STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital care of patients whose primary care needs are psychiatric in nature are limited to a hospital or distinct part of a hospital that -

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or by any other accrediting organization with comparable standards, that is recognized by the State; or
4. Meets the requirements for participation in Medicare for psychiatric hospitals; and
5. Has in effect a utilization review plan applicable to all Medicaid clients.

Inpatient Subacute Hospital Services for Individuals Age 21 and Above

This service is covered under 42 CFR 440.10 Subpart A. In addition to the acute inpatient hospital services for clients age 21 and above, Medicaid considers reimbursement for subacute inpatient hospital psychiatric services when the primary care needs are psychiatric in nature and services are limited to a hospital or distinct part of a hospital that is –

1. Maintained for the care and treatment of patients with a primary psychiatric disorder;
2. Licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients.
6. Has medical records that are sufficient to determine the degree and intensity of the treatment furnished to a client;
7. Meets staffing requirements effective to carry out an active treatment program;
8. Encourages the involvement of family members in assessment treatment planning, treatment delivery and discharge, unless prohibited through legal action or the client or because of federal confidentiality laws;

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9. Has the flexibility to meet the schedules of families, guardians and caretakers as necessary; and
10. Documents the attempts to involve family in treatment.

Subacute inpatient psychiatric hospital programs must have adequate staff to provide:

1. Comprehensive assessments including a biopsychosocial assessment, psychiatric diagnostic evaluations by an attending psychiatrist, nursing assessments, substance abuse assessments as needed, laboratory radiology or other diagnostic tests as necessary.
2. Physical examination and the ability to meet the basic medical needs of the patient.
3. Individual, group, and family psychotherapy by a licensed practitioner. Medication initiation and management services by a psychiatrist.
4. An organized, supervised milieu, psycho-educational services and other support services appropriate.

Subacute inpatient psychiatric programs must have adequate staff to meet the needs of the patients served. Essential positions available to the program are:

1. A clinical/program director;
2. Nursing services;
3. Psychotherapy services by a licensed practitioner;
4. Licensed addiction and drug abuse services as needed and appropriate by a licensed individual skilled and trained to treat substance abuse issues;
5. Psycheducational services as necessary;
6. Case Management services.

Providers of subacute inpatient hospital services must consider the following conditions to be determine the necessity for treatment.

1. Can the patient benefit from longer term evaluation, stabilization, and treatment services?
2. Is the client moderate to high risk to harm self or others?
3. Does the client have symptoms consistent with a current version of the DSM diagnosis?
4. Does the client have the ability to respond to intensive structured intervention services?
5. Is the client of moderate to high risk to relapse or have symptom reoccurrence?
6. Does the client have a high need of professional structure and intervention services?
7. Can the client be treated with short term intervention services?

All subacute inpatient psychiatric services must be prior authorized by the Department or by the Department's contracted Peer Review Organization or management designee.

10-010.03D4 Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Effective January 1, 2002, this rate will be determined by the Department and will be based on historical and future reasonable and necessary cost of providing the service. Payment will be an all-inclusive per diem including all non-physician services.

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. The subacute impatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount: The hospital-specific base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 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 (see 471 NAC 10-010.03B7).

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning July 1, 1999, and after payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

OS Notification

State/Title/Plan Number: **Neb 08-002**

Type of Action: **SPA Approval**

Required Date for State Notification: **06/06/2010**

Fiscal Impact: **FFY 08 $50,953 FFY 09 $408,244**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: **1**

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

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

Delivery System Innovation: **No**

Number of People Losing Medicaid Eligibility: **0**

Reduces Benefits: **No**

Detail: Nebraska 08-022 was originally proposed as a coverage SPA submitted to add inpatient sub-acute hospital services for individuals 21 years of age and older. The State neglected to submit reimbursement pages for this new service in its original package. After discussions with CMS the State submitted the reimbursement pages and this SPA was converted to a NIRT SPA. There were issues with overlapping SPA pages (resolved with the approval of 09-010 approved on March 12, 2010). The reimbursement methodology requires per diem payment state by dollar amount in the plan to the appropriate providers effective April 12, 2008 (the earliest possible date considering the initial omission of the rate methodology in the original submission). The rate excludes physician services, which are reimbursed separately.

There are no funding, rate methodology, UPL or DSH issues related to this amendment. The public process issues related to this amendment were resolved by the NIRT analyst.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.
This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS Contact: Tim Weidler (816) 426-6429, National Institutional Reimbursement Team