TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 46 RATES FOR HOSPITAL SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68 901 et seq. (the Medical Assistance Act).

002. DEFINITIONS. The following definitions apply:

002.01 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.

002.02 ALL PATIENT REFINED-DIAGNOSIS RELATED GROUP. A diagnosis related group classification system.

002.03 BASE YEAR. The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

002.04 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.

002.05 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.

002.06 CASE-MIX INDEX. An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

002.07 COST OUTLIER. Cases which have an extraordinarily high cost as established in this chapter so as to be eligible for additional payments above and beyond the initial diagnosis related group payment.

002.08 CRITICAL ACCESS HOSPITAL. A hospital certified for participation by Medicare as a Critical Access Hospital.

002.09 DIAGNOSIS-RELATED GROUP. A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

002.10 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.

002.11 DISPROPORTIONATE SHARE HOSPITAL. A hospital located in Nebraska is deemed to be a disproportionate share hospital by having:

(A) A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or

(B) A low-income utilization rate of 25 percent or more.

002.12 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.

002.13 DIAGNOSIS RELATED GROUP WEIGHT. A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each diagnosis related group and severity of illness.

002.14 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.

002.15 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.

002.16 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 diagnosis related group cost-to-charge ratios payments are derived from the outlier cost-to-charge ratios in the Medicare inpatient prospective payment system.

002.17 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.

002.18 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:

(A) 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

(B) 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 health maintenance organizations, Medicare, or Blue Cross.

002.19 MEDICAID ALLOWABLE INPATIENT CHARGES. Total claim submitted charges less claim non-allowable amount.

002.20 MEDICAID ALLOWABLE INPATIENT DAYS. The total number of covered Medicaid inpatient days.

002.21 MEDICAID INPATIENT UTILIZATION RATE. The ratio of allowable Medicaid inpatient days, as determined by Nebraska Medicaid, to 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.

002.22 MEDICAID RATE PERIOD. The period of July 1 through the following June 30.

002.23 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.

002.24 MEDICARE COST REPORT. The report filed by each facility with its Medicare fiscal intermediary.

002.25 NATIONAL WEIGHTS. The 3M APR-DRG National Weights are calculated using the Nationwide Inpatient Sample released by the Healthcare Cost and Utilization Project. 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. 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. If a nursing facility is affiliated with the hospital, the nursing facility cost report must be filed according to this chapter. Note specifically that time guidelines for filing nursing facility cost reports differ from those for hospitals.

002.26 NEW OPERATIONAL FACILITY. A facility providing inpatient hospital care which meets one of the following criteria:

(A) 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;

(B) A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or

(C) 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. 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.

002.27 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.

002.28 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:

(A) Metro acute care hospitals: Peer Group 1: Hospitals located in metropolitan statistical areas as designated by Medicare;

(B) Other urban acute care hospitals: Peer Group 2: Hospitals that have been redesignated to a metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as regional rural referral centers;

(C) Rural acute care hospitals: Peer Group 3: All other acute care hospitals;

(D) Psychiatric hospitals and distinct part units in acute care hospitals: Peer Group 4: 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;

(E) Rehabilitation hospitals and distinct part units in acute care hospitals: Peer Group 5: 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

(F) Critical access hospital: Peer Group 5: Hospitals that are certified as critical access hospitals by Medicare.

002.29 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.

002.30 REPORTING PERIOD. Same reporting period as that used for its Medicare cost report.

002.31 RESOURCE INTENSITY. The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

002.32 RISK OF MORTALITY (ROM). The likelihood of dying.

002.33 SEVERITY OF ILLNESS LEVEL (SOI). The extent of physiologic decompensation or organ system loss of function.

002.34 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.

002.35 UNCOMPENSATED CARE. Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

003. 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 diagnosis related group, the total per discharge payment is the sum of the operating cost payment amount; the capital-related cost payment; and when applicable direct medical education cost payment; indirect medical education cost payment; and a cost outlier payment. For inpatient services that are classified into a transplant diagnosis related group, the total per discharge payment is the sum of the cost-to-charge ratio payment amount; and when applicable direct medical education cost payment.

003.01 DETERMINATION OF OPERATING COST PAYMENT AMOUNT. The hospital diagnosis related group operating cost payment amount for discharges that are classified into a diagnosis related group is calculated by multiplying the peer group base payment amount by the applicable national relative weight.

003.01(A) CALCULATION OF THE APR-DIAGNOSIS RELATED GROUP WEIGHTS. For dates of service on or after July 1, 2014, the Department will use the All-Patient Refined Diagnosis Related Groups classifications. The National Weights published by 3M will be applied to the all patient refined-diagnosis related groups. The National Weights are calculated using the nationwide inpatient sample released by the healthcare cost and utilization project. The Department will annually update the all patient refined-diagnosis related group grouper and national relative weights with the most current available version.

003.01(B) CALCULATION OF NEBRASKA PEER GROUP BASE PAYMENT AMOUNTS. Peer group base payment amounts are used to calculate payments for discharges with a diagnosis related group. 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 state fiscal year 2011, adjusted for budget neutrality, calculated as follows: peer group 1 base payment amounts, excluding children's hospitals: multiply the state fiscal year 2011 peer group 1 base payment amount of $4,397.00 by the diagnosis related group budget neutrality factor. Children’s hospital peer group 1 base payment amounts: multiply the state fiscal year 2011 children's hospital peer group 1 base payment amount of $5,278.00 by the diagnosis related group budget neutrality factor. Peer group 2 base payment amounts: multiply the state fiscal year 2011

peer group 2 base payment amount of $4,270.00 by the diagnosis related group budget neutrality factor. Peer group 3 base payment amounts: multiply the state fiscal year 2011 peer group 3 base payment amount of $4,044.00 by the diagnosis related group budget neutrality factor. State fiscal year 2007 Nebraska peer group base payment amounts are described in this chapter. 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 is subject to annual adjustment as specified by the Department.

003.02 CALCULATION OF DIAGNOSIS RELATED GROUP COST OUTLIER PAYMENT AMOUNTS. Additional payment is made for approved discharges classified into a diagnosis related group meeting or exceeding Medicaid criteria for cost outliers for each diagnosis related group 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 all patient refined-diagnosis related groups at severity level 3 and at severity level 4. For all other all patient refined-diagnosis related groups, 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 cost-to-charge ratios. 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.

003.02(A) HOSPITAL SPECIFIC MEDICARE OUTLIER COST-TO-CHARGE RATIOS. The Department will extract from the Center for Medicaid and Medicaid Services Prospective Payment System Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier cost-to-charge ratios effective October 1 of the year preceding the start of the Nebraska rate year.

003.02(B) OUTLIER COST-TO-CHARGE RATIO UPDATES. On July 1 of each year, the Department will update the outlier costs based on the Medicare outlier cost-to-charge ratios effective October 1 of the previous year.

003.03 CALCULATION OF MEDICAL EDUCATION COSTS.

003.03(A) CALCULATION OF DIRECT MEDICAL EDUCATION COST PAYMENTS. Direct Medical Education payments effective October 1, 2009 are based on Nebraska hospital-specific direct medical education payment rates effective during state fiscal year 2007 with the following adjustments: Estimate state fiscal year 2007 direct medical education payments for in-state teaching hospitals by applying state fiscal year 2007 direct medical education payment rates to state fiscal year 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include all patient refined-diagnosis related group discharges except psychiatric, rehabilitation and Medicaid Capitated Plans discharges. Divide the estimated state fiscal year 2007 direct medical education payments for each hospital by each hospital's number of intern and resident full time equivalents effective in

the Medicare system on October 1, 2006. Multiply the state fiscal year 2007 direct medical education payment per intern and resident full time equivalent by each hospital's number of intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008. Divide the direct medical education payments adjusted for full time equivalents effective October 1, 2008 by each hospital's number of state fiscal year 2007 claims. Multiply the direct medical education payment rates by the stable diagnosis related group budget neutrality factor. On July 1st of each year, the Department will update direct medical education payment rates by replacing each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection, with each hospital's intern and resident full time equivalents effective in the Medicare inpatient system on October 1 of the previous year. The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2010. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010. The direct medical education payment amount is subject to annual adjustment as specified by the Department.

003.03(B) CALCULATION OF INDIRECT MEDICAL EDUCATION COST PAYMENTS. Hospitals qualify for indirect medical education payments when they receive a direct medical education payment from 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 indirect medial education factor by the operating cost payment amount. The indirect medical education factor is the Medicare inpatient prospective payment system operating indirect medial education factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating indirect medical education factor shall be determined using data extracted from the Center for Medicare and Medicaid Services Prospective Payment System Inpatient Pricer Program using the following formula: Number of interns and residents divided by available beds; plus 1; to the power of 0.405; minus 1; multiplied by 1.35.

003.03(C) CALCULATION OF MANAGED CARE ORGANIZATION MEDICAL EDUCATION PAYMENTS. Medicaid will calculate annual MCO Direct Medical Education payments and managed care organization indirect medical education payments for services provided by Medicaid capitated plans from discharge data provided by the managed care organization. Managed care organization direct medical education payments will be equal to the number of managed care organization discharges times the fee-for service direct medical education payment per discharge in effect for the rate year July 1 through June 30. Managed care organization indirect medical education payments will be equal to the number of managed care organization discharges times the managed care organization indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows. Subtotal each teaching hospital’s fee-for-service inpatient acute indirect medical education prior year payments. Subtotal each teaching hospital’s fee-for-service inpatient covered prior state fiscal year charges. Divide each teaching hospital’s indirect medical education payments, by covered prior state fiscal year charges. Multiply this ratio times the covered charges in managed care organization paid claims in the base year. Divide this amount by the number of managed care organization paid claims in the base year.

003.03(D) 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 diagnosis related group. 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 state fiscal year 2007, adjusted for budget neutrality, as follows: Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 1 Capital-related payment per diem amount of $36.00 by the Stable diagnosis related group budget neutrality factor. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 2 Capital-related payment per diem amount of $31.00 by the stable diagnosis related group budget neutrality factor. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the state fiscal year 2007 Peer Group 3 Capital-related payment per diem amount of $18.00 by the Stable diagnosis related group budget neutrality factor. Capital Related Per Diem Amounts are subject to annual adjustments as specified by the Department.

003.03(E) TRANSPLANT DIAGNOSIS RELATED GROUP PAYMENTS. Transplant discharges, identified as discharges that are classified to a transplant diagnosis related group, are paid a transplant diagnosis related group cost-to-charge ratio payment and, if applicable, a direct medical education payment. Transplant diagnosis related group discharges do not receive separate cost outlier payments, independent medical examination cost payments or capital-related cost payments.

003.03(E)(i) TRANSPLANT DIAGNOSIS RELATED GROUP COST-TO-CHARGE RATIO PAYMENTS. Transplant diagnosis related group cost-to-charge ratio payments are calculated by multiplying the hospital-specific transplant diagnosis related group cost-to-charge ratio by Medicaid allowed claim charges. Transplant diagnosis related group cost-to-charge ratio are calculated as follows: Extract from the centers for Medicare and Medicaid services prospective payment system Inpatient pricer program for each hospital the Medicare inpatient prospective payment system operating and capital outlier cost to charge 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 cost-to-charge ratio in effect for the Medicare system on October 1, 2008; sum the operating and capital outlier cost-to-charge ratio; multiply the sum of the operating and capital outlier cost-to-charge ratios by the transplant diagnosis related group budget neutrality factor. On July 1 of each year, the Department will update the Transplant diagnosis related group cost-to-charge ratios based on the percentage change in Medicare outlier cost-to-charge ratios effective October 1 of the two previous years, before budget neutrality adjustments. Effective July 1, 2011, the transplant diagnosis related group cost-to-charge ratios will be reduced by 2.5%. Effective July 1, 2012, the transplant diagnosis related group cost-to-charge ratios will be increased by 1.54%. Effective July 1, 2013, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2014, the transplant diagnosis related group cost-to-charge ratios will be increased by 2.25%. Effective July 1, 2015, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2016, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%. Effective July 31, 2019, the transplant diagnosis

related group cost-to-charge ratios will be increased by 2%. Effective July 1, 2020, the transplant diagnosis related group cost-to-charge ratios will be increased by 2%.

003.03(E)(ii) TRANSPLANT DIAGNOSIS RELATED GROUP DIRECT MEDICAL EDUCATION PAYMENTS. Transplant diagnosis related group direct medical education payments are calculated using the same methodology described in subsection this chapter, with the exception that in step 4, direct medical education per discharge payment amounts are adjusted by the transplant diagnosis related group budget neutrality factor. On July 1st of each year, the Department will update transplant direct medical education payment per discharge rates as described in this regulation. On July 1st of each year, the Department will update transplant diagnosis related group direct medical education payment per discharge rates as described in this chapter.

003.03(F) BUDGET NEUTRALITY FACTORS. Peer Group Base Payment Amounts, are multiplied by budget neutrality factors, determined as follows:

003.03(F)(i) DEVELOP FISCAL SIMULATION ANALYSIS. The Department will develop a fiscal simulation analysis using Medicaid inpatient fee-for-service paid claims data from state fiscal year 2011. The fiscal simulation analysis includes discharges grouped into a diagnosis related group 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.

003.03(F)(ii) 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 state fiscal year 2011 base rates by 61.05%.

003.03(G) 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.

003.03(G)(i) 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 facilities 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.

003.03(H) 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 diagnosis related group payment. The average daily rate is calculated as the full diagnosis related group 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 diagnosis related group. For hospitals receiving a transferred patient, payment is the full diagnosis related group payment and, if applicable, cost outlier payment.

003.03(I) 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.

003.03(J) READMISSIONS. Medicaid adopts Medicare peer review organization regulations to control increased admissions or reduced services. All 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.

003.03(K) INTERIM PAYMENT FOR LONG-STAY PATIENTS. 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.

003.03(K)(i) 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.

003.03(L) PAYMENT FOR NON-PHYSICIAN ANESTHETIST FEES. Hospitals which meet the Medicare exception for payment of certified registered nurse anesthetist fees as a pass-through by Medicare will be paid for certified registered nurse anesthetist fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for certified registered nurse anesthetist services. Costs will be calculated using the hospital's specific anesthesia cost-to-charge ratio. Certified registered nurse anesthetist fees must be billed using revenue code 964 - Professional Fees Anesthetist on the HCFA-1450, UB-92, claim form.

004. NON-PAYMENT FOR HOSPITAL ACQUIRED CONDITIONS. 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 a hospital acquired condition, those secondary diagnosis codes that have been identified as Medicare hospital acquired conditions when not present on hospital admission.

005. 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: $715.32 for 1 and 2 days of service; $661.55 for 3 and 4 days of service; $631.18 for 5 and 6 days of service; and $601.14 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2015, the tiered per diem rate will be: $731.41 for 1 and 2 days of service; $676.43 for 3 and 4 days of service; $645.38 for 5 and 6 days of service; and $614.67 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2016, the tiered per diem rate will be: $747.87 for 1 and 2 days of service; $691.65 for 3 and 4 days of service; $659.90 for 5 and 6 days of service; and $628.50 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 31, 2019, the tiered per diem rate will be: $777.79 for 1 and 2 days of service; $719.32 for 3 and 4 days of service; $686.30 for 5 and 6 days of service; and $653.64 for 7 and greater days of service. For payment of inpatient hospital psychiatric services, effective July 1, 2020, the tiered per diem rate will be: $809.00 for 1 and 2 days of service; $748.00 for 3 and 4 days of service; $714.00 for 5 and 6 days of service; and $680.00 for 7 and 8 days of service.

005.01 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. 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.

006. 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: the hospital-specific base payment per diem rate; the hospital-specific capital per diem rate; and 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.

006.01 ADJUSTMENT OF HOSPITAL-SPECIFIC BASE PAYMENT AMOUNT. The hospital specific per diem rates may be adjusted annually as specified by the Department.

006.02 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 this chapter.

007. PAYMENT FOR SERVICES FURNISHED BY A CRITICAL ACCESS HOSPITAL. Effective for cost reporting periods beginning July 1, 2015, and after payment for inpatient services of a critical access hospital 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 rule, ceilings on hospital operating costs, and the reasonable compensation equivalent limits for physician services to providers. Subject to the 96-hour average on inpatient stays in critical access hospitals, items and services that a critical access hospital 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.

008. RATES FOR STATE-OPERATED INSTITUTIONS OF MENTAL DISEASE. Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated institutions of mental diseases will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

009. 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:

(A) 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 Medicaid. This requirement does not apply to a hospital:
  (i) The inpatients of which are predominantly individuals under 18 years of age;
  (ii) Which does not offer non-emergency obstetric services to the general population as of December 21, 1987; or

(iii) 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;

(B) Only Nebraska hospitals which have a current enrollment with Medicaid will be considered for eligibility as a disproportionate share hospital; and

(C) When notified by the Department that the hospital qualifies as a disproportionate share hospital, each hospital must certify to Medicaid that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the disproportionate share hospital payment.

009.01 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.

009.01(A) MEDICAID INPATIENT UTILIZATION RATE. 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 Medicaid management information system 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 Medicaid management information system claims file data will be included.

009.02(B) LOW INCOME UTILIZATION RATE. 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. 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.

009.02 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.

(A) The Department will calculate the Medicaid shortfall as follows:

(i) 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 from the Centers for Medicare and Medicaid Services 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.

(ii) 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 Centers for Medicare and Medicaid Services 2552 cost report; and

(2) Multiplying the total Medicaid allowable charges times the ancillary cost-to-charge ratio.

(iii) The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital; and

(iv) The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.

(B) 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 Centers for Medicare and Medicaid Services 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 Centers for Medicare and Medicaid Services 2552 report for the same fiscal year used in determining cost; and

(C) The Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Medicaid shortfall plus the cost of uninsured care.

009.03 DISPROPORTIONATE SHARE PAYMENTS. Disproportionate share payments will be made each federal fiscal year 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 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. 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.

009.03(A) METHODS. For federal fiscal year 2007 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.

009.03(A)(i) 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.

009.03(A)(i)(1) POOL 1. Total funding to Pool 1 will be $1,000,000. In federal fiscal year 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. First, each hospital's Medicaid days, which include days from the Medicaid management information system 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. Second, the ratio resulting from such division will be multiplied times the total funding for pool 1 to determine each hospital's payment. 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. If payment is reduced to a hospital within pool 1, the additional funds will be redistributed pro rata to eligible hospitals within pool 1.

009.03(A)(i)(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.

009.03(A)(i)(2)(a) POOL 2. Total funding to pool 2 will be $3,154,000 for federal fiscal year 2007, and $2,654,000 for federal fiscal year 2008. For federal fiscal year 2009 and following years, the total funding will be the amount for federal fiscal year 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. First, each hospital's Medicaid days, which include days from the Medicaid management information system 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. Second, the ratio resulting from the division will be multiplied times the total funding for Pool 2 to determine each hospital's payment. 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. If payment is reduced to a hospital within pool 2, the additional funds will be redistributed pro rata to eligible hospitals within pool 2.

009.03(A)(i)(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.

009.03(A)(i)(3)(a) POOL 3 FUNDING. Total funding for pool 3 will be $3,138,000 for federal fiscal year 2007, and $3,638,000 for federal fiscal year 2008. For federal fiscal year 2009 and following years, the total funding will be the amount for federal fiscal year 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.

009.03(A)(i)(4) DISPROPORTIONATE SHARE PAYMENT FOR STATE OWNED INSTITUTIONS FOR MENTAL DISEASE 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.

009.03(A)(i)(4)(a) POOL 4 FUNDING. Total funding for Pool 4 will be $1,811,337 annually. The Department will calculate payments as follows.

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. Payment to each hospital will be equal to the cost of its uncompensated care. 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 pro rata.

009.03(A)(i)(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.

009.03(A)(i)(5)(a) POOL 5 FUNDING. 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 disproportionate share hospital 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.

009.03(A)(i)(6) UNCOMPENSATED CARE POOL. Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

009.03(A)(i)(6)(a) POOL 6 FUNDING. Total funding to Pool 6 will be the remaining balance of the total, federal and state, disproportional share hospital funding minus the funding for pools 1, 2, 3, 4, and 5, The Department will calculate payments as follows. Disproportionate share hospital payments to a hospital under all other pools will be subtracted from the hospital's disproportionate share hospital upper payment limit before allocating payments under pool 6. The costs for uncompensated care resulting from participation in county administered general assistance 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. 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. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount. The total computable payment will be commensurate with the charges for uncompensated care

resulting from participation in county administered general assistance program; or the state administered public behavioral health system. The annual payment amount will be dispersed in twelve monthly payments. 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. If payments to hospitals under this pool exceed the total allotment to Nebraska, the payments will be reduced pro rata.

009.03(B) LIMITATIONS ON DISPROPORTIONATE SHARE PAYMENTS. 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. 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.

009.04 REDISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL 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 disproportionate share hospital state plan rate year 2011, if the results of audits conducted in accordance with the disproportionate share hospital final rule indicate that a hospital has exceeded the hospital specific disproportionate share hospital limit the amount of disproportionate share hospital 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 disproportionate share hospital 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.

009.04(A) CALCULATION. The Department will calculate the redistribution as follows. 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 disproportionate share hospital payment and disproportionate share hospital limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospital payment and disproportionate share hospital limit for all hospitals in the pool. 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. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospital payment limit, the payment will be reduced. If payment is reduced to a hospital within a pool, the additional funds will be redistributed pro rata to eligible hospitals within the pool. If all hospitals within the Pool have reached their disproportionate share hospital limit, the remaining funds will be carried forward to be redistributed to all eligible hospitals. For pool 6, each hospital's difference between their disproportionate share hospital payment and disproportionate share hospital limit will include funds redistributed from pools 1 through 5 above.

009.04(B) FINAL REDISTRIBUTION. The final redistribution will be calculated as follows. First, for any funds that were not redistributed for each pool in which funds were recouped, each hospitals, except for pool 4 institutions of mental disease difference between their disproportionate share hospitals payment and disproportionate share hospitals limit will be calculated. The difference will be divided by the sum of the difference between the disproportionate share hospitals payment and disproportionate share hospitals limit for all non-institutions of mental disease hospitals. 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. If the sum of the original disproportionate share hospital payment and redistribution payment exceeds the disproportionate share hospitals payment limit, the payment will be reduced. If payment is reduced to a hospital, the additional funds will be redistributed pro rata to eligible non-institutions of mental disease hospitals within the pool. If all non-institutions of mental disease hospitals have reached their disproportionate share hospital limit, the federal portion of remaining funds will be returned to the Centers for Medicare and Medicaid Services.

010. 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: metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; rural acute care hospitals, all other acute care hospitals; 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 this chapter; and 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 this chapter. 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.

010.01 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 this chapter only when the Medical Director of the Department has determined that:

(A) The client requires specialized services that are not available in Nebraska; and
(B) No other source of the specialized services can be found to provide the services at the rate established in this chapter.

011. 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 this chapter.

011. 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 Medicaid 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 this chapter. This is an exception to policies related to the elimination of combined billing in this chapter.

012. 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.

013. 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.

014. 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: Metro acute care hospitals, hospitals located in a metropolitan statistical area as designated by Medicare; Other urban acute care hospitals, hospitals that have been redesignated to an metropolitan statistical area by Medicare for federal fiscal year 1995 or 1996 or hospitals designated by Medicare as a regional rural referral center; rural acute care hospitals, all other acute care hospitals with 30 or more base year Medicaid discharges; Psychiatric Hospitals and distinct part units in acute care hospitals, hospitals that are licensed as psychiatric hospitals by the Department and distinct parts as defined in these regulations; Rehabilitation hospitals and distinct part units in acute care hospitals, hospitals that are licensed as rehabilitation hospitals by the Department and distinct parts as defined in these regulations; and critical access hospital, hospitals that are certified as critical access hospitals by Medicare.

015. 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.

016. RECAPTURE OF DEPRECIATION. A hospital which is sold for a profit and has received Medicaid payments for depreciation, shall refund to the Department the lower of: the amount of depreciation allowed and paid by the Department; or the product of the ratio of Medicaid allowed inpatient days to total inpatient days; and the amount of gain on the sale as determined by the Medicare intermediary. The year or years for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

017. ADJUSTMENT TO RATE. Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current 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.

018. 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. 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, the Department may pay for the pre-admission screening process 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 pre-admission screening process 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 pre-admission screening process days must be separate from the claim for the inpatient days paid at the acute rate. The pre-admission screening process days will be disallowed as acute care days and Medicaid will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the pre-admission screening process day. Pre-admission screening process days will not be considered in computing the hospital's prospective rate.

019. 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, 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.

020. 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.

021. 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. A hospital may also request an adjustment to its rate.

022. REQUEST FOR RATE ADJUSTMENTS. Requests for rate adjustments are subject to the rules contained in this section.

022.01 REQUESTS. Hospitals may submit a request to the Department for an adjustment to their rates for the following:

(A) 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;

(B) 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:

(i) 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.

(ii) Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.

(C) 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:

(i) One-time occurrence;

(ii) Less than twelve-month duration;

(iii) Could not have been reasonably predicted;

(iv) Not of an insurable nature;

(v) Not covered by federal or state disaster relief; and

(vi) Not a result of malpractice or negligence.

022.02 CALCULABLE. 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.

022.03 RATE ADJUSTMENT REQUIREMENTS. In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following, 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; 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; 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.

022.04 RATE ADJUSTMENT REQUEST SUBMISSION. Requests for rate adjustments must be submitted in writing to the Division. 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.

022.05 APPLICABILITY. 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.

022.06 NO EXCEEDING ACTUAL MEDICAID COST. 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.