal fees for drafting a policy on performing background checks would likely be different than legal fees for defending a case in court. While further defining reasonableness may serve to limit facility costs, it also may limit the Department's ability to exclude other costs that were not anticipated in rule. The Department needs the latitude provided by these amendments to fairly and prudently examine costs dependent upon the situation in which they are incurred.

General comments on association dues: The following questions were asked. Should expenses of a nursing facility to fund its membership in an industry trade association be deemed as a necessary expense and used as an expense that leads to higher revenue in the form of Medicaid dollars from the state? In addition, if the expenditures for, and of, a trade association are deemed to be warranted, and therefore result in increases in Medicaid costs, should limits exist on association expenditures to ensure that they are both appropriate and reasonable?

Another comment stated that very little is known about association dues but that association dues have a significant impact on Medicaid costs. The person commenting wanted to know specifically if Medicaid dollars were used to purchase land, buildings, and equipment for a professional association.

Department response: Under these amendments, association dues may be an allowable cost for nursing facilities if the dues are related to patient care. Professional provider associations provide to member facilities many services that do have a direct impact on nursing home residents. Associations present staff training, promote best practices, and provide technical assistance to nursing facilities and are equipped to provide this type of training and information to a large number of providers in an efficient manner. While it is true that provider associations also often serve as lobbyists for their members' interests, the Department already treats their lobbying costs as unallowable, as required by federal law. The adopted amendments, however, state this practice more explicitly than does the current rule.

Comments on costs "directly" related to patient care: Two respondents were concerned that the key word "directly" has been proposed for removal from the existing regulation, specifically in paragraph 81.6(11)"o." The removal of the word "directly" is significant and problematic. The argument could be made that many fees are related to patient care, but not directly related.

Department response: After reviewing these comments, the Department agrees that the word "directly" should not be omitted from paragraph 81.6(11)"o" and has revised the first sentence of the paragraph to read: "Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care." It should be noted that this change does not mean that these costs will be automatically considered unallowable; rather, all reported costs in this category will still be reviewed to determine which ones are allowable or unallowable.

Comments on the definition of "reasonable" costs: Three of the respondents expressed concern that expenses must be reasonable in order to be reimbursed. To make the policy effective, a process must be in place that identifies the level of detail needed to determine whether the "reasonable" test is met. In addition, reporting instructions should require that amounts for legal, accounting, and consulting fees should be reported in hourly and total amounts rather than reported as a lump sum.

Department response: The term "reasonable" is widely used in both statutes and rules to represent what is appropriate under usual or ordinary circumstances. In reviewing cost reports, the Department considers a reasonable cost as one which would be paid by a prudent, cost-conscious buyer. This determination not only pertains to the amount of the reported costs, but also to whether a cost is allowable or not allowable in its entirety. While further defining reasonableness may serve to limit facility costs, it also may limit the Department's ability to exclude other costs that were not anticipated

in rule. The Department needs the latitude provided by these amendments to fairly and prudently examine costs dependent upon the situation in which they are incurred.

Comments on auditing and data resources: Three respondents provided commentary in this area. All of the respondents generally agreed that adequate resources do not exist within DHS to allow for comprehensive capture of data from multiple sources in order for appropriate analysis to be done. The respondents asked the Department to request those staff or contract resources in the next budget cycle, and for the Legislature to grant that request.

Department response: The Department's provider cost audit and rate setting contractor performs a desk review of cost reports for all 450+ nursing facilities within the state. This review typically includes not only consideration of the data reported on the cost report form but also includes other data that the Department requests from the facility, such as a working trial balance, audited financial statements, or original source documentation of costs. Under these amendments, much of this additional documentation will be required from facilities at the time the cost report is submitted. The Department works with its contractor to develop procedures to implement the rules so that significant misstatements are not missed. Any increase in reviewing or auditing activity beyond the current level would require the appropriation of additional funds by the Legislature.

Requests to modify the proposed language in the amendments: Specifically, the respondents requested changes to Items 4 and 15 of the proposed rule making for the purpose of adding clarity.

Department response: The intent of the provisions in those items is to clarify that these costs are allowable for residents of a facility, but not allowable for outpatient services provided to persons not residing in the facility. In order to better convey this distinction, the Department has revised the definition of "direct care component" in Item 4 to read as follows:

"*'Direct care component'* means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. 'Direct care component' also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service."

The Department revised the introductory paragraph of 81.6(11)"r" in Item 15 to read as follows:

"*r.* Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments."

The Department also added the word "outpatient" before the word "therapy" in the next to last sentence of subparagraph (2) of 81.6(11)"r." The subparagraph now reads as follows:

"(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification."

In addition to the changes made in response to comments received, the Department has revised paragraph "1" of the home health agencies provider category in Item 2 so that the paragraph reflects the amendments adopted in Item 1 of **ARC 0964C**, which was published in the July 24, 2013, Iowa Administrative Bulletin.

The Council on Human Services adopted these amendments on August 14, 2013.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective November 1, 2013.

The following amendments are adopted.

ITEM 1. Amend subparagraph **78.19(1)"a"(1)** as follows:

(1) Services are provided in the ~~recipient's~~ member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a ~~recipient~~ member residing in a ~~nursing facility or~~ residential care facility are payable when the facility submits a signed statement ~~is submitted signed by the facility~~ that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a ~~recipient~~ member residing in a nursing facility or an intermediate care facility for ~~the mentally retarded~~ persons with an intellectual disability since these facilities are responsible for providing or paying for services required by ~~recipients~~ members.

ITEM 2. Amend subrule **79.1(2)**, provider categories "Home health agencies," "Occupational therapists," "Physical therapists," and "Rehabilitation agencies," as follows:

Provider category	Basis of reimbursement	Upper limit
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal care for ~~persons~~ members aged 20 or under	No change.	No change.
3. Administration of vaccines	No change.	No change.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	No change.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	No change.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	No change.

ITEM 3. Rescind the definition of "Department's accounting firm" in rule **441—81.1(249A)**.

ITEM 4. Amend rule **441—81.1(249A)**, definition of "Direct care component," as follows:

"Direct care component" means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. "Direct care component" also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

ITEM 5. Amend rule 441—81.6(249A), introductory paragraph, as follows:

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the ~~department's accounting firm~~ Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report ~~to the department's accounting firm. Costs for patient care services shall be reported, divided into the subcategories of "Direct Patient Care Costs" and "Support Care Costs." Costs associated with food and dietary wages shall be included in the "Support Care Costs" subcategory. The~~

~~financial and statistical report shall be submitted in an electronic format approved by the department~~. These reports shall be based on the following rules.

ITEM 6. Amend subrule 81.6(2) as follows:

81.6(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial ~~statement~~ statements of the facility. 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. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which 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. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

ITEM 7. Amend subrule 81.6(3) as follows:

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports ~~to the department's accounting firm no later than three months after the close of the facility's established fiscal year~~ electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report ~~to the department's accounting firm~~ electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. 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 Iowa Medicaid enterprise provider cost audit and rate setting unit 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 nursing 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 81.6(3)*"e."*

c. 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 as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within ~~this~~ the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(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 Iowa Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which 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 provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit 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.

g. 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 Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the ~~department's accounting firm~~ Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

ITEM 8. Amend paragraph **81.6(10)"a"** as follows:

a. Routine daily services shall represent the established charge for daily care. Routine daily services ~~are those services which~~ include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or X-ray services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

ITEM 9. Amend subparagraph **81.6(11)"e"(3)** as follows:

(3) ~~Each~~ At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section ~~601J.1, subsection 1,~~ 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code ~~chapter 601J~~ section 324A.5 and ~~820—[09,A] chapter 2~~ 761—Chapter 910 of the Iowa department of ~~transportation~~ transportation's rules ~~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~~ shall~~,~~ result in disallowance of vehicle costs and other costs associated with transporting residents.

ITEM 10. Amend subparagraph **81.6(11)"h"(1)** as follows:

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. ~~It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.~~ Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include 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 shall 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 Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit 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 81.6(3)*"e."*

ITEM 11. Adopt the following **new** subparagraph **81.6(11)"h"(7)**:

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

ITEM 12. Adopt the following **new** subparagraph **81.6(11)"h"(8)**:

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11)*"h"*(4) to 81.6(11)*"h"*(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility 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. In the case that an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

ITEM 13. Amend paragraph **81.6(11)"i"** as follows:

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

ITEM 14. Rescind paragraph **81.6(11)"o"** and adopt the following **new** paragraph in lieu thereof:

o. 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 unallowable:

(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. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below 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.

ITEM 15. Adopt the following **new** paragraphs **81.6(11)"q"** to **"t"**:

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)*"c."* The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

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

ITEM 16. Amend paragraph **81.6(12)"a"** as follows:

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services 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. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. 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) to (4) No change.

ITEM 17. Rescind subrule 81.6(13) and adopt the following **new** subrule in lieu thereof:

81.6(13) *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 summary and adjustments following a review of a financial and statistical report. 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 Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

ITEM 18. Amend subrule 81.6(15) as follows:

81.6(15) *Payment to new owner.* An existing facility with a new owner shall continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent

financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the ~~department's accounting firm~~ Iowa Medicaid enterprise provider cost audit and rate setting unit of the date ~~its~~ the facility's fiscal year will end.

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