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State/Territory Name: NE

State Plan Amendment (SPA) #: 14-0002

This file contains the following documents in the order listed:

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

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

OCT 15 2014

Courtney Miller, Deputy Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: Nebraska State Plan Amendment TN: 14-002

Dear Ms. Miller:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-002. This amendment transitions the inpatient hospital reimbursement methodology to one based on the all patient refined diagnosis related groups (APR-DRG).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 14-002 is approved effective July 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-02

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $0.00
b. FFY 2015 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 1a, 1b, 1c, 1e, 1f, page 2-8 and 10-14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 1a, 1b, 1c, 1e, 1f, page 2-8 and 10-14

10. SUBJECT OF AMENDMENT:
APR-DRG

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Courtney Miller

14. TITLE:
Deputy Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
April 3, 2014

16. RETURN TO:

Nancy Keller
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 15 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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.

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).

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.

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.

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.

Page 4 left blank intentionally

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, 2014 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 2011Peer 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.

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.

10-010.03B3 Calculation of Medical Education Costs

10-010.03B3a 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.

SFY 2007 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect September 1, 2007.

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, 2008, as described in step 3 of this subsection, with each hospital's intern and resident FTEs 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. Effective July 1, 2011, the direct medical education amount shall be reduced by 2.5 percent. Effective July 1, 2012, the direct medical education amount shall be increased by 1.54 percent. Effective July 1, 2013, the direct medical education amount shall be increased by 2.25 percent.

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

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program using the following formula:

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

On July 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.

10-010.03B3c Calculation of MCO Medical Education Payments: Nebraska Medicaid will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by NMMCP capitated plans from discharge data provided by the MCO. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the fee-for service direct medical education payment per discharge in effect for the rate year July 1 through June 30.

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.

10-010.03B5 – (RESERVED)

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges. Transplant DRG CCRs are calculated as follows:

1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.
2. Sum the operating and capital outlier CCRs.
3. Multiply the sum of the operating and capital outlier CCRs by the Transplant DRG budget neutrality factor.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years, before budget neutrality adjustments.

Effective July 1, 2011, the Transplant DRG CCRs will be reduced by 2.5 percent. Effective July 1, 2012, the Transplant DRG CCRs will be increased by 1.54 percent. Effective July 1, 2013, the Transplant DRG CCRs will be increased by 2.25 percent.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation, with the exception that in step 4, DME per discharge payment amounts are adjusted by the Transplant DRG budget neutrality factor.

On July 1st of each year, the Department will update Transplant DME payment per discharge rates as described in 10-010.03B3a of this regulation.

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.

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.