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State/Territory Name: IA

State Plan Amendment (SPA) #: 23-0013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

December 7, 2023

Ms. Elizabeth Matney, Medicaid Director
Iowa Medicaid Enterprise
1305 E. Walnut Street
Des Moines, IA 50319

RE: IA 23-0013

Dear Ms. Matney:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0013. This SPA updates nursing facility rates using a new cost report period and inflation factor.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment IA 23-0013 is approved effective July 1, 2023. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Fred Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0013

2. STATE: IA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. §447.200

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 1,794
b. FFY 24 $ 7,175

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D pages 1-4, 5a-5d, 6, 13a, 14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, page 1 supersedes MS-01-34
pages 2, 2a,5a, 5b,supersedes IA-23-009
pages 2b, 5d supersedes MS-07-018
pages 3, 4, 6, 14 supersedes MS-01-34
page 5c supersedes MS-05-020
page 13a supersedes IA-18-001

9. SUBJECT OF AMENDMENT

Update nursing facility rates using a new cost report period and inflation factor in accordance with Iowa Senate File (SF) 561.

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Elizabeth Matney

13. TITLE
Medicaid Director

14. DATE SUBMITTED
09/20/2023

15. RETURN TO
Elizabeth Matney
Medicaid Director
Department of Human Services
Iowa Medicaid Enterprise
1305 East Walnut Street
Des Moines, IA 50319

FOR CMS USE ONLY

16. DATE RECEIVED
9/21/2023

17. DATE APPROVED
December 7, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Medicare-Certified Hospital-Based Facilities That Provide Only Skilled-Level Care

1. Introduction

Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care receive Medicaid reimbursement based on a modified price- based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted semi-annually to account for changes in the Medicaid day-weighted case-mix index.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall 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.

   In no case shall 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.

b. 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, 200 I, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
   - 66.67 percent of the July 1, 2002, modified price-based rate.

   In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following l2 months.

c. Payment rates for services rendered from July l, 2003, and thereafter will be 100 percent of the modified price-based rate.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For facilities receiving both an ICF and SNF Medicaid rate on June 30, 2001, the June 30, 2001, Medicaid rate referenced above is the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

The subsections below reflect the details of this reimbursement plan.

2. Definition of Allowable Costs and Calculation of Per Diem Costs

Allowable costs are determined using Medicare methods. Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given services or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

For purposes of calculating the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, facility costs are divided into two components:

- The "direct care component" is the portion attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
- The "non-direct care component" is the portion attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

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 shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period.

Effective July 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2020 less an additional 1.5%.

3. 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. The facility cost report period case-mix index is the day-weighted case-mix index for the cost report period, carried to four decimal places.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/0l/2001- 12/31/200 I financial reporting period would use the facility-wide day-weighted case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

4. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the Medicare-certified hospital-based nursing facility rate components.

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.

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the direct care and non-direct care patient-day-weighted medians shall be calculated using the latest Medicaid cost 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.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated, using the latest completed Medicaid cost report with a fiscal year end of the preceding December 31 or earlier. Effective July 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2020 less an additional 1.5%.

5. Excess Payment Allowance Calculation

The Medicare-certified hospital-based nursing facility excess payment allowance is calculated as follows:

a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):

- The direct care patient-day-weighted median times 95 percent times the provider's Medicaid day-weighted case-mix index, minus
- A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted case-mix index.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

In no case shall the excess payment allowance exceed ten percent times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

b. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to 65 percent times the difference of the following (if greater than zero):

- The non-direct care patient-day-weighted median times 96 percent,
- Minus a provider's allowable per patient day non-direct care cost.

In no case shall the excess payment allowance exceed eight percent times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

6. Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted semi-annually to account for changes in the provider's Medicaid day-weighted case-mix index, plus a potential excess payment allowance and a capital cost per diem instant relief add-on for qualifying nursing facilities as described in Supplement 4 to Attachment 4.19-D, not to exceed an overall rate component limit.

The direct care and non-direct care rate components are calculated as follows:

- The direct care component is equal to the provider's normalized allowable per patient day costs times the provider's Medicaid day-weighted case-mix index plus the allowed excess payment allowance.
- The non-direct care component is equal to the provider's allowable per patient day costs plus the allowed excess payment allowance and the capital cost per diem instant relief add-on for qualifying nursing facilities.

In no instance shall a rate component exceed the rate component limit, defined as follows:

- The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid day-weighted case-mix index.
- The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 110 percent or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit as described in Supplement 4 to Attachment 4.19-D.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

8. Exceptions to the Rate-Setting Process (Cont.)

a. Fraud and Abuse

When fraud or abuse has been verified, the facility's prospective reimbursement rate shall be adjusted. If the facility's base year cost is subsequently determined to have been based on false or misleading information, an appropriate adjustment shall be made to the base year rate and all resulting overpayments shall be recouped. Such adjustments do not preclude other sanctions authorized by statute or regulation.

9. (Reserved for future use.)

10. Revaluation of Assets

The provisions of Section 1902(a)(13)(c) of the Social Security Act shall be followed.

11. Provider Appeals

In accordance with 42 CFR 447.253(c), if a provider of service is dissatisfied with the determination of the base year allowable cost, the provider may file an appeal and request reconsideration from the Administrator of the Division of Medical Services in the Department. The appeal must be in writing, clearly state the nature of the appeal, and be supported with all relevant data.

The Administrator of the Division of Medical Services will review the material submitted, render a decision and advise the provider accordingly within a period of 90 days.

12. Cost Reporting

Participating nursing facilities are required to complete a financial and statistical report approved by the Department.

13. Audits

Each participating facility is subject to a periodic audit of its fiscal and statistical records.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Other Non-State-Owned Nursing Facilities

The methodology in this section applies to all nursing facilities that are not state-owned, including facilities for people with mental illness who are aged 65 or over, except for:

- Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care (see Section A)
- Facilities serving special populations (see Section D)

1. Introduction

Non-state-owned nursing facilities receive Medicaid reimbursement based on a modified price-based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted semi-annually to account for changes in the Medicaid day-weighted case-mix index.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 200I, 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.

In no case shall 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.

b. 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 HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
- 66.67 percent of the July 1, 2002, modified price-based rate.

In no case shall the July l, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following 12 months.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

However, for purposes of calculating the per diem cost for administrative, environmental, and property expenses, total patient days are the greater of the actual inpatient days or 85 percent of the facility's license capacity.

For the rate period beginning July 1, 2023, and ending June 30, 2025, for purposes of calculating the per diem cost for administrative, environmental, and property expenses, total patient days are the greater of the actual inpatient days or 70 percent of the facility's license capacity.

Effective July 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to January 1, 2020 less an additional 1.5%.

c. 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. The facility cost report period case-mix index is the day-weighted case-mix index for the cost report period, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide day-weighted case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

d. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the non-state-owned nursing facility rate components.

The per diem normalized direct care cost for each non-state-owned 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.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned direct care and non-direct care patient-day-weighted medians shall 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.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated using the latest completed financial and statistical report with a fiscal year end of the preceding December 31 or earlier. Effective July 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to. January 1, 2020 less an additional 1.5%.

e. Excess Payment Allowance Calculation

Two classes of non-state-operated providers are recognized for computing the excess payment allowance calculation.

- Facilities that are located in a metropolitan statistical area (MSA) as defined by CMS.
- Facilities that are not located in an MSA.

For non-state-operated facilities not located in an MSA, 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 zero (0) percent times the difference of the following (if greater than zero):

- The direct care non-state-operated patient-day-weighted median times 95 percent times the provider's Medicaid day-weighted case-mix index, minus
- A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted case-mix index.

In no case shall the excess payment allowance exceed ten percent times the non-state-operated direct care patient-day-weighted median.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

(2) For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent time the difference of the following (if greater than zero):

- The non-direct care non-state-operated patient-day-weighted median times 96 percent, minus
- A provider's allowable non-direct care cost per patient day.

In no case shall the excess payment allowance exceed eight percent times the non-state-operated non-direct care patient-day-weighted median.

For non-state-operated nursing facilities located in an MSA, 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 zero (0) percent times the difference of the following (if greater than zero):

- The direct care non-state-operated patient-day-weighted median times 95 percent times the wage index factor specified below times the provider's Medicaid day-weighted case-mix index, minus
- The provider's normalized allowable normalized per patient day direct care costs times the provider's Medicaid day-weighted case-mix index.

In no case shall the excess payment allowance exceed ten percent times the non-state-operated direct care patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002 shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based MSA wage indices, as published by the CMS each July. The geographic wage index adjustment shall not exceed $8 per patient day.

(2) For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):

- The non-direct care non-state-operated patient-day-weighted median times 96 percent, minus
- The provider's allowable per patient day non-direct care cost.

In no case shall the excess payment allowance exceed eight percent times the non-state-operated non-direct care patient-day-weighted median.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

f. Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted semi-annually to account for changes in the provider's Medicaid day-weighted case-mix index, plus a potential excess payment allowance and a capital cost per diem instant relief add-on for qualifying nursing facilities as described in Supplement 4 to Attachment 4.19-D, not to exceed an overall rate component limit.

The direct care and non-direct care rate components are calculated as follows:

- The direct care component is equal to the provider's normalized allowable per patient day costs times the provider's Medicaid day-weighted case-mix index plus the allowed excess payment allowance.

  For facilities located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day- weighted median times 120 percent times the wage index factor times the provider's Medicaid day-weighted case-mix index.

  For facilities not located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid day-weighted case-mix index.

- The non-direct care component is equal to the provider's allowable per patient day costs plus the allowed excess payment allowance and the capital cost per diem instant relief add-on for qualifying nursing facilities. The component limit is the non-direct care non-state-owned nursing facility patient-day-weighted median times 110 percent or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit as described in Supplement 4 to Attachment 4.19-D.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

Additional reimbursement for non-state-owned nursing facilities based on accountability measures shall also be available beginning July 1, 2002, in amounts up to 3 percent of the sum of the non-state-owned nursing facility direct care patient-day-weighted median plus the non-state-owned nursing facility non-direct care patient-day-weighted median.

See Supplement 3 to Attachment 4.19-D for a description of these accountability measures.

g. Exceptions to the Rate-Setting Process

Exceptions to the rate-setting process are made under the following circumstances:

(1) Ventilator Incentive

A special rate to care for ventilator-dependent patients is paid to a facility if the patient meets the requirements for skilled and ventilator care. The reimbursement rate is equal to the sum of:

- The Medicare-certified hospital-based nursing facility direct care patient-day-weighted median times 120 percent times the provider's Medicaid day-weighted case mix index, plus
- The Medicare-certified hospital-based nursing facility non-direct care rate patient-day-weighted median times 110 percent.

(2) Fraud and Abuse

When fraud or abuse has been verified, the facility's prospective reimbursement rate shall be adjusted. If the facility's base year cost is subsequently determined to have been based on false or misleading information, an appropriate adjustment shall be made to the base year rate and all resulting overpayments shall be recouped. Such adjustments do not preclude other sanctions authorized by statute or regulation.

C. Case Mix Index Calculation

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the minimum data set (MDS) submitted by each facility.

Standard Version 5,12b case-mix indices developed by CMS are the basis for calculating the day-weighted case-mix index and are used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate.

Each completed and submitted assessment is assigned a RUG- III 34 group. This RUG-III group shall be translated to the appropriate case- mix index.

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

From the individual resident case-mix indices, two day-weighted case-mix indices for each Medicaid nursing facility shall be determined four times per year. The quarterly day-weighted-case mix index will be calculated using each assessment that is active during each quarter. The number of days each assessment is active is multiplied by the appropriate case-mix weight. Each quarter the sum of all the days multiplied by the case-mix index is divided by the days to determine the day-weighted case-mix indices.

- The facility-wide day-weighted case-mix index uses all resident day-weighted case-mix indices.
- The Medicaid-day-weighted case-mix index uses the day-weighted case-mix indices for residents where Medicaid is known to be the per diem payer source.

Assessments that cannot be classified to a RUG-III group due to errors are excluded from both day-weighted case-mix index calculations.

D. Limits on 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.

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. 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.

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

(2) The expense of one car or one van or both designated for use in transporting patients is an allowable cost.

(3) Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption from public transit coordination requirements after receipt from the Iowa Department of Transportation. shall result in _disallowance of vehicle costs and other costs associated with transporting residents.