10-010.03B1b Calculation of Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges with a stable DRG. Peer Group Base Payment Amounts effective October 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the Peer Group Base Payment Amounts effective during SFY 2007, adjusted for budget neutrality, calculated as follows:

1. Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Peer Group 1 Base Payment Amount of $3,844.00 by the Stable DRG budget neutrality factor.

2. Children's Hospital Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Children's Hospital Peer Group 1 Base Payment Amount of $4,614.00 by the Stable DRG budget neutrality factor.

3. Peer Group 2 Base Payment Amounts: Multiply the SFY 2007 Peer Group 2 Base Payment Amount of $3,733.00 by the Stable DRG budget neutrality factor.

4. Peer Group 3 Base Payment Amounts: Multiply the SFY 2007 Peer Group 3 Base Payment Amount of $3,535.00 by the Stable DRG budget neutrality factor.

SFY 2007 Nebraska Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B4 in effect on September 1, 2007 and 471 NAC 10-010.03B in effect on July 1, 2001.

Peer Group Base Payment Amounts will be increased by 0.5% for the rate period beginning October 1, 2009 and ending June 30, 2010. This rate increase will not be carried forward in subsequent years. Peer Group Base Payment Amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be increased by .5% for the rate period beginning July 1, 2010.

June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010.

10-010.03B3b Calculation of Stable DRG Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from NMAP, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program. For rates effective October 1, 2009, the Department will determine the operating IME factors effective for the Medicare system on October 1, 2008 using the following formula:

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

On July 1st of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1st of the previous year.

10-010.03XXx Calculation of MCO Medical Education Payments: NMAP will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by NMMCP capitated plans from discharge data provided by the hospital.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the MCO direct medical education payment per discharge.
    a. The MCO direct medical education payment per discharge is the hospital-specific weighted average fee-for-service DME payment rates for stable DRGs, unstable or low volume DRGs and transplant DRGs, as described in 10-010.03B3a, 10-010.03B5b and 10-010.03B6b. The weighted average amount shall be based on the claims included in the Fiscal Simulation Analysis as described in 10-010.03B7a.
    b. On July 1st of each year, the Department will update the Direct Medical Education payment rates. The Direct Medical Education rates will be increased or decreased based on the annual percentage change in the number of intern and resident FTEs

10-010.03D1 For payment of inpatient hospital psychiatric services, effective July 1, 2010, the tiered per diem rates will be:

Days of Service	Per Diem Rate
Days 1 and 2	$691.10
Days 3 and 4	$638.84
Days 5 and 6	$609.81
Days 7 and greater	$580.77

10-010.03D2 Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Beginning July 1, 2001, this rate will be determined by the Department and will be based on historical and future reasonable and necessary cost of providing the service. Specific costs to be included in the rate will not be inconsistent with those identified in 471 NAC 32-001.12.

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.

10-010.03E2 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.

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, 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: Nebraska 10-012

Type of Action: SPA Approval

Required Date for State Notification: 09/15/2010

Fiscal Impact: FFY 10 $657,380 FFY 11 $2,629,528

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

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

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective for inpatient hospital services on July 1, 2010 this SPA extends a .5% rate increase that was set to expire on June 30, 2010. Questions surrounding this increase regarding UPL and payment methodology were resolved under the previous review of this provision (NE 09-010).

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.

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