Community-Based Neurobehavioral Rehabilitation Services

Draft Administrative Rules

ITEM 1. Adopt the following **new** rule 441—77.47:

441- 77.47 Community Based Neurobehavioral Rehabilitation Services.

a. The following agencies may provide community-based neurobehavioral services

(1) An agency that is accredited by a department approved nationally recognized accreditation agency as a specialty brain injury rehabilitation service provider.

(2) Agencies not accredited by a department approved nationally recognized accreditation agency as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However; an agency that has not received accreditation within 16 months after application shall no longer be a qualified provider

b. All Community-Based Neurobehavioral Rehabilitation Service providers shall meet the following criteria:

(1) (*Standard one)* The organization meets the organizational outcome-based standards for Community-Based Neurobehavioral Rehabilitation Service providers as follows:

(a) The organization demonstrates the provision and oversight of high-quality supports and services to members,

(b) The organization demonstrates a defined mission commensurate with member's needs, desires, and abilities,

(c) The organization is fiscally sound and establishes and maintains fiscal accountability.

(d) The organization has qualified personnel trained in the provision of direct care services to people with a brain injury. The training is commensurate with the

needs of the members they serve. These personnel members demonstrate competency in performing duties and in all interactions with members including but not limited to:

(1) Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access

(2) Assistance with ADL's (activities of daily living)

(3) Quality of life issues

(4) Behavioral Supports, identification of antecedent triggers and self management

(5) Health and Medication Management

(6) Dietary and nutritional programming

(7) Assistance with identifying and utilizing assistive technology

(8) Substance Abuse and Addiction issues

(9) Promotion of maximum community inclusion and access

(10) Self management and self interaction skills

(11) Flexibility in programming to meet individual needs

(12) Teaching adaptive and compensatory strategies

(13) Community accessibility and safety

(14) Household maintenance

(15) Service support to the member's family / support system related to the member's neurobehavioral care

(e) The organization provides needed training and supports to its personnel. This training is provided before direct service provision, is ongoing and includes at a minimum:

(1) Completion of the department approved Brain Injury Training Modules

(2) Member rights.

(3) Confidentiality and privacy.

(4) Dependant Adult and Child Abuse Prevention and Mandatory Reporter Training.

(5) Individualized rehabilitation treatment plans.

(e) Within 90 day of employment employees complete CPR and First Aid course and Universal Precautions Training within first 6 months 77.47(b)(1)(b)

(f) Within twelve months of the commencement of direct service provision; treatment personnel complete the department approved nationally recognized Certified Brain Injury Specialist Training. A majority of the full time direct service personnel will maintain certification.

(g) The organization demonstrates that it has an outcome management system which measures the efficiency and effectiveness of service provision, member and stakeholder satisfaction, and access to services.

(h) The organization has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and analyzes organizational activities and services annually.

(2) Gathers information from members, family members, personnel and stakeholders, and shares the information.

(3) Conducts an internal review of member service records, including all major and minor incident reports according to subrule 77.37(8) and shares the aggregate data

(4) Tracks incident data and sentinel events; and analyzes the data to identify trends annually to assure the health and safety of members served by the organization.

(5) Continuously identifies areas in need of improvement.

(6) Develops a plan to address the identified areas in need of improvement.

(7) Implements the plan, documents the results, and reports to the governing body annually

(i). The provider shall have written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

(j) The governing body has an active role in the administration of the agency.

(k). The governing body receives and uses input from a wide range of local community interests and member representation and provides oversight that ensures the provision of high-quality supports and services to members.

(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

(a) (Standard 2) Members are valued

(b) (Standard 3) Members using the service and treatment team mutually develop an individualized service plan that focuses on the individual's strengths, barriers and interests to address neurobehavioral challenges and environmental needs as identified in the individual's assessment. Goals are based on the individual's interests and need for services.

(c) The individual's progress towards treatment goals is evaluated regularly and no less than monthly. Treatment plans are revised regularly and as the individual's status or needs change to reflect the member's progress and response to treatment.

(d) Members and their legal representatives have the right to appeal the provider's implementation of the organizational outcomes, or the organization's personnel or contractual person's action which affects the member. The provider shall distribute the policies for member appeals and procedures to members.

(e) When a member has a guardian or legal representative that person will provide informed consent to treat and provide informed consent for any restrictive measures that may be required to protect the health or safety of the member.

(f) (Standard 4) Members receive individualized services.

(g) (Standard 5) Members decide which personal information is shared and with whom.

(h) (Standard 6) Members receive assistance with financial management needed.

(i) (Standard 7) Members receive assistance with obtaining preventative, appropriate and timely medical and dental care.

(j) (Standard 8) The member's living environment is reasonably safe in the community.

(k) (Standard 9) The member's desire for intimacy is respected and supported.

(l) (Standard 10) Members have an impact on the services they receive.

Item 2. Adopt the following **new** rule 441—78.53

441- 78.53 Community Based Neurobehavioral Rehabilitation Services.

(1) Payment will be made for Community-Based Neurobehavioral Rehabilitation Services that do not duplicate other services covered in this chapter. Neurobehavioral Services identified in the plan of care may include:

(2) Addressing the physical, emotional, cognitive, medical and psychosocial residuals of the brain injury that negatively affect a member's integration and stability in the community and quality of life; **and**

(3) Improving a member's health and well-being, by reducing or managing the symptoms and behaviors that inhibit the member from functioning at the member's best possible functional level; **and**

(4) Promoting a member's recovery and resilience through increasing the member's ability to self-manage their symptoms; **and**

(5) Modifying or adapting the member's environment to improve overall functioning

78.53(1) Definition

Brain injury" means a diagnosis in accordance with 441 IAC 83.81:

Member" means a person who has been determined to be eligible for Medicaid under 441IAC Chapter 75.

Health Care means the maintaining and restoration of health by the treatment and prevention of disease especially by trained and licensed professionals

Neurobehavioral rehabilitation refers to a specialized category of neuro-rehabilitation provided by a multidisciplinary team of allied health and support staff that have been trained in, and deliver, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support an individual to maximize his/her independence in activities of daily living and ability to live in their home and community.

"Standardized Assessment" means a valid, reliable assessment tool approved by the department for use in the assessment of an individual's needs.

78.53 (2) Member Eligibility

Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis

To be eligible for community based neurobehavioral rehabilitation services the member must have brain injury diagnosis as listed in **83.81**

b. Risk factors. The member has the following risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency and severity that the member is at risk of hospitalization, institutionalization, incarceration or homelessness; **and**

(2) The member has undergone or is currently undergoing treatment more intensive than outpatient care more than once in the member's life; **or**

(3) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care other than hospitalization, institutionalization, incarceration or homelessness.

c. Need for assistance*.* The member has a need for assistance demonstrated by meeting the following criteria on a continuing or intermittent basis:

The member exhibits neurobehavioral symptoms in such frequency, severity and/or intensity that specialty intervention at this level is required;

d. ***Needs assessment****.* A standardized neurobehavioral assessment that has been reviewed or completed by a qualified professional licensed as a Neuro-Psychologist, Neurologist, M.D., or D.O. The neurobehavioral assessment documents the member's need for this level of specialty service, and, based on the assessment the Iowa Medicaid Enterprise, Medical Services Unit has determined that the member is in need of specialty neurobehavioral rehabilitation services.

(1) Standards for assessment. Each member will have had a standardized needs assessment completed within ninety days prior to application. Each needs assessment will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to their brain injury which must include the following:

(a) identification of the neurobehavioral needs that put them at risk including but not limited to: verbal aggression, physical aggression, self-harm, unwanted sexual behavior, perseveration, repetitive behavior, wandering or elopement,

lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(b) Identification of triggers of unwanted behaviors and the member's ability to self manage their symptoms

(c) the member's rehabilitation and medical care history to include medication history and status

(d) the member's employment history and the member's barriers to employment

(e) the member's dietary and nutritional needs

(f) the member's community accessibility and safety

(g) the member's access to transportation

(h) the member's history of substance abuse

(i) the member's vulnerability to exploitation and history of risk to exploitation

(j) the member's history and status of relationships, natural supports and socialization

(2) Emergency Admission. In the event that emergency admission is required the assessment shall be completed within ten calendar days of admission.

78.53(3) Covered Services

a. Service Setting.

(1) Community-Based Neurobehavioral Residential services are available to a member living in a residential care facility (3-5 bed) with a brain injury specialty designation licensed by the Department of Inspections and Appeals; or

(2) Community-Based Neurobehavioral Transitional Support services are available to a member living in their own home

(3) No payment shall be made for this level of specialty care when provided in a medical institution such as a intermediate care facility for persons with Intellectual Disabilities nursing facility or skilled nursing facility

b. Community-Based **Neurobehavioral Rehabilitation Residential services when identified in the treatment plan may include:**

(1) Promotion of a program structure and support for individuals served so they can re-learn or regain skills for maximum community inclusion and access

*(2)*Customization of the physical and social environment to address the unique needs of the individual

*(3)*Members receive assistance in obtaining preventative, appropriate and timely medical and dental care

(4) Assistance with ADL's (activities of daily living)

(5) Auxiliary Service Coordination

(6) Behavioral Supports

(7) Medication management and consultation with pharmacy

(8) Dietary and nutritional programming

(9) Assistance with obtaining and use of assistive technology

*(10)*Sobriety support development

(11) Assist with the self-identification of antecedent triggers

(12) Assistance with preparation for transition to less intensive services including accessing the community

(13) Flexibility in programming to meet individual needs

(14) Assistance with re-learning coping and compensatory strategies

(15) Support and assistance in seeking substance abuse and co-occurring disorders counseling

(16) Support and assistance with obtaining legal consultation and services

(17) Assistance with community accessibility and safety

(18) Assistance with re-learning household maintenance

(19) Assistance with recreational and leisure skill development

(20) Assistance with the development and application of self-advocacy skills to navigate the service system

(21) Opportunities to learn about brain injury and individual needs following brain injury

(22) Support for carrying out the individuals' goals in the rehabilitation treatment plan

(23) Assistance with pursuit of education and employment goals

(24) Protective oversight in the residential setting and community.

(25) Assistance and education to family, providers and other support system interests, supporting the individual receiving neurobehavioral rehabilitation services.

(26) Transitional support and training

(27) Transportation essential to the attainment of the individuals' goals in the rehabilitation treatment plan

(1) **Transitional Support** Neurobehavioral rehabilitation services shall include transitional support post residential discharge post service support provided to family, the service provider and others supporting the individual. Reimbursement shall be made at the provider's established hourly rate for this service. The post service support **when identified in the treatment plan may include:** Promotion of a program structure and support for individuals served so they can re-learn or regain skills for maximum community inclusion and access

(2) Customization of the physical and social environment to address the unique needs of the individual

(3) Behavioral Supports

(4) Assistance with obtaining and use of assistive technology

(5) Sobriety support development

(6) Assist with the self-identification of antecedent triggers

(7) Assistance and education to family, providers and other support system interests, supporting the individual receiving neurobehavioral rehabilitation services.

d. Approval of treatment plan.

The community-based neurobehavioral services provider shall submit the treatment plan, the results the member' of the formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial treatment plan. The IME medical services unit shall approve the provider's initial treatment plan if:

(1) The treatment plan conforms to the medical necessity requirements in subrule **78.53(3)**

(2) The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional trained in the diagnosis and treatment of brain injury and are a Neuro-Psychologist, Neurologist, M.D., or D.O.

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan

(5) The plan does not exceed ninety days duration; and

(6) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when requesting approval for subsequent plans.

b. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan according to the conditions in paragraph *"a"* if the services are recommended by Neuro-Psychologist, Neurologist, MD, or D.O. who has:

(1) Examined the member;

(2) Reviewed the most recent diagnosis and treatment plan;

(3) Evaluated the member's progress, including a review of the member's most recent neurobehavioral assessment

(4) Submitted the results of the assessment review with the recommendation that this level of specialty care is medically necessary.

e. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved; and

(7) Member satisfaction.

(8) The providers compliance with standards listed in 441 IAC 77.47

78.53(3) ***Medical necessity.*** Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

~~**79.1(25) Reimbursement for Community-Based Neurobehavioral Rehabilitation Services**~~

~~Reimbursement for community-based neurobehavioral rehabilitation services shall be made on a prospective cost-related basis. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied. The per diem rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph~~

~~***a. Rate determination***. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).~~

~~(1) The department shall determine the reasonable costs of services based on the annual cost report and Medicare cost principles~~

~~(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.~~

~~**b. Interim rate**. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim~~

basis, pending determination of the community-based neurobehavioral rehabilitation provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid Enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(25) *"c"* (1).

c. **Maximum Rate**. All calculated per diem rates shall be subject to the upper rate maximum set in 79.1(2)

d. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form XXX-XXXX Financial and Statistical Report for Community-Based Neurobehavioral Rehabilitation Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles

and requirements specified in OMB Circular A-87. Costs reported under community-based neurobehavioral rehabilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under services.

82.5(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

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

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

d. 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.

e. 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. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.~~

~~(2) Reasonableness—requires that the compensation allowance be such an 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 $1,926 per month plus $20.53 per month per licensed bed capacity for each bed over 60, not to exceed $2,852 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 a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.~~

~~(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 clinical director 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 relative 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 as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.~~

~~*f.* Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.~~

~~*g.* Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made.~~

~~*h.* 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 which 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.~~

~~*i.* 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 which 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 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.~~

~~*j.* A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly average basis, at the date the lease was entered into. When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility. The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.~~

~~*l.* Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses~~

~~*m.* Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid~~

~~decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs for more than 120 days following the decertification date.~~

~~(n) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period. Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.~~

~~(m) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period~~

~~1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.~~

~~2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes~~

Comment [lmm1]: This reimbursement methodology section is still under development.

d. Documentation Standards. Community-Based Neurobehavioral Rehabilitation Service Providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of 441 IAC 79.3.

79.3 d. Basis for service requirements for specific services

(40) Community Based Neurobehavioral Rehabilitation Services

1. *Department approved assessment tool*
2. *Clinical records documenting diagnosis, treatment history*
3. *Progress or status notes.*
4. *Service notes or narratives.*
5. *Procedure, laboratory, or test orders and results.*
6. *Therapy Notes*
7. *Medication administration records.*
8. *Form 470-0042, Case Activity Report. (RCF placement)*