441—81.5(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 to the department. All Medicare-certified hospital-based nursing facilities must submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.5(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility, may result in the penalties specified in subrule 81.14(1).

81.5(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial 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 that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. 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.

81.5(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the department 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 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 department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the 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 81.5(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 81.5(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 the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by the department.

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

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

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 department 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 60 days prior to the first date of the change.

81.5(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates will be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below will be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, will be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.5(16). In no case will the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed $94, times an inflation factor pursuant to subrule 81.5(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case will the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.5(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities will be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities will be updated annually without a quarterly adjustment.

81.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.5(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.5(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.5(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

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

81.5(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

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

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

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

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

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

e. Laundry revenue shall be applied to laundry expense.

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

81.5(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following:

a. Federal and state income taxes are not allowed as reimbursable costs.

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

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

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

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility that supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in

Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings that provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

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

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits 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 department. 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 department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report will be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.5(3)*"e."*

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

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

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator is

considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.5(18).

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

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

(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.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.5(11)*"h"*(4) through 81.5(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.

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.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition).

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.5(12).

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

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

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

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

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

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

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

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

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

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those that commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.5(11)*"l,"* the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)*"j"* plus the landlord's other expenses, plus a reasonable rate of return; or
2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.5(11)*"l,"* the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)*"j"* plus the landlord's other expenses; or
2. Actual rent payments.

n. 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. However, 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.

o. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.5(21)*"a."*

p. 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)*"d."* The department 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.

q. 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 department will 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 will 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.

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

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

t. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

u. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.5(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. 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) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

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

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

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

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

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

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

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.5(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 department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.5(14) *Payment to new facility.* The payment to a new facility will be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.5(16)*"c."* After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component will be adjusted by the facility's average Medicaid case-mix index pursuant to subrule 81.5(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility's first fiscal year, rates will be established in accordance with subrule 81.5(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

81.5(15) *Payment to new owner.* An existing facility with a new owner will 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 of the date the facility's fiscal year will end.

81.5(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate.

a. Calculation of per diem cost. For purposes of calculating the non-state government owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs will be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost will be determined by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001; July 1, 2003; July 1, 2004; July 1, 2005; and every second year thereafter, total reported allowable costs will be adjusted using the inflation factor specified in subrule 81.5(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state government owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7)) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses will be inpatient days as determined in subrule 81.5(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.5(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.5(19).

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

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

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.5(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting will be recalculated. The non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.5(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, will be inflated to July 1, 2004, using the inflation factor specified in subrule 81.5(18).

d. Excess payment allowance.

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area as defined by CMS, not including Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area as defined by CMS (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

The wage index factor will be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by CMS each July. The geographic wage index adjustment will not exceed $8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than

zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph *"d,"* not to exceed the rate component limits determined by the methodology in paragraph *"f."*

(1) For non-state government owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.5(19), plus the allowed excess payment allowance as determined by the methodology in paragraph *"d."*

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph *"d"* and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph *"h."*

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities will be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.5(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs *"d"* and *"e,"* in no instance will a rate component exceed the rate component limit defined as follows:

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph *"d"* times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

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

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state government owned nursing facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the "payment period") for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types will not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The department will annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The

maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	Payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	Payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	Payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	Payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	Payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	Payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	Payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	Payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	Payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent

Standard	Measurement Period	Value	Source
developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.			entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to August 1, 2024, the facility is deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIAL list of facilities meeting the standard
Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points. A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIAL list of facilities meeting the standard
Subcategory: Staffing			
Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities. Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Financial and Statistical Report, as analyzed by the department. The facility cost report period case-mix index shall be used to normalize nursing hours.
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%	Financial and Statistical Report, as analyzed by the department

Standard	Measurement Period	Value	Source
		10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	
Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.	Calendar year ending December 31 of the payment period	5 points	Self-certification
Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility. To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	Department report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	Department report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	Department report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures:	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of	Department report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
The facility received at least 9 points from a combination of the measures listed in this subcategory.		nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIAL list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Financial and Statistical Report, as analyzed by the department

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Financial and Statistical Report, as analyzed by the department
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Financial and Statistical Report, as analyzed by the department

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data will be drawn from a report submitted by the facility to the department. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to the department on the Nursing Facility Opinion Survey Transmittal. The department will request required source reports from the long-term care ombudsman and the department of inspections, appeals, and licensing.

(10) Calculation of potential add-on payment. The number of points awarded will be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

Score	Amount of Add-on Payment
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department will request the department of inspections, appeals, and licensing to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections, appeals, and licensing, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program will be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the department will:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.5(16)*"g"*; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete the Nursing Facility Medicaid Enhanced Payment Report to report the use of any additional payments received for the nursing facility pay-for-performance program. The report is due to the department each year by May 1. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department will publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the CMS and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph *"f."*

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph *"f."* The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

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

1. Rectification of a violation of Life Safety Code requirements; or

2. Development of home- and community-based waiver program services; or

3. Improving infection control by replacing or enhancing an HVAC system, as defined in Iowa Code section 105.2.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent. Medicaid patient day utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total patient days as reported on the facility's most current financial and statistical report. Medicaid hospice patient days will be counted toward the total nursing facility Medicaid patient days.

2. The facility meets the accountability measure criteria set forth in paragraph *"g,"* subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.

2. Services shall be provided on the direct site of the facility but not as a nursing facility service.

3. Services shall meet all federal and state requirements for Medicaid reimbursement.

4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the department. A qualifying facility may request one or both types of additional reimbursement.

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

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

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule that clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days will be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.

2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.

3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).

4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

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

1. Effective December 1, 2009, total patient days will be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days will be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government-owned facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. Estimated amounts and actual amounts will be reconciled as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on will be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph *"f."*

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

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

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days will be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned

nursing facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph *"f."* The facility's quarterly rates for the relevant period will be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid will be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit will be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date will be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval will be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

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

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership will continue under the new owner. Future reimbursement rates will be determined pursuant to subrules 81.5(15) and 81.5(16).

i. Quality incentive payment program (QIPP). The QIPP add-on rate will be made to a qualified non-state government-owned nursing facility (NSGO nursing facility) to promote, maintain, and improve resident quality of care and health outcomes.

(1) An NSGO nursing facility qualifies for participation in the QIPP if all the following conditions are met:

1. The NSGO nursing facility has executed a participation agreement with the department.

2. The NSGO nursing facility has provided proof that the entity holds the NSGO nursing facility's license and has complete operational responsibility for the NSGO nursing facility.

3. The NSGO nursing facility has filed a certification of eligibility application for the QIPP add-on rate program with the department and has received approval from the department for participation in the program.

4. The NSGO nursing facility is in compliance with all care criteria requirements.

5. The non-state government entity (NSGE) has executed a nursing facility provider contract with an NSGO nursing facility.

6. The NSGE has provided and identified the source of state share dollars for the intergovernmental transfer (IGT).

7. The NSGO nursing facility has provided proof of ownership, if applicable, as the licensed operator of the NSGO nursing facility.

8. The NSGO nursing facility has provided to the department an executed management agreement between the NSGE and the NSGO nursing facility manager if applicable.

(2) If at any time a provider is determined not eligible due to not meeting survey standards, the provider will be disqualified for the remainder of the year.

(3) An NSGO nursing facility will qualify for participation in the QIPP if all the following quality measures are met:

Quality Measures	Metrics	Tracking/Scoring	Data Resource
Staffing	**Metric 1:** Nursing facility maintains an additional four or more hours of registered nurse (RN) coverage per day beyond the CMS minimum standard (8 hrs/day). Does not include managerial hours. **Metric 2:** Nursing facility's per-resident day certified nursing assistants (CNAs), rehabilitation aid, and other contracted aid services are at or above one-half standard deviation above the statewide mean of per-resident-day CNA hours. CNA hours include those of CNAs, rehabilitation aid, and other contracted aide services. CNA hours will be normalized to remove variations in staff hours associated with different levels of resident case mix. **Metric 3:** Nursing facility's per-resident day total nursing hours are at or above one-half standard deviation above the statewide mean of per-resident-day total nursing hours. Nursing hours include those of RNs and licensed practical nurses (LPNs) including restorative nurses. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Staffing metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Payroll-based journal (PBJ) or cost reports
Infection Control	**Metric 1:** Nursing facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback. **Metric 2:** Percentage of residents with urinary tract infections (UTIs) at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on minimum data set (MDS) data as applied to the nationally reported quality measures. **Metric 3:** Percentage of residents with up-to-date pneumonia vaccine measured against a fixed benchmark that is set as the most recently published national average for the related MDS quality metric.	Infection control metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Nursing facility will be required to provide its infection control policy and procedure. In addition, facilities will need to provide information regarding training, monitoring, documentation and monitoring of required elements to meet this metric on a periodic basis CASPER Report MDS Assessment Care Compare
Quality Measures	**Metric 1:** Percentage of high-risk residents with pressure ulcers (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 2:** Percentage of residents who had a fall with major injury (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 3:** Percentage of residents who received antipsychotic medications are at rates one-half	Quality measures metrics 1, 2, 3, and 4 must be met for the facility to be eligible for per diem rate add-on payment.	CASPER Report MDS Assessment Care Compare

	standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 4:** Percentage of residents who required increased activities of daily living (ADL) assistance (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.		
State Survey Results	Number of deficiencies is at or below the state of Iowa average number of nursing facility deficiencies AND the facility has no deficiencies with a scope of F, H, I, J, K, or L.	State survey results must be met for the facility to be eligible for per diem rate add-on payment.	Department of inspections, appeals, and licensing (DIAL) surveys
Quality Assurance Performance Improvement (QAPI) Report	Nursing facility must submit QAPI reports on quarterly basis.	QAPI results must be submitted for the facility to be eligible for per diem rate add-on payment.	QAPI reports

(4) A provider must submit the Intent to Participate Agreement on or before September 30 each year and include all necessary documentation related to the quality measures.

1. Upon receipt of the participation agreement, the department will complete a determination of eligibility based on the care criteria defined above.

2. Providers will be notified of their eligibility annually within 60 days of the agreement due date.

(5) The nursing facility QIPP add-on rate provided to a participating NSGO nursing facility under the QIPP will not exceed Medicare payment principles pursuant to 42 CFR 447.272 (as amended to August 1, 2024) and will be calculated pursuant to 42 CFR 438.6 (as amended to August 1, 2024). The QIPP add-on rate will be calculated and paid as follows:

1. The methodology utilized to calculate the upper payment limit will be based on the data available during the calculation period.

2. The eligible amount used in determining the QIPP add-on rate will be the difference between the state Medicaid payment and the Medicare upper payment limit as determined, on an annual basis, using all Medicaid claims, including fee-for-service (FFS) and Medicaid managed care claims.

3. The difference calculated under numbered paragraph “2” will be divided by total patient days pursuant to subrule 81.5(7).

4. The QIPP add-on rate will be paid prospectively.

(6) A participating NSGO nursing facility shall notify the department of any change of ownership that may affect the participating NSGO nursing facility’s continued eligibility for the QIPP a minimum of 30 days prior to such change.

1. If a participating NSGO nursing facility changes ownership to a privately owned entity, on or after the first day of the QIPP add-on rate calculation period, the privately owned provider is no longer eligible for the QIPP add-on rate.

2. A participating facility must meet the CMS and department requirements to be classified as an NSGO nursing facility. All changes of ownership must be a fair market value transaction.

3. If it is determined that a provider is not a qualified NSGO nursing facility per CMS and the department, the provider shall repay all QIPP add-on payments to the department.

(7) Providers that do not meet eligibility requirements above will be notified of the metrics that were not met.

(8) A participating NSGO nursing facility shall secure allowable intergovernmental transfer funds from a participating NSGE to provide the state share amount. The process for the intergovernmental transfer shall comply with the following:

1. The department, or the department’s designee, will notify the participating NSGO nursing facility of the state share amount to be transferred in the form of an intergovernmental transfer for purposes of seeking federal financial participation for the QIPP add-on rate, within 15 business days after the end of

each month. The participating NSGO shall have until the end of the month to remit payment of the state share amount in the form of an intergovernmental transfer to the department or the department's designee.

2. If there is any outstanding intergovernmental transfer amount at the end of the payment period, the provider will not be able to participate in the QIPP the following year.

81.5(17) *Cost report documentation.* All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.5(18) *Inflation factor.* The department will consider an inflation factor in determining the reimbursement rate. The inflation factor will be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting will be used to determine the inflation factor.

81.5(19) *Case-mix index calculation.*

a. The RUG-III Version 5.12b, 34 group, index maximizer model will be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.12(9). Standard Version 5.12b case-mix indices developed by CMS will be the basis for calculating the average case-mix index and will be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.5(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment will be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group will be translated to the appropriate case-mix index referenced in paragraph *"a."* From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility will be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors will be excluded from both average case-mix index calculations.

81.5(20) *Medicare crossover claims for nursing facility services.*

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including but not limited to qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.5(21) *Nursing facility quality assurance payments.*

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance assessment pass-through will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through will equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance add-on of $37 per patient day will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on the Nursing Facility Medicaid Enhanced Payment Report demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference will be used to increase compensation and costs of employment for direct care workers determined pursuant to Iowa Code section 249L.4.

(2) No less than 60 percent of the difference will be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to Iowa Code section 249L.4.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 has been approved by CMS, none of the nursing facility rate-setting methodologies of this subrule will become effective.

e. End date. If CMS determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule will be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department will:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]