

10-010 Payment for Hospital Services:

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

This subsection applies to hospital inpatient discharges occurring on or after July 1, 2004~~9~~.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective rate using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

For rates effective October 1, 2004~~9~~, and later, each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, ~~and disproportionate share adjustment(s)~~, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Base Year: The period covered by the most recent final-settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Budget Neutrality: Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

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, birth weight, 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.

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~~ costs by hospitals for discharges associated with each stable 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.

Hospital-Specific Cost-to-Charge Ratio: Hospital-Specific Cost-to-Charge Ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-Specific Cost-to-Charge Ratios used for outlier cost payments, Low Volume/Unstable DRG CCR payments and Transplant DRG CCR payments are derived from the outlier CCRs in the Medicare inpatient prospective payment system.

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.

Low Volume DRG: DRGs with less than 10 claims in the two year claims dataset used to calculate DRG relative weights.

Market Basket Index (MBI): ~~The estimate of the 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 the CMS Prospective Payment System Input Price Index, using the most recent historical and forecast amounts.~~

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

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

Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by NMAP, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

Medical Review: Review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

Medicare Cost Report: The report filed by each facility with its Medicare intermediary.

The Medicare cost report is available through the National Technical Information Service at the following address:

U.S. Department of Commerce  
Technology Administration  
National Technical Information Service  
Springfield, VA 22161

A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;

2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 5 and Peer Group 6.

Reporting Period: Same reporting period as that used for its Medicare cost report.

Stable DRG: DRGs with at least 10 claims and a sufficient numbers of claims to pass the stability test in the two year claims dataset used to calculate DRG relative weights, excluding psychiatric, rehabilitation and transplant DRGs.

Subspecialty Care Unit: Provision of comprehensive maternal and neonatal care services for both admitted and transferred mothers and neonates of all risk categories, including basic and specialty care services; provision of research and educational support; analysis and evaluation of regional data, including those on complications; and initial evaluation of new high-risk technologies.

Tax-Related Costs: Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234) or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state or federal government, but not including income taxes.

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

Unstable DRG: DRGs without sufficient numbers of claims to pass the stability test in the two year claims dataset used to calculate DRG relative weights.

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital.

For inpatient services that are classified into a stable DRG, The the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
  - a. Direct Medical Education Cost Payment;
  - b. Indirect Medical Education Cost Payment; and
  - c. A Cost Outlier Payment.

For inpatient services that are classified into a low volume or unstable DRG or a transplant DRG, the total per discharge payment is the sum of -

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable - Direct Medical Education Cost Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount is calculated for each discharges that are classified into a stable DRG is calculated by multiplying the peer group base payment amount by the Nebraska-specific DRG relative weight. Centers for Medicare and Medicaid (CMS) DRG definitions are adopted except for neonates.

~~10-010.03B1a Nebraska-Specific Weights:~~ Two sets of weights are developed for DRGs for treatment of neonates. One set of weights is developed from charges associated with treating neonates in a subspecialty care unit for some portion of their hospitalization in hospitals meeting the criteria for providing subspecialty care. The second set of weights is developed from charges associated with treating neonates in hospitals that do not meet subspecialty care criteria. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

~~Hospitals must notify NMAP in writing within ten working days if their subspecialty care unit no longer meets the criteria for subspecialty care. Notification shall be sent to Department of Health and Human Services Finance and Support.~~

10-010.03B1a Calculation of Nebraska-Specific DRG Relative Weights: For dates of admission on and after October 1, 2009, the Department will use the AP-DRG Grouper to determine DRG classifications. DRG relative weights are based on the average cost per discharge of each stable DRG, using Nebraska Medicaid inpatient fee-for-service paid claims data from the two most recently available and fully adjudicated state fiscal years. For DRG relative weights effective October 1, 2009, the Department will use SFY 2006 and SFY 2007 claims data.

The Department will include claims from all Peer Group 1, 2 and 3 in-state hospitals and claims from out-of-state hospitals with at least \$500,000 in payments and 50 claims in the two year claims dataset used for the relative weight calculation.

1. Nebraska Medicaid inpatient fee-for-service paid claim costs are calculated as follows:
  - a. Extract the most recently available hospital Medicare cost report data with reporting periods that overlap the claims data used in the relative weight calculation. For DRG relative weights effective July 1, 2009, extract FYE 2007 Medicare cost report data.
  - b. Calculate hospital-specific cost-to-charge ratios (CCRs) for each standard Medicare ancillary cost center, excluding direct medical education costs.
  - c. Calculate hospital-specific cost per diems for each standard Medicare routine cost center, excluding direct medical education costs.
  - d. Estimate the cost of each claim, excluding direct medical education costs. The ancillary portion of the claim cost is calculated by multiplying the Medicaid allowed charges at the revenue code level by the corresponding ancillary cost center CCR. The routine portion of the claim cost is be calculated by multiplying the Medicaid allowed days at the revenue code level by the corresponding routine cost center cost per diem.
  - e. Inflate the ancillary portion of the claim costs based on the change in price index levels from the midpoint of the claims data service month to the midpoint of the rate year.
  - f. Inflate the routine portion of the claim costs based on the change in price index levels from the midpoint of the Medicare cost reporting period to the midpoint of the rate year.
  - g. Calculate inflation using CMS hospital price index levels published by Global Insight Inc.

2. Nebraska-specific relative weights are calculated as follows:

- a. Remove from the claims data all psychiatric, rehabilitation, transplant, Medicaid Capitated Plans, and Critical Access Hospital discharges;
- b. Remove Transfer claims with days less than the DRG average length of stay;
- c. Remove statistical outlier claims with estimated costs 3 times the DRG standard deviation above or below the DRG mean cost per discharge for each DRG;
- d. Remove claims with low volume DRGs with less than 10 claims;
- e. Of the remaining claims, conduct a stability test to using a statistical sample size calculation formula to determine the minimum number of claims within each DRG classification needed to calculate stable relative weights. Calculate the required size of a sample population of values necessary to estimate a mean cost value with 90 percent confidence and within an acceptable error of plus or minus 20 percent given the populations estimated standard deviation.
- f. Remove claims with unstable DRGs without sufficient numbers of claims to pass the stability test
- g. Of the remaining claims, determine the arithmetic mean Medicaid cost per discharge for each DRG by dividing the sum of all Medicaid cost for each DRG by the number of discharges;
- h. Of the remaining claims, determine the statewide arithmetic mean Medicaid cost per discharge by dividing the sum of all costs for all discharges in the State by the number of discharges;
- i. For each remaining, or stable DRG, divide the DRG arithmetic mean Medicaid cost per discharge by the statewide arithmetic mean Medicaid cost per discharge to determine the DRG relative weight;

10-010.03B1b Calculation of Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges with a stable DRG. Peer Group Base Payment Amounts effective October 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the Peer Group Base Payment Amounts effective during SFY 2007, adjusted for budget neutrality, calculated as follows:

1. Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Peer Group 1 Base Payment Amount of \$3,844.00 by the Stable DRG budget neutrality factor.
2. Children's Hospital Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Children's Hospital Peer Group 1 Base Payment Amount of \$4,614.00 by the Stable DRG budget neutrality factor.
3. Peer Group 2 Base Payment Amounts: Multiply the SFY 2007 Peer Group 2 Base Payment Amount of \$3,733.00 by the Stable DRG budget neutrality factor.
4. Peer Group 3 Base Payment Amounts: Multiply the SFY 2007 Peer Group 3 Base Payment Amount of \$3,535.00 by the Stable DRG budget neutrality factor.

~~10-010.03B1b Calculation of Nebraska-Specific DRG Relative Weights and Case-Mix Index Peer Group Base Payment Amounts: Relative weights calculated for the rate period ending June 30, 2001, shall remain in effect. For payment purposes, relative weights are calculated using all applicable discharges for a single year for a period from January 1, through December 31, for the calendar year ending 2 years prior to the effective date of the recalibration. Statistical outliers which exceeded the average mean charges value by three standard deviations are excluded from the calculations.~~

~~Nebraska-specific weights are calculated from Medicaid charge data using the following calculations:~~

- ~~1. Determine the Medicaid charges for each discharge;~~
- ~~2. Remove all psychiatric, rehabilitation, Medicaid Capitated Plans, and Critical Access Hospital discharges;~~
- ~~3. Determine the arithmetic mean Medicaid charges per discharge for each DRG by dividing the sum of all Medicaid charges for each DRG by the number of discharges;~~
- ~~4. Determine the statewide arithmetic mean Medicaid charges per discharge by dividing the sum of all charges for all relevant discharges in the State by the number of discharges;~~
- ~~5. For DRGs with 10 or more cases, divide the DRG arithmetic mean charges per discharge for each DRG by the statewide arithmetic mean charges per discharge to determine the Nebraska-specific relative weight for each DRG;~~
- ~~6. For DRGs with less than 10 cases, relative weights will be borrowed from the Medicare relative weights that were effective for the Medicare program on October 1 of the preceding year.~~
- ~~7. Adjust the relative weights so that the average of all discharges equals 1.0.~~

~~10-010.03B2a Recalibrating Relative Weights: Relative weights calculated for the rate period beginning July 1, 2001 remain in effect.~~

~~10-010.03B2b Calculating the Base Year Case Mix Index: For purposes of determining base rates, a base year case mix index is calculated for each hospital using all applicable claims with a first date of service that is within the base year cost reporting period. Facility specific base year case mix indices are calculated as the sum of relative weights for all base year claims, divided by the number of claims.~~

~~10-010.03B3 Calculation of Case-Mix Adjusted Hospital-Specific Base Year Operating Cost Per Discharge: Medicaid case-mix adjusted hospital-specific base year operating costs per discharge amounts are calculated from base year Medicare cost reports. For purposes of this calculation, the Medicare cost report which the Department shall use in the computation of the prospective rate process for any hospital which files more than one Medicare cost report for reporting periods ending during any calendar year is the one which covers—~~

- ~~1. At least nine months, and~~
- ~~2. The greatest period of time.~~

~~For any hospital which files Medicare cost reports for more than one reporting period ending during a calendar year but does not file a cost report covering a period of at least nine months, the computation rates will be based on aggregate data from all cost reports filed for reporting periods ending during that calendar year.~~

~~The Department may utilize cost report data that is not final-settled in instances where a final-settled Medicare cost report for a hospital is not available. For example, if two hospitals merge into a single provider entity, and the combined provider entity does not have a combined cost report that is final-settled, the Department may utilize a more recently completed combined cost report that is not final-settled.~~

~~Operating costs are calculated as follows:~~

- ~~1. Routine service costs—Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed costs.~~
- ~~2. Inpatient ancillary service costs—Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.~~
- ~~3. Total hospital-specific base year operating costs amounts are equal to the sum of Medicaid routine service costs and Medicaid inpatient ancillary service costs, less the building and fixtures portion of capital-related costs and direct medical education costs.~~
- ~~4. Hospital-specific base year operating costs are divided by the hospital's base year case-mix index and the number of base year Medicaid discharges, and if applicable, the hospital's indirect medical education factor.~~

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. 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).

SFY 2007 Nebraska Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B4 in effect on September 1, 2007 and 471 NAC 10-010.03B in effect on July 1, 2001.

Peer Group Base Payment Amounts will be increased by 0.5% for the rate period beginning October 1, 2009 and ending June 30, 2010. This rate increase will not be carried forward in subsequent years. Peer Group Base Payment Amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be inflated by 1.50% for the rate period beginning July 1, 2010 and for the rate period beginning July 1, 2011.

10-010.03B52 Calculation of Stable DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a stable DRG meeting or exceeding Medicaid criteria for cost outliers for each stable DRG classification. 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 Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is ~~60%~~ 80% 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%~~ 85%.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs effective in the Medicare system on October 1, 2008.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B63 Calculation of Stable DRG Medical Education Costs

10-010.03B63a Calculation of Stable DRG 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. 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%.

NMAP will calculate a quarterly Direct Medical Education payment for services provided by NMMCP capitated plans from discharge data provided by the plan(s). Payment will be the number of discharges times the direct medical education cost payment as calculated in 471 NAC 10-010.03B6a.

For discharges with stable DRGs, Direct Medical Education (DME) payments effective October 1, 2009 are based on Nebraska hospital-specific DME payment rates effective during SFY 2007 with the following adjustments:

1. Estimate SFY 2007 DME payments for in-state teaching hospitals by applying SFY 2007 DME payment rates to SFY 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include discharges with stable DRGs, unstable or low volume DRGs and transplant DRGs. Exclude all psychiatric, rehabilitation and Medicaid Capitated Plans discharges.
2. Divide the estimated SFY 2007 DME payments for each hospital by each hospital's number of intern and resident FTEs effective in the Medicare system on October 1, 2006.
3. Multiply the SFY 2007 DME payment per intern and resident FTE by each hospital's number of intern and resident FTEs effective in the Medicare inpatient system on October 1, 2008.
4. Divide the DME payments adjusted for FTEs effective October 1, 2008 by each hospital's number of SFY 2007 claims.
5. Multiply the DME payment rates by the stable DRG budget neutrality factor.

SFY 2007 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect September 1, 2007.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection, with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year. The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2009. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through June 30, 2009, will be increased by 1.50% for the rate period beginning July 1, 2010 and for the rate period beginning July 1, 2011.

10-010.03B63b Calculation of Stable DRG Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from NMAP, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the sum of the operating cost payment amount and the outlier payment amount times 72.64%.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program. For rates effective October 1, 2009, the Department will determine the operating IME factors effective for the Medicare system on October 1, 2008 using the calculated as following formulas:

$$\text{--}\{1 + (\text{Number of Interns and Residents/Available Beds})\}^{0.405} \text{--} 1\} * 1.35$$

On July 1<sup>st</sup> of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1<sup>st</sup> of the previous year.

Effective July 1, 2001 to June 30, 2002:

$$\text{--}\{1 + (\text{Number of Interns and Residents/Available Beds})\}^{0.405} \text{--} 1\} 1.60$$

Effective July 1, 2002 and thereafter:

$$\text{--}\{1 + (\text{Number of Interns and Residents/Available Beds})\}^{0.405} \text{--} 1\} 1.35$$

~~Base rates will be adjusted by the applicable IME factor.~~

10-010.03B7 Calculation of Medicaid Capital Related Costs: Medicaid capital-related per diem costs are calculated from base year Medicare cost reports as follows:

- ~~1. Routine service capital-related costs -- Medicaid routine service capital-related costs are calculated by allocating total hospital routine service capital-related costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing bed costs and observation bed capital-related costs.~~
- ~~2. Inpatient ancillary service capital-related costs -- Medicaid inpatient ancillary service capital-related costs are calculated by multiplying an overall ancillary capital-related cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary capital-related cost-to-charge ratio is calculated by dividing the sum of the capital-related costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.~~
- ~~3. Total capital-related costs are equal to the sum of Medicaid routine service capital-related costs and Medicaid inpatient ancillary service capital-related costs.~~

4. ~~Building and fixtures capital-related costs are calculated by multiplying total capital-related costs times a percentage determined by dividing total hospital building and fixtures costs by total hospital capital costs.~~
5. ~~The capital-related per diem cost is calculated by dividing Medicaid building and fixtures capital-related costs by the sum of base year Medicaid acute care and bassinets patient days.~~

~~Effective July 1, 2003, capital costs are calculated as 100% of the peer group weighted median cost per day. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day.~~

10-010.03B84 Calculation of Stable DRG Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis for stable DRGs. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the stable DRG. Capital-related payment per diem amounts effective July 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2007, adjusted for budget neutrality, as follows:

1. Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 1 Capital-related payment per diem amount of \$36.00 by the Stable DRG budget neutrality factor.
2. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 2 Capital-related payment per diem amount of \$31.00 by the Stable DRG budget neutrality factor.
3. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 3 Capital-related payment per diem amount of \$18.00 by the Stable DRG budget neutrality factor.

SFY 2007 Capital-Related Cost Payments are described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03B5 Low Volume and Unstable DRG Payments: Discharges that are classified into a Low Volume or Unstable DRG are paid a Low Volume and Unstable DRG CCR payment and, if applicable, a DME payment. Low Volume and Unstable DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B5a Low Volume and Unstable DRG CCR Payments are calculated by multiplying the hospital-specific Low Volume/Unstable DRG CCR by Medicaid allowed claim charges. Low Volume/Unstable DRG CCRs are calculated as follows:

1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective July 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.
2. Sum the operating and capital outlier CCRs.
3. Multiply the sum of the operating and capital outlier CCRs by the Low Volume / Unstable DRG budget neutrality factor.

On July 1 of each year, the Department will update the Low Volume/Unstable DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years, before budget neutrality adjustments.

10-010.03B5b Low Volume and Unstable DRG DME Payments: Low Volume and Unstable DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation, with the exception that in step 4, per discharge payment amounts are adjusted by the Low Volume/Unstable DRG budget neutrality factor.

On July 1<sup>st</sup> of each year, the Department will update Low Volume and Unstable DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges. Transplant DRG CCRs are calculated as follows:

1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.
2. Sum the operating and capital outlier CCRs.
3. Multiply the sum of the operating and capital outlier CCRs by the Transplant DRG budget neutrality factor.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years, before budget neutrality adjustments.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation, with the exception that in step 4, DME per discharge payment amounts are adjusted by the Transplant DRG budget neutrality factor.

On July 1<sup>st</sup> of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B7 Budget Neutrality Factors: Peer Group Base Payment Amounts, Capital-Related Cost Payments, Direct Medical Education Cost Payments, Low Volume/Unstable DRG CCRs and Transplant DRG CCRs are multiplied by budget neutrality factors, determined as follows:

10-010.03B7a Develop Fiscal Simulation Analysis: The Department will develop a fiscal simulation analysis using Nebraska Medicaid inpatient fee-for-service paid claims data from the most recently available and fully adjudicated state fiscal year from all Peer Group 1, 2 and 3 in-state hospitals and claims from out-of-state hospitals with at least \$500,000 in payments and 50 claims in the two year claims dataset used for the relative weight calculation. Include discharges with stable DRGs, unstable or low volume DRGs and transplant DRGs. Exclude all psychiatric, rehabilitation and Medicaid Capitated Plans discharges. For rates effective October 1, 2009, the Department will create a fiscal simulation analysis using SFY 2007 claims data.

In the fiscal simulation analysis, the Department will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.

10-010.03B7b Determine Budget Neutrality Factors: The Department will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments, inflated by Peer Group Base Payment Amount increases approved by the Department from the end of the claims data period to the rate year. For rates effective October 1, 2009, the Department will inflate the SFY 2007 reported claim payments by 5.45%.

The Department will develop separate budget neutrality factors for stable DRG discharges, low volume/unstable DRG discharges and transplant DRG discharges as follows:

1. Set the Stable DRG budget neutrality factor applied to stable DRG Peer Group Base Payment Amounts, Capital-Related Cost Payments and DME Cost Payments in the fiscal simulation analysis such that stable DRG claim simulated payments are equal to the stable DRG claims data inflated reported payments.

2. Set the Low Volume / Unstable DRG budget neutrality factor applied to low volume/unstable DRG CCRs and DME Cost Payments in the fiscal simulation analysis such that low volume/unstable DRG claim simulated payments are equal to the low volume/unstable DRG claims data inflated reported payments.
3. Set the Transplant DRG budget neutrality factor applied to transplant DRG CCRs and DME Cost Payments in the fiscal simulation analysis such that transplant DRG claim simulated payments are equal to the transplant DRG claims data inflated reported payments.

10-010.03B9 (Reserved)

10-010.03B408 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B108a 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, 2007 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, 20037, the peer group base payment amount and the direct medical education payment amount will be reduced by 1.7% and remain in effect until June 30, 20048. The peer group base payment amount and the direct medical education payment amount will be inflated by 1.90% for the rate period beginning July 1, 2008.~~

10-010.03B129 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.

10-010.03B15a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B16 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

10-010.03C Non-Payment for Hospital Acquired Conditions: NMAP will not make payment for those claims which are identified as non-payable by Medicare as a result of avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This provision applies only to those claims in which Medicaid is a secondary payor to Medicare.

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

~~All psychiatric 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 psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. The per diem will be the sum of-~~

- ~~1. The peer group 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.~~

Tiered rates will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

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 the day of discharge.

Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan.

~~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 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.~~

10-010.03D1 For payment of inpatient hospital psychiatric services, effective October 1, 2009, the tiered per diem rates will be:

Days of Service	Per Diem Rate
Days 1 and 2	\$687.66
Days 3 and 4	\$635.66
Days 5 and 6	\$606.78
Days 7 and greater	\$577.88

The tiered per diem rates listed above were increased by .5% effective October 1, 2009 through June 30, 2010. This rate increase will not be carried forward in subsequent years. Tiered rates excluding the .5% increase for October 1, 2009 through June 30, 2010 will be increased by 1.0% for the rate period beginning July 1, 2010 and by 1.5% for the rate period beginning July 1, 2011.

~~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. 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.

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 per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: The hospital-specific per diem rates will be inflated by 2% effective October 1, 2009. The hospital-specific per diem rates will be inflated by 1.0% for the rate period beginning July 1, 2010 and 1.5 %for the rate period beginning July 1, 2011.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning July 1, 1999, and after payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital:
  - a. The inpatients of which are predominantly individuals under 18 years of age; or
  - b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
  - c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with the Nebraska Medicaid Assistance Program will be considered for eligibility as a Disproportionate Share Hospital.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services using the same methods described in this regulation for in-state hospitals, except that out-of-state hospitals do not receive direct medical education cost payments or indirect medical education cost payments. Payments for services are determined by assigning out-of-state hospitals to the appropriate peer group. at the peer group rate for a like peer group of Nebraska hospitals.— The peer groups are —

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
2. Rural Acute Care Hospitals: All other acute care hospitals;
3. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
4. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

For peer groups 1 and 3, oOperating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the appropriate peer group weighted median capital per diem rate. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day. The cost-to-charge ratios for out-of-state hospitals that meet the criteria for inclusion in the calculation of DRG relative weights at section 10-010.03B1a of this regulation are determined using the same method described for in-state hospitals in Section 10-010.03B of this regulation. The cost-to-charge ratios for all other out-of-state hospitals are is the peer group average of in-state hospitals.

Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

Tiered rates as described in 10-010.03D1, will be used for all psychiatric services, regardless of the type of hospital providing the service. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payments for rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Payments for rehabilitation hospitals are based on average of the in-state hospital specific per diem rates for the appropriate type of service. Capital-related cost payments are made based on the in-state peer group capital per diem rate.

The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.