

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital licensed as a Critical Access Hospital by the Department of Health and Human Services Regulation and Licensure under 175 NAC 9 and certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year, ~~and are inflated to the midpoint of the rate year using the MBI.~~

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative charges by hospitals for discharges associated with each DRG. That is, the Nebraska-specific DRG weight reflects the relative charge for treating discharges in all DRGs in Nebraska hospitals.

Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and
2. The total amount of the hospital's charges for hospital inpatient services attributable to uncompensated care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to uncompensated care does not include contractual allowances and discounts (other than for uncompensated care for patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Market Basket Index (MBI): The estimate of the ~~quarterly~~ annual rate of change in the costs of goods and services that are representative of goods and services used by hospitals in the production of inpatient care, from HCFA's ~~the~~ CMS Prospective Payment System Input Price Index, using the most recent historical and forecast amounts.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

10-010.03B4 Calculation of Peer Group Base Payment Amount: Peer group base payment amounts are calculated as a percentage of the weighted median of case mix adjusted hospital-specific base year operating costs per discharge, ~~inflated to the midpoint of the rate year using the MBI.~~ The peer group case-weighted median is determined and is multiplied by a percentage:

1. For metro acute care hospitals, the percentage is 85%;
2. For other urban acute care hospitals, the percentage is 100%;
3. For rural acute care hospitals, the percentage is 100%.

10-010.03B4a Consideration for Hospitals that Primarily Service Children: Effective January 1, 1997, a hospital qualifies for this group when it is located in Nebraska and is certified as meeting the criteria, as a children's hospital, for exclusion from the Medicare Prospective Payment System (PPS). The Department will make operating cost payments calculated at 120% of the peer group base payment amount for peer group 1 (Metro Acute Hospitals).

10-010.03B5 Calculation of Cost Outlier Payment Amounts: Additional payment is made for approved discharges meeting or exceeding Medicaid criteria for cost outliers for each DRG. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus \$50,000. Cost of the discharge is calculated by multiplying the hospital-specific cost-to-charge ratio determined from the base year cost report times the allowed charges. Additional payment for cost outliers is 60% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 67.5%.

10-010.03B6 Medical Education Costs

10-010.03B6a Calculation of Direct Medical Education Cost Payments: Hospital-specific direct medical education costs reflect the Nebraska Medical Assistance Program's average cost per discharge for approved intern and resident programs. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year ~~and adjusted annually for inflation using the market basket index.~~ Effective for the rate period beginning July 1, 2007 through August 31, 2007, the direct medical education payment amount will be inflated using the MBI. Effective September 1, 2007 direct medical education cost payments will be decreased by 1.70% and will remain in effect until June 30, 2008. Effective July 1, 2008 direct medical education payments will be inflated 1.90%. To determine the direct medical education payment amount for each discharge, adjusted amounts are allocated to the Medicaid program based on the percentage of Medicaid patient days to total patient days in the base-year, and are divided by the number of base year Medicaid discharges and multiplied by 75%.

10-010.03B10a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's final settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B11 Adjustment of Rates: Effective for the rate period beginning July 1, 2003~~7~~ through August 31, 2007, the peer group base payment amount and the direct medical education payment amount will be inflated using the MBI. Effective September 1, 2003~~7~~, the peer group base payment amount and the direct medical education payment amount ~~in effect for the rate period ending June 30, 2003~~ shall will be reduced by ~~3.45~~ 1.7% and remain in effect until June 30, 2004~~8~~. The peer group base payment amount and the direct medical education payment amount will be inflated ~~using the MBI~~ by 1.90% for the rate period beginning July 1, 2004~~8~~.

10-010.03B12 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

10-010.03D1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, ~~adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B3, #1, 2, 3)~~ per patient day for all psychiatric free-standing hospitals and Medicare-certified distinct part units. Per diem amounts are weighted by patient days, and the peer group median is determined.

10-010.03D2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03D3 Calculation of Direct Medical Education Per Diem Rate: Hospital-specific direct medical education costs reflect NMAP's average cost per patient day for approved interns and residents. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year, ~~and adjusted for inflation using the MBI.~~ To determine the direct medical education payment amount paid for each patient day, adjusted amounts are divided by the number of base year Medicaid psychiatric patient days and multiplied by 75%.

10-010.03D4 Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Beginning July 1, 2001, this rate will be determined by the Department and will be based on historical and future reasonable and necessary cost of providing the service. Specific costs to be included in the rate will not be inconsistent with those identified in 471 NAC 32-001.12.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission but not for the day of discharge.

(07-1-2007)
MANUAL LETTER #

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

NMAP SERVICES
471 NAC 10-010.03E1

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount:

The hospital-specific base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, ~~adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B3, #1, 2, 3)~~ per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.