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 increased by .5% for the rate period beginning July 1, 2010. The Peer Group Base Payment Amount effective July 1, 2010 will be reduced by 2.5% effective July 1, 2011.

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 $53,000. 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.

June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the direct medical education amount shall be reduced by 2.5 percent.

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.

10-010.033B3c 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. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the MCO direct medical education payment per discharge. The MCO direct medical education payment per discharge is the hospital-specific fee-for-service DME payment rates for stable DRGs, unstable or low volume DRGs and transplant DRGs in effect for the rate year July 1 through June 30.

1. 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 prior year payments.
    b. Subtotal each teaching hospital's fee-for-service inpatient covered prior state fiscal year charges.
    c. Divide each teaching hospital's indirect medical education payments, by covered prior state fiscal year charges.
    d. Multiply the ratio described in subsection c. above times the covered charges in MCO paid claims in the base year.
    e. Divide the amount calculated in subsection d. above by the number of MCO paid claims in the base year.

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.

Capital-Related Payment Per Diem Amounts effective July, 2010 will be reduced by 2.5% effective July 1, 2011.

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.

Effective July 1, 2011, the low volume/unstable DRG CCRs will be reduced by 2.5 percent.

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.

Effective July 1, 2011, the Transplant DRG CCRs will be reduced by 2.5 percent.

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 DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: The hospital-specific per diem rates will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the transplant DRG DME rates will be reduced by 2.5%.

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, 2011, and after payment for inpatient services of a CAH is ninety-seven point five percent (97.5%) of 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:	**NE 11-022**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**03/11/2012**
Fiscal Impact:	**FY 2011 $ (769,345)** **FY 2012 $(2,308,036)**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective July 1, 2011, this SPA reduces inpatient hospital service payment rates by 2.5%. This amendment also modifies the medical education payment methodology to allow for annual updates so that payments more closely reflect hospital case mix changes.

Regarding access to care, the Nebraska Medicaid agency communicated with providers and other stakeholders prior to July 1st. Medicaid actively engaged a variety of providers, provider organizations and client representatives to communicate Medicaid's fiscal limitations and legislative mandate to reduce expenditures. The proposed rate reduction was discussed at the Medical Assistance Advisory Committee on February 9, 2011, March 9, 2011, April 13, 2011 and on May 11, 2011. In attendance at the advisory meetings among others, were representatives from provider associations, providers, advocacy groups and Medicaid clients. The communication efforts conducted by Medicaid allowed Medicaid to monitor and measure provider reactions and concerns with regard to rate reductions. In general, while they expressed disappointment about reductions, the providers understand the current state budgetary circumstances and remain committed to serving the Medicaid population.

In the last several years prior to the recession, Medicaid was able to increase rates for many of the most utilized services. The rate reductions implemented this fiscal year bring rates to levels that have, in the past, been adequate in maintaining provider enrollment and client access. Providers have not expressed the need to

eliminate this level of care or reduce the numbers admitted to inpatient psychiatric hospital services.

Medicaid reviewed utilization data from the MMIS system to establish a baseline and continues to monitor utilization to insure there has not been a drop in access. Medicaid shared the rate reduction information at the Medical Assistance Advisory Committee. Providers did not indicate that this reduction would affect client access. The Division of Behavior Health in the Nebraska Department of Health and Human Services funds inpatient psychiatric hospital services for low income Nebraskan's who are not Medicaid eligible. The Division of Behavior Health had a similar reduction of rates without experiencing an access problem.

The State utilizes data from the Medicaid Management Information System (MMIS), the Eligibility System, and claims payment system to analyze access. In addition to provider participation, the State also looks at changes in Medicaid enrollment, service utilization, and client calls regarding access or claims payment issues. That State has identified three measures that are known to influence health care access, and that would provide useful data on access to determine if there is an issue: i) percent change in Medicaid enrollment (measured quarterly), ii) provider Geo-Access reports, (quarterly reports that track the availability of providers and their proximity to beneficiaries), and iii) service utilization reports (monthly).

To date, Medicaid has not seen a decrease in providers willing to care for Medicaid clients or an increase in client complaints regarding access to psychiatric care. Medicaid will continue to monitor their access measures and ensure that accessibility does not decrease.

Other Considerations:	**Prior to submitting this SPA, the Nebraska Division of Medicaid Long-Term Care sought consultation from federally recognized Native American Tribes with the State to discuss the impact that the proposed SPA might have, if any, on the Tribes. No comments were received.** **We do not recommend the Secretary contact the governor.**
CMS Contact:	**Tim Weidler, NIRT 816-426-6429**