

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/01 less 3%.
Hospitals (Outpatient)	Prospective reimbursement for providers listed at 441—paragraphs 78.31(1) "a" to "f." See 79.1(16)	Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 6/30/01 less 3%.
	Fee schedule for providers listed at 441—paragraphs 78.31(1) "g" to "n." See 79.1(16)	Rates in effect on 6/30/01 less 3%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. 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 recipients. 2. Fee schedule for service provided for all other Medicaid recipients.	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 12/31/00 cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Local education agency services providers	Fee schedule	Fee schedule
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/01 less 3%.
MR/CMI/DD case management providers	Monthly fee for service with cost settlement. See 79.1(1) "d"	Retrospective cost-settled rate
Nurse-midwives	Fee schedule	Fee schedule in effect 6/30/01 less 3%.

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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 100%. 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 65%. 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>

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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 100%. 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 65%. 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.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/01 less 3%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/01 less 3%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Physical therapists	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a.” Supplemental payments for services at qualifying hospitals. See 79.1(7)“b.”	Fee schedule in effect 6/30/01 less 3%. Supplemental payments as provided in 79.1(7)“b.”

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Podiatrists	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Prescribed drugs	See 79.1(8)	\$5.17 dispensing fee. (See 79.1(8) "a" and "e")
Psychiatric medical institutions for children (Inpatient)	Prospective reimbursement	Reimbursement rate for provider based on per diem rates for actual costs on 6/30/00, not to exceed a maximum of \$147.20 per day
(Outpatient day treatment)	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/01 less 3%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
Rehabilitation services for adults with a chronic mental illness providers, including:		
1. Rehabilitation support services providers, including:		
Community living skills training services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Employment-related services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
2. Day program services providers, including:		
Skills training providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Skills development providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Rehabilitative treatment services	Reasonable and necessary costs per unit of service based on data included on the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049. See 441—185.101(234) to 441—185.112(234). A provider who is an individual may choose between the fee schedule in effect November 1, 1993 (See 441—subrule 185.103(7)) and reasonable and necessary costs.	Rate in effect on 6/30/01

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Rural health clinics (RHC)	Retrospective cost-related See 441—88.14(249A)	<ol style="list-style-type: none"> 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 6/30/01 less 3%.
State-operated institutions	Retrospective cost-related	

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

Services of the physician 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.

79.1(5) Reimbursement for hospitals.

a. Definitions.

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

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

“Base year cost report” shall mean the hospital’s cost report with fiscal year end on or after January 1, 2001, and before January 1, 2002, 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 of time 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, 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.