

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

PREAMBLE

These rules describe the assessment of the fee authorized by Iowa Code section 249A.21. The rules explain how the fee is determined and paid, and under what conditions collection of the fee will be terminated.

441—36.1(249A) Assessment of fee. Intermediate care facilities for the mentally retarded (ICFs/MR) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. Effective January 1, 2008, the fee shall equal 5.5 percent of the total revenue of the facility for the facility's preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year.

441—36.2(249A) Determination and payment of fee for facilities certified to participate in the Medicaid program. For facilities certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year submitted pursuant to rule 441—82.5(249A), as adjusted pursuant to 441—subrules 82.5(10) and 82.17(1).

36.2(2) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.2(3) The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment.

36.2(4) Rescinded IAB 6/4/08, effective 5/15/08.

441—36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program. For facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.3(1) Any licensed ICF/MR in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

36.3(2) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year as submitted and audited pursuant to subrule 36.3(1).

36.3(3) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.3(4) The facility shall pay the assessed fee to the department on or before the fifteenth day of each month. Any additional amount due for past months as the result of an adjustment to the initial assessment is due 30 days after the department notifies the facility of the additional amount.

441—36.4(249A) Termination of fee assessment. If federal financial participation to match the assessed fee becomes unavailable under federal law, the assessment terminates on the date the federal statutory, regulatory, or interpretive change takes effect.

441—36.5 Reserved.

These rules are intended to implement Iowa Code section 249A.21.

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

PREAMBLE

These rules describe the nursing facility quality assurance assessment authorized by Iowa Code chapter 249L. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.6(249L) Assessment.

36.6(1) *Applicability.* All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

- a. Nursing facilities operated by the state.
- b. Non-state government-owned or government-operated nursing facilities.
- c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.6(2) *Assessment level.* Effective July 1, 2012, the assessment level for each nursing facility shall be determined on an annual basis and shall be effective for the state fiscal year.

a. Effective July 1, 2011, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the number of licensed beds on file with the department of inspections and appeals as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, continuing care retirement center designations as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of \$1 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the Iowa Medicaid enterprise as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. All other nursing facilities are required to pay a quality assurance assessment of \$5.26 per non-Medicare patient day.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.7(249L) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.7(1) Each nursing facility shall pay the quality assurance assessment to the department on a quarterly basis. The facility shall:

- a. Use Form 470-4836, Nursing Facility Quality Assurance Assessment Calculation Worksheet, to calculate the quarterly assessment amount due.
- b. Submit Form 470-4836 and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.7(2) The facility shall calculate the amount of the quarterly assessment due by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level as determined in subrule 36.6(2).

36.7(3) If the department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the department shall notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.7(4) A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.7(5) For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.8 and 36.9 Reserved.

These rules are intended to implement Iowa Code chapter 249L.

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

PREAMBLE

These rules describe the hospital health care access assessment authorized by Iowa Code chapter 249M. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.10(249M) Application of assessment.

36.10(1) *Participating hospitals.* For the purpose of the health care access assessment program, a "participating hospital" is defined as a non-state-owned hospital licensed under Iowa Code chapter 135B that is paid on a prospective payment system basis by Medicare and the medical assistance programs for inpatient and outpatient services.

36.10(2) *Assessment.* Participating hospitals are required to pay a quarterly health care access assessment equal to 1.26 percent of net patient revenue as specified in the hospital's fiscal year 2008 Medicare cost report. "Net patient revenue" means all revenue reported for acute patient care and services but does not include:

- a.* Contractual adjustments,
- b.* Charity care,
- c.* Bad debt,
- d.* Medicare revenue, or
- e.* Other revenue derived from sources other than hospital operations including but not limited to:
 - (1) Nonoperating revenue,
 - (2) Other operating revenue,
 - (3) Skilled nursing facility revenue,
 - (4) Physician revenue, and
 - (5) Long-term care revenue.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.11(249M) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.11(1) The department shall calculate the annual amount of the health care access assessment as 1.26 percent of net patient revenue as specified in the participating hospital's fiscal year 2008 Medicare cost report. The annual amount shall be divided by four to calculate the quarterly amount.

36.11(2) Each participating hospital shall pay the health care access assessment to the department on a quarterly basis. The hospital shall submit the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.11(3) A participating hospital shall retain and preserve the Medicare cost report and financial statements used to prepare the cost report for a period of three years.

36.11(4) If the department determines that a participating hospital has underpaid or overpaid the health care access assessment, the department shall notify the hospital of the amount of the unpaid health care access assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.11(5) A participating hospital that fails to pay the health care access assessment within the time frame specified in subrule 36.11(2) shall pay a penalty in the amount of 1.5 percent of the health care access assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the department determines that good cause is shown for failure to comply with payment of the health care access assessment, the department shall waive the penalty or a portion of the penalty.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.11(6) The department shall deduct the quarterly amount due from Medicaid payments to the participating hospital if the department has not received the health care access assessment by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.12(249M) Termination of health care access assessment. If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

These rules are intended to implement Iowa Code chapter 249M.

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