

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.

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APR-DRG (All Patient Refined Diagnosis Related Group): A Diagnosis Related Group classification system.

Base Year: The period covered by the most recent 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.

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each DRG and Severity of Illness (SOI).

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 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.

LONG TERM ACUTE CARE HOSPITAL (LTACH): A hospital that is licensed as a general acute care hospital that focuses on treating patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. Patients treated in a Long Term Acute Care Hospital are not generally appropriate for lower level-of-care settings, but are expected to improve to lower level-of-care status.

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

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.

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 Nebraska Medicaid, 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 fiscal intermediary.

National Weights: The 3M APR-DRG National Weights are calculated using the Nationwide Inpatient Sample (NIS) released by the Healthcare Cost and Utilization Project (HCUP).

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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.

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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 base payment amount is the same for all hospitals in a peer group except Peer Group 1 (Children's Hospitals), Peer Group 5 and Peer Group 6.

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

Resource Intensity: The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

Risk of Mortality (ROM): The likelihood of dying.

Severity of Illness level (SOI): The extent of physiologic decompensation or organ system loss of function.

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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.

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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 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 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 DRG is calculated by multiplying the peer group base payment amount by the applicable national relative weight.

10-010.03B1a Calculation of the APR-DRG Weights: For dates of service on or after July 1, 2014, the department will use the All-Patient Refined Diagnosis Related Groups (APR-DRG) grouper to determine DRG classifications. The National Weights published by 3M will be applied to the APR-DRGs. The National Weights are calculated using the Nationwide Inpatient Sample (NIS) released by the Healthcare Cost and Utilization Project (HCUP). The Department will annually update the APR-DRG grouper and national relative weights with the most current available version.

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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. The Peer Group Base Payment amount effective July 31, 2019, will be increased by 2% effective July 1, 2020. The Peer Group Base Payment amount effective July 1, 2020 will be increased by 2% effective July 1, 2021. The Peer Group Base Payment amount effective July 1, 2021 will be increased by 2% effective July 1, 2022. The Peer Group Base Payment amount effective July 1, 2022 will be increased by 3%, effective July 1, 2023.

10-010.03B2 Calculation of DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a DRG meeting or exceeding Medicaid criteria for cost outliers for each 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 \$30,000 for all neonate and nervous system APR-DRGs at severity level 3 and at severity level 4. For all other APR-DRGs, 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 \$51,800. 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% of the difference between the hospital's cost for the discharge and the outlier threshold.

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.

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.

Calculation of Medical Education Costs

Calculation of Direct Medical Education Cost Payments:

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 all APR-DRG discharges except 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.

Nebraska hospital-specific DME payment rates are described in state regulations.

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 of the year preceding the beginning of the Nebraska rate year.

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Calculation of Indirect Medical Education (IME) Cost Payments:

Indirect medical education (IME) cost payments shall be made to eligible Nebraska teaching hospitals and are calculated by multiplying an IME Factor by the Operating Cost Payment amount.

To calculate annual IME Factor on July 1 of each year, the Department will extract from the CMS Web Pricer Inpatient Prospective Payment System (PPS) the hospital-specific intern-to-bed ratio effective October 1 of the year preceding the beginning of the Nebraska rate year. Hospitals excluded from the Medicare prospective payment system under 42 CFR § 412.23 will have a provider specific intern-to-bed ratio calculated using their Medicare cost report.

The intern-to-bed ratio is then utilized in the formula below to calculate the annual IME Factor:

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

The IME Factor is not subject to Nebraska Legislative appropriations.

Calculation of MCO Medical Education Payments: The Department will calculate annual MCO direct medical education (DME) payments and MCO indirect medical education (IME) payments for services provided by capitated plans from discharge data provided by the plans.

1. MCO DME payments will be equal to the number of MCO discharges times the fee-for-service DME payment per discharge.
2. MCO IME payments will be equal to the fee-for-service IME operating factor multiplied by the MCO payments for hospital operating costs.

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. Capital-Related payment Per Diem amounts effective July 31, 2019, will be increased by 2% effective July 1, 2020. Capital-related payment per diem amounts effective July 1, 2020 will be increased by 2% effective July 1, 2021. Capital-related per diem amounts effective July 1, 2021 will be increased by 2% effective July 1, 2022. Capital-related payment per diem amounts effective July 1, 2022 will be increased by 3%, effective July 1, 2023.

10-010.03B5 – (RESERVED)

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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.

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 Web Pricer Inpatient Prospective Payment System (PPS) 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, 2022, the Transplant DRG CCRs will be increased by 2%.
Effective July 1, 2023, the Transplant DRG CCRs will be increased by 3%.
Effective July 1, 2024, the Transplant DRG CCRs will not be increased.

Transplant DRG DME Payments: Transplant DME cost payments are based on Nebraska hospital specific DME payment rates determined each State Fiscal Year. Each SFY Nebraska hospital specific Transplant DME payment rates shall be adjusted by a percentage. This percentage shall be determined by Nebraska Legislature appropriations. The Transplant DME payment rates are adjusted annually and shall be effective each July 1.

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, 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 SFY 2011. The fiscal simulation analysis includes discharges grouped into a DRG and excludes all psychiatric, rehabilitation and transplant discharges.

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 July 1, 2014, the Department will inflate the SFY 2011 base rates by 61.05%.

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 reconciliation will be made within 6 months following receipt by the Department of the facility's 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.

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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: Nebraska Medicaid adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All Nebraska Medicaid 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: Nebraska Medicaid'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 (HAC)

Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as an HAC, those secondary diagnosis codes that have been identified as Medicare HACs when not present on hospital admission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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TN # New Page

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Non-Payment for Hospital Acquired Conditions:

Effective July 1, 2011 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Health Care-Acquired Condition (HCAC).

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges.

Provider Preventable conditions (PPC), which includes Health Care-Acquired Condition (HCAC), with diagnosis codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Providers must identify and report PPC occurrences.

For hospitals reimbursed under a per diem methodology, to the extent that the cost of the hospital acquired condition can be isolated, payment for the cost of the hospital acquired condition will be denied.

Non-Payment for Other Provider Preventable Conditions

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report other provider preventable conditions.

Prohibition on payments for PPC, and HCAC, shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid proportionate share hospital payments.

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TN # New Page

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 |

For payment of inpatient hospital psychiatric services, effective July 1, 2020, the tiered per diem rate will be:

| Days of Service | Per Diem Rate |
|--------------------|---------------|
| Days 1 and 2 | \$809.00 |
| Days 3 and 4 | \$748.00 |
| Days 5 and 6 | \$714.00 |
| Days 7 and greater | \$680.00 |

For payment of inpatient hospital psychiatric services, effective July 1, 2023, the tiered per diem rate will be:

| Days of Service | Per Diem Rate |
|------------------------|----------------------|
| Days 1 and 2 | \$994.30 |
| Days 3 and 4 | \$919.55 |
| Days 5 and 6 | \$877.34 |
| Days 7 and greater | \$835.60 |

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. Hospital-Specific Per Diem
2. Direct Medical Education (DME) Cost Payment, 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. Per diem payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations.

Payments for Long Term Acute Care Hospital (LTACH) Services:

Payments for long term acute care hospitals discharges are made on a prospective per diem, depending on whether the client requires ventilator or non-ventilator services (whichever is applicable), as determined by prior authorization review. A prior authorization is required for all long term acute care hospital services for either ventilator or non-ventilator services.

The per diem will be the sum of:

1. LTACH ventilator or non-ventilator per diem; and
2. Direct Medical Education (DME) Cost Payment, 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 the day of discharge.

To establish baseline per diem rates for both ventilator and non-ventilator LTACH services, Nebraska modeled state fiscal year 2025 (SFY25) LTACH per diem rates separately for non-ventilator and ventilator services, where ventilator services are identified based on ICD-10 procedure code.

The SFY25 LTACH routine per diem rate for non-ventilator cases is based on the statewide average Medicaid LTACH cost per day for LTACH non-ventilator encounters, excluding Medicare crossover and dual eligible claims, and with an appropriations' adjuster.

The SFY25 LTACH ventilator per diem rate includes a positive 15% rate differential in comparison to non-ventilator LTACH services based on a higher cost determination during initial rate establishment. The ventilator rate differential percentage will be reevaluated during each rebasing period and adjusted as needed.

Per diem payment amounts are subject to annual adjustment as specified by Nebraska Legislative appropriations and are periodically rebased.

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%. Effective July 1, 2020, the transplant DRG DME rates will be increased by 2%. Effective July 1, 2021 the transplant DRG DME rates will be increased by 2%. Effective July 1, 2022, the transplant DRG DME rates will be increased by 2%. Effective July 1, 2023, the transplant DRG DME rates will be increased by 3%.

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.

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. On July 1, 2020, there will be a 4% rate increase. On July 1, 2021 there will be a 2% rate increase. On July 1, 2022, there will be a 17% rate increase. On July 1, 2023, there will be a 3% 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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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 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.
3. When notified by the Department that the hospital qualifies as a Disproportionate Share Hospital (DSH), each hospital must certify to the Nebraska Medical Assistance Program that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the DSH payment.

10-010.03H1 Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital's Medicaid days, which includes the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the MMIS claims file data will be included.

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2. To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease (IMDs). For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

10-010.03H2 Disproportionate Share Hospital Upper Payment Limit and Uncompensated Care Calculation: The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

1. The Department will calculate the Medicaid shortfall as follows:
 - a. The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
 - (1) Calculating a hospital's routine cost per day for each cost center (e.g. Adult, Pediatrics, etc) from the CMS 2552 cost report by dividing the total costs by the total days, and
 - (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year,
 - b. The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
 - (1) Calculating a hospital's ancillary cost to charge ratio from the CMS 2552 cost report, and
 - (2) Multiplying the total Medicaid allowable charges times the ancillary cost to charge ratio.
 - c. The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital.
 - d. The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.
2. The Department will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the CMS cost report used in determining costs. The Department will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the overall cost-to-charge ratio determined using each hospital's CMS 2552 report for the same fiscal year used in determining cost.
3. The Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Medicaid shortfall plus the cost of uninsured care.

10-010.03H3 Disproportionate Share Payments: Disproportionate share payments will be made each federal fiscal year (FFY) following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services (CMS) in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken.

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To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

10-010.03H3a For FFY07 and succeeding years, the Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

10-010.03H3a(1) Basic Disproportionate Share Payment (Pool 1): Pool 1 consists of eligible hospitals in Peer Groups 2, 3, and 6 that are not eligible under Pool 6.

10-010.03H3a(1)(a) Total funding to Pool 1 will be \$1,000,000. In FFY 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of- state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.
2. Second, the ratio resulting from such division will be multiplied times the total funding for Pool 1 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under section 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals within Pool 1.

10-010.03H3a(2) Basic Disproportionate Share Payment Pool 2: Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

10-010.03H3a(2)(a) Total funding to Pool 2 will be \$3,154,000 for FFY 2007, and \$2,654,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment for Pool 2 as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 2.
2. Second, the ratio resulting from the division will be multiplied times the total funding for Pool 2 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 2, the additional funds will be redistributed prorata to eligible hospitals within Pool 2.

10-010.03H3a(3) Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 3): Pool 3 consists of the hospital that both primarily serves children age 20 and under, and has the greatest number of Medicaid days.

10-010.03H3a(3)(a) Total funding for Pool 3 will be \$3,138,000 for FFY 2007, and \$3,638,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.

10-D10.03H3a(4) Disproportionate Share Payment for State Owned Institutions for Mental Disease (IMD) Hospitals and for eligible hospitals in Peer Group 4 (Pool 4): Pool 4 consists of state owned institutions for mental disease and other eligible hospitals in Peer Group 4.

10-010.03H3a(4)a Total funding for Pool 4 will be \$1,811,337 annually. The Department will calculate payments as follows:

1. Each eligible hospitals must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospitals cost to charge ratio.
2. Payment to each hospital will be equal to the cost of its uncompensated care.

3. If the total of all disproportionate share payment amounts for Pool 4 exceeds the federally determined disproportionate share hospital limit for Nebraska, the will be reduced prorata.

10-010.03H3a(5) Non-Profit Acute Care Teaching Hospital Affiliated with a State-Owned University Medical College (Pool 5): Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

10-0103H3a(5)(a) Total funding to Pool 5 will be \$15,000,000. For FFY 08 and following years the funding will be increased annually by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) .

The Department will calculate the DSH payment to Pool 4 5 as an amount equal to the cost of its uncompensated care.

If the payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

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10-010.03H3a(6) Uncompensated Care Pool (Pool 6): Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance (GA) program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

10-010.03H3a(6)(a) Total funding to Pool 6 will be the remaining balance of the total (federal and state) DSH funding minus the funding for Pools 1, 2, 3, 4, and 5, The Department will calculate payments as follows:

1. DSH payments to a hospital under all other pools will be subtracted from the hospital's DSH upper payment limit before allocating payments under Pool 6.
2. The costs for uncompensated care resulting from participation in county administered general assistance (GA) program will be reported by the county; and costs for the state administered public behavioral health system will be reported by each hospital. Reported costs will be subject to audit by the Department.
3. A ratio for each hospital will be determined based on the uncompensated cost for each hospital to the total of uncompensated cost for all hospitals in Pool 6.
4. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount.
5. The total computable payment will be commensurate with the charges for uncompensated care resulting from participation in county administered general assistance (GA) program; or the state administered public behavioral health system.
6. The annual payment amount will be dispersed in twelve monthly payments.
7. If payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(g) of the Social Security Act, the payment will be reduced to the payment limit.
8. If payments to hospitals under this pool exceed the total allotment to Nebraska, the payments will be reduced prorata.

10-010.03H3b Limitations on disproportionate share payments:

- (1) No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923 (g)(1)(A) of the Social Security Act.
- (2) Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act.

10-010.03H4 Redistribution of DSH Overpayments: As required by Section 1923(j) of the Social Security Act related to auditing and reporting of Disproportionate Share Hospital payments, the Department will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009.

Beginning in DSH State Plan Rate Year 2011, if the results of audits conducted in accordance with the DSH final rule indicate that a hospital has exceeded the hospital specific DSH limit the amount of DSH payment in excess of uncompensated care costs will be recouped. Any funds recouped shall first be recouped from Pool 1 through 5 payments and then from Pool 6 payments and shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds recouped from Pools 1 through 6 shall first be redistributed to each eligible hospital in the Pool in which the hospital payment was recouped. Any recouped funds that are not able to be distributed within the Pool will accumulate and be redistributed to all eligible hospitals. The Department will calculate the redistribution as follows:

1. Pool Redistribution
 - a. First, for each Pool in which funds were recouped beginning with Pool 1 and proceeding in Pool numerical order, each hospital's difference between their DSH payment and DSH limit will be calculated. The difference will be divided by the sum of the difference between the DSH payment and DSH limit for all hospitals in the Pool.
 - b. Second, the ratio resulting from such division will be multiplied times the total funding recouped for the Pool to determine each hospital's redistribution payment.
 - c. If the sum of the original DSH payment and redistribution payment exceeds the DSH payment limit, the payment will be reduced.
 - d. If payment is reduced to a hospital within a Pool, the additional funds will be redistributed prorata to eligible hospitals within the Pool. If all hospitals within the Pool have reached their DSH limit, the remaining funds will be carried forward to be redistributed to all eligible hospitals. For Pool 6, each hospital's difference between their DSH payment and DSH limit will include funds redistributed from Pools 1 through 5 above.
2. Final Redistribution
 - a. First, for any funds that were not redistributed for each Pool in which funds were recouped, each hospital's (except for Pool 4 IMDs) difference between their DSH payment and DSH limit will be calculated. The difference will be divided by the sum of the difference between the DSH payment and DSH limit for all non-IMD hospitals.
 - b. Second, the ratio resulting from such division will be multiplied times the total recouped funding not already distributed to determine each hospital's redistribution payment.
 - c. If the sum of the original DSH payment and redistribution payment exceeds the DSH payment limit, the payment will be reduced.
 - d. If payment is reduced to a hospital, the additional funds will be redistributed prorata to eligible non-IMD hospitals within the Pool. If all non-IMD hospitals have reached their DSH limit, the federal portion of remaining funds will be returned to CMS.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services 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;
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 the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
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 the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the 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 ratio is the peer group average.

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.

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

10-010.03J1 Exception: The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that-

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under 471NAC 10-010.03ff.

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10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.030, and/or 10-010.03J. This is an exception to policies related to the elimination of combined billing in 471 NAC 10-003.05C and following.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting Following a Hospital Merger: Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.

10-010.030 Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1-5. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals located in a 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 a Regional Rural Referral Center;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year Medicaid discharges;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health 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 Nebraska Department of Health and distinct parts as defined in these regulations.
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

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10-010.03P Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

10-010.03Q Recapture of Depreciation: A hospital which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of
 - a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
 - b. The amount of gain on the sale as determined by the Medicare intermediary.

$$\frac{\text{\# of Medicaid Inpatient Days}}{\text{Total \# of Inpatient Days}} \times \text{Gain on Sale in \$} = \text{Recapture Amount}$$

The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

10-010.03R Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

10-010.03S Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no . skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

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When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the PASP days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the PASP days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill for class of care 81 and enter the prior authorization document number from Form MC-9 on Form HCFA-1450 (UB-92). The claim for the PASP days must be separate from the claim for the inpatient days paid at the acute rate. The PASP days will be disallowed as acute care days and NMAP will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the PASP day. PASP days will not be considered in computing the hospital's prospective rate.

10-010.03T Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, and/or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

10-010.03U Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

10-010.03V Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2-003 ff. A hospital may also request an adjustment to its rate (see 471 NAC 10-010.03W).

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10-010.03W Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. extraordinary circumstances are limited to -
 - a. Changes in routine and ancillary costs, which are limited to -
 - (1) Intern and resident related medical education costs; and
 - (2) Establishment of a subspecialty care unit;
 - b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.
3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
 - a. One-time occurrence;
 - b. Less than twelve-month duration;
 - c. Could not have been reasonably predicted;
 - d. Not of an insurable nature;
 - e. Not covered by federal or state disaster relief;
 - f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.

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In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.
2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.
3. The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

Requests for rate adjustments must be submitted in writing to the Administrator, Medicaid Division, Nebraska Department of Health and Human Services Finance and Support. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under no circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.

10-010.03X Administrative Finality: See 471 NAC 3-001.09.

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

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STATE: NEBRASKA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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

Reimbursement for inpatient psychiatric services for under age 19 in a PRTF is based on a Medicaid fee schedule established by the State of Nebraska with prospective, statewide per diem rates for each reimbursement category of facility. Payment will be a per diem for active treatment on each child's treatment plan provided by the facility. Medically necessary services and/or supplies, including dental, vision, diagnostic/radiology, prescribed medications, not otherwise included in the PRTF rate when that care is reflected in the individual's plan of care may be billed directly to Medicaid. Physician activities on the treatment plan provided by and in the facility will be paid separately. The reimbursement categories are as follows:

- General hospital-based PRTF;
- General free-standing PRTF; and
- Specialty free-standing PRTF, including facilities treating multiple conditions or sexually deviant behaviors

The fee schedule will be based on modeled costs. Costs for private, in-state facilities consistent with 42 CFR Section 413, Nebraska regulations and policies, OMB Circular A-122 and the Medicare Provider Reimbursement Manual (CMS Publication 15-1), commercial third party payments and market rates will be considered when establishing the fee schedules. For PRTFs, the rates will consider the allowable costs as reported by providers in a standardized expense report. The cost data are adjusted to reflect changes in the service definition, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect. In addition, the cost data are adjusted for cost of living increases. DHHS will not pay more than the facility's usual and customary daily charges billed for eligible recipients. Fees will not exceed the Medicare upper limit when applicable. Fees will be consistent with efficiency, economy and quality of care per Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200. Fees will be sufficient to assure the availability of services to clients as required by 42 CFR 447.204. DHHS will not cost settle for services provided to recipients admitted to privately operated PRTFs reimbursed under the above fee schedule prospective payment system. The statewide prospective fee schedule per diems shall constitute full reimbursement for privately operated PRTFs with pharmacy, medically necessary services and/or supplies including dental, vision, diagnostic/radiology, not included in the PRTF rate and physician services being paid separately. Public PRTFs are IMDs and will be cost-settled per Attachment 4.19A, page 18. The PRTF per diem rates are for Medicaid clients under nineteen years of age unless, per 42 CFR 435.1009, the child was receiving PRTF inpatient psychiatric services under 42 CFR 440.160 prior to his 19th birthday, in which case the child may receive services until he is unconditionally released or, if earlier, the date he reaches age 19. Payment rates do not include costs of providing educational services.

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STATE: NEBRASKA

http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 1, 2023, 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>. From the landing page, scroll down to the fee schedule for the specific program and year.

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STATE: NEBRASKA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NON-ACUTE STAY – TEMPORARY

Medicaid will reimburse a hospital at one hundred percent of the statewide average nursing facility per diem rate for an individual if the individual: (a) Is enrolled in the medical assistance program; (b) has been admitted as an inpatient to such hospital; (c) no longer requires acute inpatient care and discharge planning as described in 42 C.F.R. 482.43; (d) requires nursing facility level of care upon discharge; and (e) is unable to be transferred to a nursing facility due to a lack of available nursing facility beds available to the individual or, in cases where the transfer requires a guardian, has been approved for appointment of a public guardian and the State Court Administrator is unable to appoint a public guardian.

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