Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/00 increased by 3%
Hospitals (Outpatient)	Prospective reimbursement for providers listed at 441—paragraphs 78.31(1)*"a"* to *"f."* See 79.1(16)	Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 6/30/00 increased by 3%
	Fee schedule for providers listed at 441—paragraphs 78.31(1)*"g"* to *"n."* See 79.1(16)	Rates in effect on 6/30/00 increased by 3%
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Infant and toddler program providers	Fee schedule	Fee schedule
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from 12/31/99 cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Local education agency services providers	Fee schedule	Fee schedule
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/00 plus 0.7%
Nurse-midwives	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology

Provider category	Basis of reimbursement	Upper limit
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A)	Seventieth percentile of facility costs as calculated from all 6/30/00 cost reports
2. Skilled nursing care provided in:		
Hospital-based facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $346.20 per day for hospital-based skilled facilities
Freestanding facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $163.41 per day for freestanding skilled facilities
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Orthopedic shoe dealers	Fee schedule	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Physical therapists	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology, excluding anesthesia services. Anesthesia services will be reimbursed at the Iowa Medicaid fee schedule rate in effect 6/30/00 plus 0.7%.

Provider category	Basis of reimbursement	Upper limit
Podiatrists	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Prescribed drugs	See 79.1(8)	$4.13 or $6.42 dispensing fee (See 79.1(8)*"a"* and *"e"*)
Psychiatric medical institutions for children		
(Inpatient)	Prospective reimbursement	Reimbursement rate for provider based on per diem rates for actual costs on 6/30/00, not to exceed a maximum of $147.20 per day
(Outpatient day treatment)	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Psychologists	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Rehabilitation agencies	Retrospective cost-related	Reimbursement rate for agency in effect 6/30/00 plus 0.7%
Rehabilitation services for adults with a chronic mental illness providers, including:		
1. Rehabilitation support services providers, including:		
Community living skills training services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Employment-related services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
2. Day program services providers, including:		
Skills training providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Skills development providers	Retrospective cost-related. See 79.1(19)	Retrospective rate

Provider category	Basis of reimbursement	Upper limit
Rehabilitative treatment services	Reasonable and necessary-costs per unit of service based on data included on the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049. See 441—185.101(234) to 441—185.107(234). A provider who is an individual may choose between the fee schedule in effect November 1, 1993 (See 441—subrule 185.103(7)) and reasonable and necessary costs.	No cap
Rural health clinics (RHC)	Retrospective cost-related See 441—88.14(249A)	1. 100% of reasonable cost as determined by Medicare cost reimbursement principles 2. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" above
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/00 plus 0.7%
State-operated institutions	Retrospective cost-related	

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule which is determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician are reimbursed on the basis of a fee schedule (see subrule 79.1(1)*"c"*). This payment is made directly to the physician.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" shall mean the hospital's cost report with fiscal-year-end on or after January 1, 1998, and prior to January 1, 1999, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting regulations for cost reporting periods ending on or after January 1, 1998, and prior to January 1, 1999.

"Blended base amount" shall mean the case-mix adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation, capital costs, direct medical education costs, and costs associated with treating a disproportionate share of poor patients and indirect medical education are added to form a final payment rate.

"Capital costs" shall mean an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean an add-on to the blended base amount which shall compensate for costs associated with direct medical education. Costs associated with direct medical education are determined from the hospital base year cost reports, and are inflated and case-mix adjusted. On or after July 1, 1997, the direct medical education payment shall be directly reimbursed from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share payment" shall mean an add-on to the blended base amount which shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be directly reimbursed from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the five components (the blended base amount, capital costs, direct medical education, disproportionate share and indirect medical education) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing. On or after July 1, 1997, the direct and indirect medical education costs and the disproportionate share costs shall be directly reimbursed through the graduate medical education and disproportionate share fund and shall not be included in the final payment rate or displayed in the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or lowly reimbursed patients for inpatient services.

"Indirect medical education costs" shall mean costs that are not directly associated with running a medical education program, but that are incurred by the facility because of that program. Types of these costs would be costs of maintaining a more extensive library to serve educational needs.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Medicaid-certified unit" shall mean a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa department of inspections and appeals on or after October 1, 1987, and is certified for reimbursement according to procedures contained in 79.1(5)*"r"* by the Iowa Medicaid fiscal agent.

These units may be certified for operation by the Iowa department of inspections and appeals, acting on behalf of the state of Iowa, or Medicare. Neonatal units may be certified using standards adopted by the Iowa department of public health and set forth by the American Academy of Pediatricians in "Recommendations Based on Standards for Hospital Care of the Newborn Infant."

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Peer review organization (PRO)" shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

"Transfer" shall mean the movement of a patient from a bed in a non-Medicaid-certified unit of a hospital to a bed in a non-Medicaid-certified unit of another hospital.

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus add-ons for capital costs, medical education costs, disproportionate share payment, and indirect medical education. This blended base amount plus add-ons is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. For payments made to providers for claims with dates of discharge on or after July 1, 1997, the final payment rate shall not contain the add-on amounts for direct or indirect medical education or for disproportionate share payments. Federal DRG definitions are adopted except as provided below:

(1) Medicaid-certified substance abuse units. Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in Medicaid-certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age Medicaid-certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only Medicaid-certified substance abuse units. Hospitals with these units are reimbursed using the weight that reflects the age of each patient.

(2) Neonatal intensive care units. Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Medicaid-certified psychiatric units. Four sets of DRG weights are developed for DRGs concerning psychiatric treatment. The first set of weights reflects charges associated with the treatment of adult psychiatric patients in Medicaid-certified psychiatric units. The second set of weights reflects charges associated with the treatment of adolescent patients in mixed-age Medicaid-certified psychiatric units. The third set of weights reflects charges associated with the treatment of adolescent patients in designated adolescent-only Medicaid-certified psychiatric units. The fourth set of weights reflects charges associated with the treatment of psychiatric patients in hospitals without Medicaid-certified psychiatric units. Hospitals are reimbursed using the weight that reflects the patient's age and the setting for psychiatric treatment.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 1997, through December 31, 1998, and paid through March 31, 1999, the recalibration will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment and including transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 1997, to December 31, 1998, and paid through March 31, 1999. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 1998 fiscal year and paid through March 31, 1999, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures the total calculated dollar expenditures based on hospitals' base year cost reports for capital costs, medical education costs, and calculation of actual payments that will be made for additional transfers, outliers, physical rehabilitation services, and indirect medical education. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix adjusted average cost per discharge. The hospital-specific case-mix adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs, or covered reasonable charges as determined by the hospital's base year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, the payments that will be made for nonfull DRG transfers, outliers, and physical rehabilitation services if included. The remaining amount is case-mix adjusted, adjusted to reflect inflation, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system or cost report, whichever is greater, for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount. Four payments are added on to the blended base amount.

(1) Capital costs. Capital costs are included in the rate table listing and added to the blended base amount prior to setting the final payment rate schedule. This add-on reflects a 50/50 blend of the statewide average case-mix adjusted capital cost per discharge and the case-mix adjusted hospital-specific base year capital cost per discharge attributed to Iowa Medicaid patients. Allowable capital costs are determined by multiplying the capital amount from the base year cost report by 80 percent. The 50/50 blend is calculated by adding the case-mix adjusted hospital-specific per discharge capital cost to the statewide average case-mix adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation.

(2) Direct medical education costs. Direct medical education costs are included in the rate table listing if applicable to the provider, and added to the blended base amount plus other add-ons prior to setting the final payment rate if the date of the patient's discharge is prior to July 1, 1997. The amount added on reflects Iowa Medicaid's average cost per discharge for hospital-specific direct medical education adjusted for case-mix. This add-on is determined from the base year cost report and is adjusted to reflect inflation. If the date of discharge is on or after July 1, 1997, the costs for direct medical education are reimbursed according to policy at paragraph *"y"* from the graduate medical education and disproportionate share fund.

(3) Disproportionate share adjustment. Two separate and distinct groups are identified for the calculation of routine or supplemental disproportionate share payments. The first group eligible for routine disproportionate share payments includes all hospitals which qualify under the following rules without regard to the facility's status as a teaching facility or bed size. The second group eligible for supplemental disproportionate share payments includes all in-state hospitals qualifying under either the low-income utilization rate or the Medicaid utilization rate which are state-owned, acute-care hospitals, and which have more than 500 beds. In-state hospitals which qualify for both distinct groups may receive payment under both the routine and supplemental disproportionate share methodologies. However, supplemental disproportionate share payments will be made only for claims that have dates of discharge on or after October 1, 1992.

Compensation for routine disproportionate share payments for indigent patients is included in the rate table listing if applicable to the provider and the claim has a date of discharge before July 1, 1997. This amount is added to the blended base amount plus add-ons prior to setting the final payment rate. Compensation for supplemental disproportionate share payments is calculated and paid monthly. Hospitals qualify for disproportionate share payments based on information contained in the hospital's available 1998 submitted Medicaid cost report, and other supporting schedules. Either routine or supplemental disproportionate share payments are determined when the hospital's low-income utilization rate, as defined by the ratio of gross billings for all Medicaid, bad debt, and charity care patients to total billings for all patients, is 25 percent or greater. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments. Hospitals also qualify for either routine or supplemental disproportionate share payments when the hospital's inpatient Medicaid utilization rate, defined as the number of total Medicaid days, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients, exceeds one standard deviation from the statewide average Medicaid utilization rate. Children's hospitals, defined as hospitals with inpatients predominantly under 18 years of age, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

To qualify for routine or supplemental disproportionate share payments, the hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to persons who are entitled to Medicaid for obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Starting July 1, 1993, the routine disproportionate share payment add-on is established as a minimum payment of 1.00 percent of the hospital's blended base cost per discharge plus add-ons if the claim has a discharge date prior to July 1, 1997. The scale increases 1.00 percent for each standard deviation above the mean Medicaid utilization rate for hospitals receiving Medicaid payments in the state. The standard deviation percentage rates will be increased to a maximum of 2.50 percent per standard deviation off the mean if additional federal funds for disproportionate share become available under the cap on disproportionate share payments imposed under Public Law 102-234. Disproportionate share hospitals will be notified of any change in disproportionate share payment rates within ten working days after the change.

The supplemental disproportionate share payment is established as an additional payment of 166 percent of the hospital's total calculated reimbursement for a case. For this purpose, total calculated reimbursement includes any routine disproportionate share payment. Hospitals which are state-owned, acute-care facilities with over 500 beds may receive both the routine disproportionate share payment and the supplemental disproportionate share payment. The supplemental disproportionate share payment will be paid on a monthly cycle using the same paid inpatient DRG claims to calculate the reimbursement amount.

Hospitals that qualify for routine disproportionate share payments under both the low-income utilization and the Medicaid utilization guidelines shall qualify for routine disproportionate share payment under the Medicaid utilization payment scale.

Hospitals that qualify for routine disproportionate share payments under the low-income utilization guidelines and do not qualify under the Medicaid utilization guidelines shall be paid the minimum payment as established under the Medicaid utilization payment scale.

Out-of-state hospitals serving Iowa Medicaid patients qualify for routine disproportionate share payments based on their state's Medicaid agency's calculation of the Medicaid inpatient utilization rate. Payment is through the Iowa Medicaid utilization payment scale for routine disproportionate share payment, based on the number of standard deviations greater than the hospital's own state average Medicaid utilization rate. Out-of-state hospitals may not qualify for supplemental disproportionate share payments.

In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total routine and supplemental disproportionate share payments cannot exceed the amount of the federal cap expressed under Public Law 102-234, and supplemental disproportionate share payments cannot exceed the lesser of (1) the applicable state appropriation or (2) the federal cap minus the routine disproportionate share payments.

(4) Indirect medical education costs. Recognition for indirect medical education costs incurred by hospitals is made through an add-on to the blended base rate cost per discharge for claims with dates of discharge before July 1, 1997. Hospitals qualify for indirect medical education payments when they receive a direct medical education add-on payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. For those qualifying hospitals, two distinct classes of indirect medical education add-on payments shall be established. The add-on payment for the first class (routine) is determined by qualifying for an indirect medical education payment from Medicare without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. The add-on payment for the first class shall be determined by multiplying the hospital's Medicaid indirect medical education factor by the sum of 50 percent of the statewide average base cost per discharge and 50 percent of the statewide average capital cost per discharge. The second class (supplemental) is determined by qualifying for an indirect medical education payment from Medicare, being an Iowa state-owned hospital with greater than 500 beds, and having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The add-on payment for the second class shall be paid monthly and shall be determined by multiplying the hospital's Medicaid indirect medical education factor by the sum of five times the statewide average base cost per discharge and five times the statewide average capital cost per discharge. The Medicaid indirect medical education factor is determined from the following equation:

$$\frac{(\text{residents} + \text{interns})}{(\text{beds})} \times 1.159$$

The number of interns, residents and beds is based on information contained in the hospital's Medicare cost report which will be updated when rebasing and recalibration are performed. A hospital may qualify to receive both classes of indirect medical education payments.

f. *Outlier payment policy.* Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The PRO will select a 10 percent random sample of outlier cases identified on fiscal agent claims data from all Iowa and bordering state hospitals. At least one case every six months per facility will be selected for review if available.

Staff will review the cases to perform admission review, quality review, discharge review, and DRG validation. Questionable cases will be referred to a physician reviewer for medical necessity and quality of care concerns. Day outlier cases will be reviewed to identify any medically unnecessary days which will be "carved out" in determining the qualifying outlier days. Cost outlier cases will be reviewed for medical necessity of all services provided and to ensure that services were not duplicately billed, to determine if services were actually provided, and to determine if all services were ordered by a physician. The hospital's itemized bill and remittance statement will be reviewed in addition to the medical record.

On a quarterly basis, the PRO will calculate denial rates for each facility based on completed reviews during the quarter. All outlier cases reviewed will be included in the computation or error rates. Cases with denied charges which exceed $1000 for inappropriate or nonmedically necessary services or days will be counted as errors.

Intensified review may be initiated for hospitals whose error rate reaches or exceeds the norm for similar cases in other hospitals. The error rate is determined based on the completed outlier reviews in a quarter per hospital and the number of those cases with denied charges exceeding $1000. The number of cases sampled for hospitals under intensified review may change based on further professional review and the specific hospital's outlier denial history.

Specific areas for review will be identified based on prior outlier experience. When it is determined that a significant number of the errors identified for a hospital is attributable to one source, review efforts will be focused on the specific cause of the error. Intensified review will be discontinued when the error rate falls below the norm for a calendar quarter. Providers will continue to be notified of all pending adverse decisions prior to a final determination by the PRO. If intensified review is required, hospitals will be notified in writing and provided with a list of the cases that met or exceeded the error rate threshold. When intensified review is no longer required, hospitals will be notified in writing. Hospitals with cases under review must then submit all supporting data from the medical record to the PRO within 60 days of receipt of the outlier review notifications, or outlier payment will be recouped and forfeited.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the greater of 23 days of care or two standard deviations above the average statewide length of stay for a given DRG. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally filed for DRG payment.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to PRO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or for disproportionate share costs, exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid. Those hospitals that are notified of any outlier review initiated by the PRO must submit all requested supporting data to the PRO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the PRO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Medicaid-certified substance abuse and psychiatric units. When a patient is discharged to or from an acute care hospital and is admitted to or from a Medicaid-certified substance abuse or psychiatric unit, both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Medicaid-certified physical rehabilitation units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a Medicaid-certified rehabilitation unit and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a physical rehabilitation unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in Medicaid-certified physical rehabilitation units which are paid per diem.

i. Payment for Medicaid-certified physical rehabilitation units. Medicaid-certified physical rehabilitation payment is prospective based on a per diem rate calculated for each hospital by establishing a base year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's cost report for the hospital's 1998 fiscal year. No recognition will be given to the professional component of the hospital-based physicians except as noted under 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Updating, rebasing, and recalibration. Updating of base payment amounts by the Data Resources, Inc. hospital market basket index shall be performed annually if funds permit. Base amounts shall be rebased and weights recalibrated every three years.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. For those hospitals which wish to submit a cost report no less than 120 days prior to rebasing using data for Iowa Medicaid patients only, that provider will receive a case-mix adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount. Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data. Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share add-ons if the last date of service is prior to July 1, 1997, or disproportionate share payments according to paragraph *"y"* if the last date of services is on or after July 1, 1997. If a hospital qualifies for reimbursement for the direct medical education or indirect medical education component under Medicare guidelines, it shall qualify for this add-on component for reimbursement purposes in Iowa if the date of service is prior to July 1, 1997, or shall be reimbursed for those components according to paragraph *"y"* if the date of service is on or after July 1, 1997. Hospitals which wish to submit the HCFA 2552 (or HCFA accepted substitute) cost report must do so within 60 days from the date of patient discharge to the state of Iowa's fiscal agent. Hospitals which elect to submit cost reports for the determination of blended rates must submit new reports on an annual basis within 90 days of the close of the hospital's fiscal year end. When audited, finalized reports become available from the Medicare intermediary, these should be submitted to the Iowa Medicaid fiscal agent.

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare PRO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the PRO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the PRO. Inpatient or outpatient services which require preadmission or preprocedure approval by the PRO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the PRO to the fiscal agent and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the PRO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare PRO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the fiscal intermediary after a patient's discharge. Payment for outlier days or costs is determined when the claim is filed with the fiscal agent, as described in paragraph *"f."* When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Administrator, Division of Medical Services, Iowa Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50309-0114, and shall include the patient's name, state identification number, date of admission, brief summary of the case, current listing of charges, and physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days. A departmental employee will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa foundation for medical care (IFMC) to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IFMC and cannot be found to be medically necessary on other grounds, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification of special units. Medicaid certification of substance abuse, psychiatric and rehabilitation units is based on the Medicare reimbursement criteria for these units. Neonatal units are certified using standards adopted by the department of public health in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. In Iowa, the department of inspections and appeals is responsible for Medicaid certification of these units for in-state hospitals.

Additional certification for reimbursement by the Iowa Medicaid fiscal agent is required for reimbursement of physical rehabilitation services on a per diem basis, for reimbursement of psychiatric or substance abuse services in adolescent-only or adult-only units, and for reimbursement of neonatal units as a level II or level III unit. To receive additional certification, the Medicare PPS exemption notice must be forwarded to the Iowa Medicaid fiscal agent every fiscal year when it becomes available. Supplemental Form 2977, indicating all the various certified programs for which the hospital may become certified, must also accompany the PPS exemption notice. This form will be available from the fiscal agent as part of the enrollment process or on request. Hospitals that elect to receive additional certification for substance abuse units must submit approved documentation of the Iowa substance abuse inspection to the Medicaid fiscal agent, plus additional documentation of the specific substance abuse programs available at the facility, staffing, facility information, treatment standards, and description of the population served by the facility. The Medicaid fiscal agent will notify the facility of the additional reimbursement certification for the provider after review of those documentation submissions. The additional reimbursement certification will be retroactive to the first day of the month during which the application is received by the Medicaid fiscal agent. Hospitals that have had additional reimbursement certification prior to July 1, 1993, do not have to reapply for certification by Medicaid but must submit the appropriate PPS exemption notices as they become due and available.

An out-of-state hospital may receive Medicaid-certified unit status as a qualifying psychiatric unit when the unit is eligible for reimbursement under the Medicare prospective payment system. Out-of-state hospitals must submit a copy of the Medicare PPS exemption notice to the Iowa Medicaid fiscal agent in order to receive Medicaid certification as a substance abuse unit or certification for reimbursement as an adolescent-only or adult-only psychiatric unit. Neonatal units are accepted as being certified when the hospital is inspected by the home state agency responsible for licensing, using standards set forth by the American Academy of Pediatrics for newborn care and that notice is forwarded to the Medicaid fiscal agent for reimbursement certification as a level II or level III neonatal unit. Out-of-state hospitals are not recognized as having special units for substance abuse or physical rehabilitation treatment. Reimbursement for physical rehabilitation is through the DRG payment. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment. There will be no retroactive payment adjustment made (to a certified higher level payment) when the hospital fails to make timely application for reimbursement certification.

s. Cost report adjustments. Hospitals with cost reports adjusted by Medicare through the cost settlement process on or after October 1, 1996, may appeal to the department the hospital-specific base amount and add-ons used in calculating the Medicaid DRG payment, if the Medicare adjustment results in material changes to the rates. Any appeal of the DRG rate due to Medicare's adjustment process must be made in writing to the department within 30 days of Medicare's finalization and notification to the provider. If the provider does not notify the department of the adjusted amounts within the 30-day period, no costs shall be reconsidered for adjustment by Iowa Medicaid. Claims adjustment reflecting the changed rates shall only be made to claims that have been processed within one year prior to the notification from the provider or the beginning of the rebasing period, whichever is less.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 26, 1991.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) Except as provided in subparagraph (2) below, the department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) The department may pay a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. In order to treat all hospitals equally and spread malpractice reimbursement payments equitably over future years, each hospital's base-year payment amount reflects a direct apportionment of 7 ½ percent of malpractice premiums incurred in that year by Medicaid. This is the most recent average malpractice insurance rate information available and was determined by the Health Care Financing Administration using nationwide surveys from hospitals reporting malpractice data.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new operation. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The amount in the fund and distributions from the fund shall be calculated from the following components:

(1) Allocation for direct medical education. To determine the total amount of funding that will be allocated to the graduate medical education and disproportionate share fund for direct medical education, the department shall:

1. Sum all direct medical education payments using paid claims to qualifying providers on or after July 1, 1998, and through June 30, 1999.

2. Sum all direct medical education payments using claims reimbursed to qualifying providers when those claims have been used as a basis for the calculation of capitation rates and reimbursement with any health maintenance organization (HMO) or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for direct medical education. The direct medical education PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for direct medical education (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for direct medical education Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated amounts.

(2) Distribution of direct medical education. Distribution of the fund for direct medical education shall be on a monthly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of direct medical education reimbursement (based upon paid claims to qualifying hospitals) and multiplying that percentage by the amount in the fund for direct medical education.

If a hospital fails to qualify for the provision of medical education under Medicare regulations, the amount of money that could have been allocated to that hospital shall be removed from the total fund.

(3) Allocation for indirect medical education. To determine the total amount of funding that will be allocated for the graduate medical education and disproportionate share fund for indirect medical education, the department shall:

1. Sum all routine indirect medical education payments using paid claims to qualifying providers on or after July 1, 1998, and through June 30, 1999.

2. Sum all routine indirect medical education payments from claims made to qualifying providers when those claims have been used as a basis for the calculation of capitation rates and reimbursement with any HMO or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for routine indirect medical education. The indirect medical education PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for routine indirect medical education (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for indirect medical education Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated updates.

(4) Distribution of indirect medical education. Distribution of the fund for indirect medical education shall be on a monthly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of indirect medical education reimbursement (based upon paid claims to qualifying hospitals) and multiplying the total amount of money allocated to the graduate medical education and disproportionate share fund for indirect medical education by each respective hospital's percentage.

If a hospital fails to qualify for the provision of medical education under Medicare regulations, the amount of money that would otherwise be allocated to that hospital shall be removed from the total fund.

(5) Allocation for disproportionate share. To determine the total amount of funding that shall be allocated to the graduate medical education and disproportionate share fund for disproportionate share payments, the department shall:

1. Sum all routine disproportionate share payments using paid claims to qualifying providers on or after July 1, 1998, and through June 30, 1999.

2. Sum all routine disproportionate share payments from claims made to qualifying providers when those claims have been used as a basis for the calculation of capitation rates and reimbursement with either an HMO or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for routine disproportionate share. The disproportionate share PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for routine disproportionate share (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for disproportionate share Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated updates. The total amount of disproportionate share reimbursement cannot exceed the cap that was implemented under Public Law 102-234.

(6) Distribution of disproportionate share fund. Distribution of the fund for disproportionate share shall be on a monthly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of direct medical education reimbursement (based upon paid claims to qualifying hospitals) and dividing the total amount of money allocated to the graduate medical education and disproportionate share fund for disproportionate share by each respective hospital's percentage.

If a hospital fails to qualify for reimbursement for disproportionate share under Iowa Medicaid regulations, the amount of money that would otherwise be allocated for that hospital shall be removed from the total fund.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Money shall be added to or subtracted from the graduate medical education and disproportionate share fund when the average monthly Medicaid population deviates from the previous year's averages by greater than 5 percent. The average annual population (expressed in a monthly total) shall be determined on June 30 for both the previous and current years by adding the total en-rolled population for all respective months from both years' B-1 MARS report and dividing each year's totals by 12. If the average monthly number of enrolled persons for the current year is found to vary more than 5 percent from the previous year, a per member per month (PMPM) amount shall be calculated for each component (using the average number of eligibles for the previous year calculated above) and an annualized PMPM adjustment shall be made for each eligible person that is beyond the 5 percent variance.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid prior to adjustment that exceed reasonable costs shall be recovered by the department. The base rate upon which the DRG and APG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid recipients for the coming year using the most recent utilization as submitted to the fiscal agent and Medicare cost principles.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Health Care Financing Administration (HCFA). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by HCFA to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

79.1(8) *Prescribed drugs.* The amount of payment shall be based on several factors in accordance with 42 CFR 447.331—333 as amended to October 28, 1987:

a. *"Estimated acquisition cost (EAC)"* is defined as the average wholesale price as published by First Data Bank less 10 percent.

"Maximum allowable cost (MAC)" is defined as the upper limit for multiple source drugs established in accordance with the methodology of the Health Care Financing Administration (HCFA) as described in 42 CFR 447.332(a)(i) and (ii).

The basis of payment for prescribed drugs for which the MAC has been established shall be the lesser of the MAC plus a professional dispensing fee of $4.13 or the pharmacist's usual and customary charge to the general public.

The basis of payment for drugs for which the MAC has not been established shall be the lesser of the EAC plus a professional dispensing fee of $6.42 or the pharmacist's usual and customary charge to the general public.

If a physician certifies in the physician's handwriting that, in the physician's medical judgment, a specific brand is medically necessary for a particular recipient, the MAC does not apply and the payment equals the average wholesale price of the brand name product less 10 percent. If a physician does not so certify, and a lower cost equivalent product is not substituted by the pharmacist, the payment for the product equals the established MAC.

Equivalent products shall be defined as those products which meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

b. The determination of the unit cost component of the drug shall be based on the package size of drugs most frequently purchased by providers.

c. No payment shall be made for sales tax.

d. All hospitals which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Hospitals receive reimbursement for the administration of vaccines to Medicaid recipients through the DRG reimbursement for inpatients and APG reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that a maximum allowable reimbursable cost for these drugs shall be established by the department at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

79.1(9) *Nursing facility reimbursement for skilled nursing care.* Reimbursement shall be prospective based on a per diem rate calculated for each facility by establishing a base year per diem to which an annual index is applied.

a. The base year per diem rate shall be the Medicaid cost per diem as determined using the facility's 1998 fiscal year-end Medicare cost report. The base per diem rate for facilities enrolled since 1998 will be determined using the facility's first finalized Medicare cost report. Determination of allowable costs for the base year will be made using Medicare methods in place on December 31, 1998. For facilities that have elected to receive the low Medicare volume prospective payment rate for 1998, the Medicare 1998 prospective payment rate plus ancillary costs attributable to skilled patient days and not payable by Medicare shall be used to determine the facility's Medicaid costs per patient day.

A new skilled facility shall be reimbursed at an interim rate determined by Medicare or, for facilities not participating in Medicare, at an interim rate determined using Medicare methodology. The initial interim rate shall be either the rate used by Medicare or a per diem (using Medicare methodology) developed using a projected cost statement from the facility. When the facility submits the first cost report to Medicare, the facility shall send a copy to the Medicaid fiscal agent. A new prospective rate shall be established based on this cost report effective the first day of the month in which the cost report is received. Interim and final rates may not exceed the maximum allowable costs established in paragraph *"d"* below unless the facility meets the requirements in paragraph *"e"* below.

b. In-state facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, have a failed attempt at weaning or are inappropriate for weaning, and have medical needs that require skilled care as determined by the Iowa Foundation for Medical Care shall receive reimbursement for the care of these patients equal to the maximum allowable cost for the type of facility (or, for disproportionate share facilities, the rate paid pursuant to paragraph *"e"*) plus a $100 per day incentive factor. Facilities may continue to receive reimbursement at these rates for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled criteria for those 30 days.

c. Nursing facilities providing skilled nursing care shall be classified as either hospital-based or free-standing (non-hospital-based). A hospital-based facility is under the management and administration of a hospital regardless of where the skilled beds are physically located.

d. Effective February 1, 2000, the maximum allowable cost for skilled care shall be $346.20 per day for hospital-based facilities and $163.41 per day for freestanding facilities.

e. Nursing facilities enrolled in the Iowa Medicaid program on May 31, 1993, providing skilled nursing care and serving a disproportionate share of Medicaid recipients shall be exempt from the payment ceiling. Nursing facilities which enroll in the Iowa Medicaid program on or after June 1, 1993, provide skilled care, and serve a disproportionate share of Medicaid recipients shall have an upper limit on their rate not to exceed 150 percent of the ceiling for the class of skilled nursing facility.

For nursing facilities providing skilled nursing care, a disproportionate share of Medicaid recipients shall exist when the total cost of skilled services rendered to Medicaid recipients in any one provider fiscal year is greater than or equal to 51 percent of the facility's total allowable cost for skilled services for the same fiscal year except as provided in subparagraphs (1) and (2). The department shall determine which providers qualify for this exemption.

(1) Nursing facilities enrolled in the Iowa Medicaid program on May 31, 1993, and meeting disproportionate share requirements on that date shall continue to be exempted from the payment ceiling if the total cost of services rendered to Medicaid recipients in any one provider fiscal year drops below 51 percent, but the total cost of services to Medicaid recipients is greater than 35 percent of the facility skilled nursing allowable cost for the same fiscal year.

For facilities meeting this condition, a 10 percent reduction in the Medicaid payment rate shall be made. For each percentage point in the facility's overall utilization rate (rounded to the nearest whole number) below 75 percent, a further 1 percent reduction shall be made in the Medicaid payment rate, in addition to any occupancy adjustment already made by the Medicare program.

(2) A facility meeting the conditions of subparagraph (1) as of July 1, 1996, or at a subsequent time, shall be subject to the following conditions and requirements:

- A census report shall be submitted to the department which verifies the Medicaid and overall occupancy of the facility for the entire year immediately preceding application by a facility to be reimbursed according to the conditions of this subrule.
- The initial rate for a facility approved for reimbursement under provisions of subparagraph (1) shall be the allowable Medicaid rate on the effective date less 10 percent and any further applicable percentage reduction.

Subsequent rate calculations shall be based on the annual cost report prepared by a facility subject to the limitations of this subparagraph and subject to an allowable rate of increase approved by the Iowa general assembly. These adjustments shall be effective July 1 of each year.

f. The current method for submitting billings and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

g. Out-of-state nursing facilities providing skilled nursing services shall be reimbursed at the same level as in their state of residence.

h. Payment for outpatient services by certified skilled nursing facilities shall be made at the Medicare rate of reimbursement.

i. Rates for skilled nursing facilities shall be rebased every three years.

j. Freestanding skilled facilities with a case-mix index above the statewide average for the previous reporting period shall receive a case-mix adjustment of $5.20 added to their daily rate for a six-month period. The case-mix index of each facility and the statewide average case-mix index are calculated by the United States Health Care Financing Administration from the minimum data set (MDS) report submitted by each facility pursuant to 441—subrule 81.13(9).

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by recipient.* A copayment in the amount specified shall be charged to recipients for the following covered services:

a. Nullified by 1992 Iowa Acts, H.J.R. 2015.

b. The recipient shall pay $1.00 copayment on each covered drug prescription, including each refill, and for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The recipient shall pay $2.00 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and sickroom supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, optometrists, opticians, rehabilitation agencies, psychologists, and ambulance services.

d. The recipient shall pay $3.00 copayment for total covered service rendered on a given date for dental services and hearing aids.

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a recipient receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The recipient shall pay $1.00 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid recipients.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the recipient is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a recipient is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *Reimbursement for HCBS MR and BI supported community living and supported employment and HCBS AIDS/HIV, BI, elderly, ill and handicapped, and MR respite when basis of reimbursement is retrospectively limited prospective rate.* This includes home health agencies providing group respite; nonfacility providers of specialized, basic individual, and group respite; camps; and home care agencies providing specialized, basic individual, and group respite.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form SS-1703-0, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the department, division of medical services, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver 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 the waiver.

(4) Financial information shall be based on the agency'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. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) 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 noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the division of medical services by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved individual comprehensive plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer travel and transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The annual adjustment shall be equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the division of medical services. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.