

## **Table of Contents**

**State/Territory Name: NE**

**State Plan Amendment (SPA) #: 19-0010**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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**Financial Management Group**

December 3, 2019

Matthew A. Van Patton, DHA, Director  
Division of Medicaid and Long Term Care  
Nebraska Department of Health and Human Services  
301 Centennial Mall South  
Lincoln, NE 68509

RE: Nebraska SPA 19-0010

Dear Mr. Van Patton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0010. This amendment increases Inpatient Hospital service payment rates by two percent (2%) and Inpatient Psychiatric payment rates by four percent (4%) over levels previously in effect.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923(g) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 19-0010 is approved effective July 31, 2019. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan  
Director

CC: Heather Juhring  
Tim Weidler

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: NE 19-0010	2. STATE Nebraska
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 31, 2019	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY 2019      \$1,067,240 b. FFY 2020      \$6,684,743	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Att. 4.19-A Pages 5, 8, 10, 11, 16, 17, 17a, 30 Att. 4.19-A Page 16a (new page)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Att. 4.19-A Pages 5, 8, 10, 11, 16, 17, 17a, 30	
10. SUBJECT OF AMENDMENT: SFY20 Inpatient Provider Rates			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Governor has waived review <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Matthew A. Van Patton, DHA		Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509	
14. TITLE: Director, Division of Medicaid and Long-Term Care			
15. DATE SUBMITTED: September 23, 2019			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: DEC 03 2019	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Kristin Fan JUL 31 2019		22. TITLE: Director, FMG	
23. REMARKS:			

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 DRG. Peer Group Base Payment Amounts effective July 1, 2016, are calculated for Peer Group 1, 2 and 3 hospitals based on the Peer Group Base Payment Amounts effective during SFY 2011, adjusted for budget neutrality, calculated as follows:

1. Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2011 Peer Group 1 Base Payment Amount of \$4,397.00 by the DRG budget neutrality factor.
2. Children's Hospital Peer Group 1 Base Payment Amounts: Multiply the SFY 2011 Children's Hospital Peer Group 1 Base Payment Amount of \$5,278.00 by the DRG budget neutrality factor.
3. Peer Group 2 Base Payment Amounts: Multiply the SFY 2011 Peer Group 2 Base Payment Amount of \$4,270.00 by the DRG budget neutrality factor.
4. Peer Group 3 Base Payment Amounts: Multiply the SFY 2011 Peer Group 3 Base Payment Amount of \$4,044.00 by the 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 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. The Peer Group Base Payment Amount effective July 1, 2011 will be increased by 1.54% effective July 1, 2012. The Peer Group Base Payment Amount effective July 1, 2012 will be increased by 2.25% effective July 1, 2013. The Peer Group Base Payment Amount effective July 1, 2013 will be increased by 2.25% effective July 1, 2014. The Peer Group Base Payment Amount effective July 1, 2014 will be increased by 2% effective July 1, 2015. The Peer Group Base Payment amount effective July 1, 2015, will be increased by 2% effective July 1, 2016. The Peer Group Base Payment amount effective July 1, 2016, will be increased by 2% effective July 31, 2019.

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%. Effective July 1, 2012, the direct medical education amount shall be increased by 1.54%. Effective July 1, 2013, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2014, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2015, the direct medical education amount shall be increased by 2%. Effective July 1, 2016, the direct medical education amount shall be increased by 2%. Effective July 31, 2019, the direct medical education amount shall be increased by 2%.

10-010.03B3b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from Nebraska Medicaid, 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 using the following formula:

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

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.

10-010.03B3c Calculation of MCO Medical Education Payments: Nebraska Medicaid 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 MCO. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the fee-for service direct medical education payment per discharge in effect for the rate year July 1 through June 30.

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Transmittal # NE 19-0010  
Supersedes  
Transmittal # NE 16-0010

Approved DEC 03 2019 Effective JUL 31 2019



10-010.03B4 Calculation of 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. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the 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. Capital-Related Payment Per Diem Amounts effective July, 2011 will be increased by 1.54% effective July 1, 2012. Capital-Related payment Per Diem Amounts effective July, 2012 will be increased by 2.25% effective July 1, 2013. Capital-Related payment Per Diem Amounts effective July, 2013 will be increased by 2.25% effective July 1, 2014. Capital-Related payment Per Diem amounts effective July 1, 2014 will be increased by 2% effective July 1, 2015. Capital-Related payment Per Diem amounts effective July 1, 2015, will be increased by 2% effective July 1, 2016. Capital-Related payment Per Diem amounts effective July 1, 2016, will be increased by 2% effective July 31, 2019.

10-010.03B5 – (RESERVED)

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Transmittal # NE 19-0010  
Supersedes  
Transmittal # NE 16-0010

Approved DEC 03 2019

Effective JUL 31 2019

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.  
Effective July 1, 2012, the Transplant DRG CCRs will be increased by 1.54 percent.  
Effective July 1, 2013, the Transplant DRG CCRs will be increased by 2.25%.  
Effective July 1, 2014, the Transplant DRG CCRs will be increased by 2.25%.  
Effective July 1, 2015, the Transplant DRG CCRs will be increased by 2%.  
Effective July 1, 2016, the Transplant DRG CCRs will be increased by 2%.  
Effective July 31, 2019, the Transplant DRG CCRs will be increased by 2%.

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

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 acute psychiatric inpatient services. 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 is made for the day of admission, but not the day of discharge.

For payment of inpatient hospital psychiatric services, effective July 1, 2014, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	\$715.32
Days 3 and 4	\$661.55
Days 5 and 6	\$631.18
Days 7 and greater	\$601.14

For payment of inpatient hospital psychiatric services, effective July 1, 2015, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	\$731.41
Days 3 and 4	\$676.43
Days 5 and 6	\$645.38
Days 7 and greater	\$614.67

For payment of inpatient hospital psychiatric services, effective July 1, 2016, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	\$747.87
Days 3 and 4	\$691.65
Days 5 and 6	\$659.90
Days 7 and greater	\$628.50

For payment of inpatient hospital psychiatric services, effective July 31, 2019, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	\$777.79
Days 3 and 4	\$719.32
Days 5 and 6	\$686.30
Days 7 and greater	\$653.64



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.

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Transmittal # New Page  
Supersedes \_\_\_\_\_  
Transmittal # \_\_\_\_\_

DEC 03 2019  
Approved \_\_\_\_\_

Effective JUL 31 2019

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%. Effective July 1, 2012, the transplant DRG DME rates will be increased by 1.54%. Effective July 1, 2013, the transplant DRG DME rates will be increased by 2.25%. Effective July 1, 2014, the transplant DRG DME rates will be increased by 2.25%. Effective July 1, 2015, the transplant DRG DME rates will be increased by 2%. Effective July 1, 2016, the transplant DRG DME rates will be increased by 2%. Effective July 31, 2019, the transplant DRG DME rates will be increased by 2%.

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, 2015, 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.

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Transmittal # NE 19-0010  
Supersedes  
Transmittal # NE 16-0010

Approved DEC 03 2019

Effective JUL 31 2019

10-010.03D5 Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. This rate may be reviewed annually. Effective April 12, 2008, the payment for psychiatric adult subacute inpatient hospital services identified in state regulations was \$488.13. Beginning July 1, 2008, the per diem rate was \$505.21 and on November 24, 2009 onward the rate is \$512.79. On July 1, 2010, there will be a .5% rate increase. On July 1, 2011, there will be a 2.5% rate decrease. On July 1, 2012 there is a 1.54% increase. On July 1, 2013, there will be a 2.25% rate increase. On July 1, 2014, there will be a 2.25% rate increase. On July 1, 2015, there will be a 2.25% rate increase. On July 1, 2016, there will be a 2.25% rate increase. On July 31, 2019, there will be a 4% rate increase. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services.

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Transmittal # NE 19-0010  
Supersedes  
Transmittal # NE 16-0010

Approved DEC 03 2019 Effective JUL 31 2019

STATE: NEBRASKA

[http://dhhs.ne.gov/medicaid/Pages/med\\_medindex.aspx](http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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**INPATIENT PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs) FOR INDIVIDUALS UNDER AGE 19 (cont.)**

The PRTF reimbursement is for treatment, provided by and in the facility when it was found during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child's care per 42 CFR 441.155 and address on the active treatment plan. The PRTF per diem includes all care found on the active treatment plan per the assessed needs at 42 CFR 441.155 except for physician, medically necessary services and/or supplies including dental, vision, diagnostic/radiology, prescribed medications, not otherwise included in the PRTF rate, which are reimbursed separately on a fee schedule set consistent with the methodology outlined in Attachment 4.19-B, Item 12. The PRTF reasonable activities are child specific and must be necessary for the health and maintenance of health of the child while he or she is a resident of the facility. The medically necessary care must constitute a need that contributes to the inpatient treatment of the child. The Physician activities in PRTFs will be reimbursed based on a fee schedule set consistent with the methodology outlined in Attachment 4.19-B, Item 5.

The PRTF treatment activities included in the per diem rates that must be provided by the facility are those activities that can reasonably be anticipated and placed on the active treatment plan according to the assessed needs of the child. The prospective per diem rate is considered payment in full for these Medicaid-eligible portions of the payment rate per 42 CFR 447.15, and may not be balance billed to the family or legal guardian.

**PRTF Treatment Activities in Per Diem PRTF Fee Schedule Rates**

**Hospital Based PRTF**

OT/PT/ST

Laboratory

Transportation

**Free-Standing PRTF:**

OT/PT/ST

Laboratory

Transportation

Except as otherwise noted in the plan, the state-developed fee schedule are the same for both governmental and private providers of inpatient psychiatric residential treatment facility services. The agency's fee schedule rate was set as of July 31, 2019, and is effective for services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>.

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Transmittal # NE 19-0010  
Supersedes  
Transmittal # NE 16-0010

Approved DEC 03 2019 Effective JUL 31 2019