

441—79.1 (249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) “e”(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) “aa” and 79.1(16) “h.”

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
<p>HCBS waiver service providers, including:</p>	<p>Fee schedule</p>	<p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p>
<p>1. Adult day care</p>	<p>Fee schedule</p>	<p>Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/12 plus 2%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/12 rate: Veterans Administration contract rate or \$1.41 per 15-minute unit, \$22.56 per half day, \$44.91 per full day, or \$67.35 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider’s rate in effect 6/30/12 plus 2%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/12 rate, \$1.88 per 15-minute unit, \$30.06 per half day, \$60.00 per full day, or \$76.50 per extended day.</p>
<p>2. Emergency response system:</p>	<p>Fee schedule</p>	<p>Effective 1/1/13, provider’s rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: Initial one-time fee: \$50.52. Ongoing monthly fee: \$39.29.</p>
<p>Personal response system</p>	<p>Fee schedule</p>	<p>Effective 1/1/13, provider’s rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: One equipment purchase: \$313.84. Initial one-time fee: \$50.52. Ongoing monthly fee: \$39.29.</p>
<p>Portable locator system</p>	<p>Fee schedule</p>	<p>Effective 1/1/13, provider’s rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: One equipment purchase: \$313.84. Initial one-time fee: \$50.52. Ongoing monthly fee: \$39.29.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%. For intellectual disability waiver effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$5.05 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$84.58 per visit. For intellectual disability waiver effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$84.58 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to a 15-minute rate, not to exceed \$302.88 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to a 15-minute rate, not to exceed \$302.88 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed \$302.88 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$8.61 per 15-minute unit, not to exceed \$302.88 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$4.59 per 15-minute unit, not to exceed \$302.88 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed \$302.88 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$8.61 per 15-minute unit, not to exceed \$302.88 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$4.59 per 15-minute unit, not to exceed \$302.88 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed \$302.88 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed \$302.88 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.93 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$7.86 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 1/1/13: \$1,030.20 lifetime maximum. For intellectual disability waiver effective 1/1/13: \$5,151 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 1/1/13: \$6,181.20 per year.
10. Mental health outreach providers	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 7/1/13: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2%, converted to a mile or one-way trip unit rate.
12. Nutritional counseling	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$8.42 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 1/1/13: \$112.25 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$1.82 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$5.15 per 15-minute unit, not to exceed \$119.05 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$5.15 per 15-minute unit, not to exceed \$119.05 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.44 per 15-minute unit, not to exceed \$80.13 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$11.01 per 15-minute unit.
Group:	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$11.00 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$8.92 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day in effect 6/30/12 plus 2%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$8.92 per 15-minute unit. Maximum of 104 units per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$8.92 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.05 per 15-minute unit for personal care. \$1.58 per 15-minute unit for services in an enclave setting. \$2,941.38 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 1/1/13, \$6,181.20 per year.
21. Behavioral programming	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$11.01 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$11.00 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/12 plus 2%, \$49.18 per day or \$13.47 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$3.35 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$8.92 per 15-minute unit, not to exceed the maximum ICF/ID rate per day in effect 6/30/12 plus 2%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13: Not to exceed the maximum ICF/ID rate per day in effect 6/30/12 plus 2%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute or daily rate. If no 6/30/12 rate: \$3.37 per 15-minute unit or \$65.58 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 1/1/13, \$6,181.20 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$8.92 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$23.88 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$66.96 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$15.45 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.00 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Health home services provider	Fee schedule based on number of member's chronic conditions (not including conditions for which member is only at risk). Submission of the per-member per-month (PMPM) claim from the provider confirms that health home services are being provided.	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/12 or maximum Medicaid rate in effect 6/30/12 plus 2%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost-related settlement	Medicaid rate in effect 6/30/12 plus 2%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) "d")
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 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
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 annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
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 11/30/09 less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Nursing facilities: 1. Nursing facility care	<p>Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “1” and (2) “1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “2” and (2) “2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.</p>	<p>See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%. Refer to 79.1(18).
Pharmaceutical case management	Fee schedule. See 79.1(18)	
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/12 less 2%.
Qualified primary care services furnished in 2013 or 2014	See 79.1(7) "c"	Rate provided by 79.1(7) "c"
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Public health agencies	Fee schedule	Fee schedule rate.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. 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" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
Speech-language pathologists	Fee schedule	Medicare fee schedule.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

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

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. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5) "n."

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" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) "x." Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"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 payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*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.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*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. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Children’s hospitals*” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children’s Hospitals and Related Institutions.

“*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 costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly 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 percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"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 two components (the blended base amount and capital costs) 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.

"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.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means 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 nominally reimbursed patients for inpatient services.

“*Indirect medical education rate*” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*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.”

“*Low-income utilization rate*” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Medicaid inpatient utilization rate*” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, 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. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

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

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* 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. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"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.

"Rebasing implementation year" means 2008 and every three years thereafter.

"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."*

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 an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* 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 certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* 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) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include 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 with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. 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 base year cost reporting period, 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. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

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:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. 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, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(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.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. 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. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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 first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

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 QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(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 lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. 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 paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean 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 QIO 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 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 QIO must submit all requested supporting data to the QIO 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 QIO 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) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," 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 certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," 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 certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is 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 base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 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. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

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. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year 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.

(1) 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.

(2) 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 payments according to paragraph “j.”

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)“y.” Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“y.”

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO 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 QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise 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 QIO 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 QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient’s discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph “f.”

(2) 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 Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient’s name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A 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 representative 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.

(1) 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.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, 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 for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)“i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

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 5, 2001.

(1) 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. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) 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. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. *State-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state’s allotment under Public Law

102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and
2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

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 entity. 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 hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical

education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of 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.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,890,959. If a hospital fails to qualify for disproportionate share

payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.
3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

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 members (excluding members 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 before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG 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 members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

<u>Code</u>	<u>Explanation</u>
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

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 Centers for Medicare and Medicaid Services (CMS). 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 CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. 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.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor as determined by the department. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following:

- (1) Hospital inpatient unit (POS 21).
- (2) Hospital outpatient unit (POS 22).
- (3) Hospital emergency room (POS 23).
- (4) Ambulatory surgical center (POS 24).
- (5) Skilled nursing facility (POS 31).
- (6) Inpatient psychiatric facility (POS 51).
- (7) Community mental health center (POS 53).
- (8) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services furnished in 2013 or 2014. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and
2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or
2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase,

prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

- (4) Primary care services eligible for payment pursuant to this rule shall be paid at the greater of:
1. The otherwise applicable Iowa Medicaid rate;
 2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;
 3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or
 4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(A)(1).

(5) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the vaccines for children program in calendar years 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the vaccines for children program; or
2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“c,” whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:
 1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i”; or
 2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(4) The submitted charge, representing the provider’s usual and customary charge for the drug.

b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“d,” whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i”;

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”

(2) The submitted charge, representing the provider’s usual and customary charge for the drug.

c. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“k,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j.”

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j.”

(3) The submitted charge, representing the provider’s usual and customary charge for the drug.

d. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“g,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j.”

(2) The submitted charge, representing the provider’s usual and customary charge for the drug.

e. No payment shall be made for sales tax.

f. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members 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 members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

g. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“c,” whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8)“a” except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

h. An additional reimbursement amount of one cent per dose shall be added to the allowable 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.

i. For services rendered on or after August 1, 2011, and before February 1, 2013, or federal approval of the professional dispensing fee provided in paragraph 79.1(8)“j,” whichever is later, the professional dispensing fee is \$6.20 or the pharmacy’s usual and customary fee, whichever is lower.

j. Effective February 1, 2013, or upon federal approval, whichever is later, professional dispensing fees shall be amounts determined by the department based on a survey of Iowa Medicaid retail pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. For services rendered on or after February 1, 2013, and after federal approval, the dispensing fee for all drugs shall be \$10.02.

k. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies’ average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted

at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

l. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

m. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

n. Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13) "b," 78.37(16) "b," 78.38(9) "b," 78.41(15) "b," 78.43(15) "b," or 78.46(6) "b."

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

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 member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, “physician” means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

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 member receiving inpatient 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 member shall pay \$1 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 members.

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 member 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 member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)“k.” This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

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) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, 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 IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, 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 bureau of long-term care 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 service 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 transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(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.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers.

(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.

(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 provider’s new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

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

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

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 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 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.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

“Allowable costs” means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent

that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

“Ambulatory payment classification” or *“APC”* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

“Ambulatory payment classification relative weight” or *“APC relative weight”* means the relative value assigned to each APC.

“Ancillary service” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“APC service” means a service that is priced and paid using the APC system.

“Base year cost report,” for rates effective January 1, 2009, means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base APC rate” shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

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

“Cost outlier” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“Current procedural terminology—fourth edition (CPT-4)” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“Diagnostic service” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“International classifications of diseases—fourth edition, ninth revision (ICD-9)” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” 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; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPSS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1) “c.”

(2) Except as provided in paragraph 79.1(16) “h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPSS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16) “j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16) “e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.

E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPSS APC or any other Medicaid payment system.</p>
G	<p>Pass-through drugs and biologicals</p>	<p>If covered by Iowa Medicaid, the item is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPSS APC or any other Medicaid payment system.</p>
H	<p>Pass-through device categories</p>	<p>If covered by Iowa Medicaid, the device is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPSS APC or any other Medicaid payment system.</p>
K	<p>Non-pass-through drugs and biologicals</p> <p>Therapeutic radiopharmaceuticals</p>	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPSS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPSS APC or any other Medicaid payment system.</p>

L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.</p>
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”
3. The total calculated Medicaid cost for ambulance services.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital’s Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);
2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and
3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital’s fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)“v”(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, 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 QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. 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, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, 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.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which 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. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO

contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. *Final settlement for state-owned teaching hospital.*

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized

medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

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

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

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

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

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

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

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

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph "b" and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph "b." The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

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

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

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

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

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

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

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

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

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)“d.” Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

- (1) A unit of case management is 15 minutes.
- (2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).
 1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.
 2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.
- (3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).
- (4) A unit of prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).
- (5) A unit of supported employment habilitation for activities to obtain a job is:
 1. One job placement for job development and employer development.
 2. A 15-minute unit for enhanced job search.
- (6) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

- (1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.
- (2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.
- (3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.
- (4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.
- (5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.
- (6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24) "b," the department 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.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

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

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

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

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

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

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

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13]