10-010.03B2 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 Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 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 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.

10-010.03B1b 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.

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.

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;

10-010.03B1a 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.

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 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 for 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.

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.

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.

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.

2. The total amount of the hospital's charges for hospital inpatient services attributable to indigent 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 indigent care does not include contractual allowances and discounts (other than for indigent 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.

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.

DRG Weight: A number that reflects relative resource consumption as measured by the relative charges by hospitals for discharges associated with each DRG.

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 including fee-for-service, managed care, and primary care case management payments (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 fee-for-service, managed care, and primary care case management payments (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

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 10-010.03B2 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital 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.

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.

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 October 1, 2009.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective 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, 2009, 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 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.

10-010.03B3 Calculation of Stable DRG Medical Education Costs

10-010.03B3a Calculation of Stable DRG Direct Medical Education Cost Payments:

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, 2010. 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

used for the calculation of the Stable DRG Direct Medical Education Cost Payments described in subsection 10-010.03B3a. The adjusted amounts will be increased by 1.50% for the rate period beginning July 1, 2010, and for the rate period beginning July 1, 2011.

2. MCO Indirect Medical Education payments will be equal to the number of MCO discharges times the MCO indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows:
   a. Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education simulated payments using the stable DRG claims in the Department's Fiscal Simulation Analysis. Exclude unstable/low volume DRG and transplant DRG claims. Fee-for-service indirect medical education payments for stable DRG claims are described in 10-010.03B3b.
   b. Subtotal each teaching hospital's fee-for-service inpatient acute stable DRG claim covered charges, inflated to the midpoint of the rate year, in the Department's Fiscal Simulation Analysis. Exclude unstable/low volume DRG and transplant DRG claims. The Fiscal Simulation Analysis is described in 10-010.03B7a.
   c. Divide each teaching hospital's simulated indirect medical education payments, as described in subsection a. above, by inflated covered charges, as described in subsection b. above.
   d. Multiply the ratio described in subsection c. above times the covered charges in MCO paid claims in the base year, inflated to the midpoint of the rate year.
   e. Divide the amount calculated in subsection d. above by the number of MCO paid claims in the base year.
   f. On July 1st each year, the Department will update the indirect medical education payment per discharge. The indirect medical education payment per discharge amount will be increased or decreased based on the annual percentage change in Medicare's indirect medical education factor during the year.

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.

10-010.03B3b 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 operating cost payment amount.

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 following formula:

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

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

10-010.03B3c Calculation of MCO Medical Education Payments: NMAP will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by NMMCP capitated plans from discharge data provided by the hospital.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the MCO direct medical education payment per discharge.
    a. The MCO direct medical education payment per discharge is the hospital-specific weighted average fee-for-service DME payment rates for stable DRGs, unstable or low volume DRGs and transplant DRGs, as described in 10-010.03B3a, 10-010.03B5b and 10-010.03B6b. The weighted average amount shall be based on the claims included in the Fiscal Simulation Analysis as described in 10-010.03B7a.
    b. On July 1st of each year, the Department will update the Direct Medical Education payment rates. The Direct Medical Education rates will be increased or decreased based on the annual percentage change in the number of intern and resident FTEs

10-010.03B4 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 1st 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 1st 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.

10-010.03B8 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
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.

10-010.03B8a 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.

10-010.03B9 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.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B10 Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B11 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

10-010.03B12 Interim Payment for Long-Stay Patients: NMAP's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send a completed Form HCFA-1450 (UB-92) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support.

The hospital will be notified in writing if the request for interim payment is denied.

10-010.03B12a 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.

10-010.03B13 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 HCFA-1450 (UB-92) claim form.

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 Medicaid.

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

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.

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 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.

10-010.03E3 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 as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

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.

OS Notification

State/Title/Plan Number: Neb 09-10

Type of Action: SPA Approval

Required Date for State Notification: 03/14/2010

Fiscal Impact: FFY 10 $2,536,162 FFY 11 $2,629,528

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: Yes **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective for inpatient hospital services on and after October 1, 2009, this amendment will assign claims to DRGs using the AP-DRG Grouper. The amendment also provides for a budget neutrality factor, revises peer group limits and revises definitions.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS Contact:
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National Institutional Reimbursement Team