

# NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

August 13, 2020

James G. Scott, Director  
Centers for Medicare & Medicaid Services  
Kansas City Regional Operations Group  
Division of Medicaid Field Operations-North  
601 East 12<sup>th</sup> Street, Suite 355  
Kansas City, Missouri 64106-2898

RE: Nebraska SPA 20-0001 Nursing Facility Rate Methodology and Rates

Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska State Plan regarding changes to the nursing facility rate methodology and rates for state fiscal year 2021.

The Division of Medicaid and Long-Term Care sent notice on June 25, 2020 (attached) to the federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact the proposed State Plan Amendment might have, if any, on the Tribes. No comments were received.

If you have content questions, please feel free to contact Jeremy Brunssen at [jeremy.brunssen@nebraska.gov](mailto:jeremy.brunssen@nebraska.gov), or 402-471-5046 or for submittal questions, Dawn Kastens at [dawn.kastens@nebraska.gov](mailto:dawn.kastens@nebraska.gov), or 402-471-9530.

Sincerely,

Jeremy Brunssen, Interim Director  
Division of Medicaid and Long-Term Care  
Department of Health and Human Services

JB/dk

cc: Megan Buck  
Tim Weidler

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER: NE 20-0001	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, 2020	

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: 42 CFR 447 Subpart C	7. FEDERAL BUDGET IMPACT: a. FFY 2020                      \$1,992,486 b. FFY 2021                      \$6,101,573
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Att. 4.19-D, Pages 1-15, 15a, 16, 17, 18, 18a, 19-32	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Att. 4.19-D, Pages 1-15, 15a, 16, 16a, 16b, 17, 18, 18a, 19-32

10. SUBJECT OF AMENDMENT:  
Nursing Facility Rate Methodology and Rates

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Governor has waived review  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Jeremy Brunssen	
14. TITLE: Interim Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: August 13, 2020	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

12-011 Rates for Nursing Facility Services12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 12-011.06.

Assisted Living Rates means standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities.

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

IHS Nursing Facility Provider means an Indian Health Services Nursing Facility or a Tribal Nursing Facility designated as an IHS provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Level of Care means the classification of each resident based on his/her acuity level.

Median means a value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility means an institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Rate Determination means per diem rates calculated under provisions of 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 101, 102, 103 and 104.

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TN# NE20-0001

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Approved \_\_\_\_\_

Effective \_\_\_\_\_

Rate Payment means per diem rates paid under provisions of 12-011.08. The payment rate for Levels of Care 101, 102, 103, and 104 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities adjusted to include the Nursing Facility Quality Assessment Component and the Quality Measures Component (see 12-011.08D).

Revisit Fees means fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management' for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys.

Urban means Douglas, Lancaster, Sarpy, and Washington Counties. Rural means all other Nebraska counties.

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waived days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Division of Public Health's regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of the beginning of each applicable cost report period are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (Medicaid) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 12-011.08B) will not file a cost report. Rates are determined according to 12-011.08H.

12-011.04 Allowable Costs: The following items are allowable costs under Medicaid.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;

2. Comply with the standards prescribed by the Secretary of the Federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:

1. General nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician or licensed nurse practitioner, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff must aid the client as necessary, under the client's therapy program, with programs intended to maintain the function(s) being restored; to include but not limited to augmentative communication devices with related equipment and software
3. Items which are furnished routinely and relatively uniformly to all clients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, bandaids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);
5. Items which are used by individual clients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs. traction equipment, alternating pressure pad and pump, other durable medical equipment, etc. not listed in 12-009.05 and 12-009.06;
6. Nutritional supplements and supplies used for oral, parenteral or enteral feeding.
7. Laundry services, including personal clothing;
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
9. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance;
10. Injections and supplies: including syringes and needles, but excluding the cost of the drug(s) not listed in 12-009.05 and 12-009.06.

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TN #. NE 20-0001

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TN #. NE16-0006

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12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility must contract for ancillary services not readily available in the facility.

If ancillary services are provided by a licensed provider or another licensed facility, e.g., physician, dentist, physical/occupational/speech/etc., therapists, etc., the ancillary service provider must submit a separate claim for each client served.

Allowable costs paid to Physical, Occupational and Speech Therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services and seminars.

Respiratory therapy is an allowable cost.

Department-required independent QMRP assessments are considered ancillary services.

12-011.04D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants. Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Orthoses (lower and upper limb, foot and spinal);
4. Prostheses (breast, eye, lower and upper limb);
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care;
  - a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP will not make payment for ambulance service.
  - b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy enter are covered when the client is bed confined before, during and after transport and when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the Nursing Facility).

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TN #. NE 13-07

12-011.04E Payments to Nursing Facility Provider Separate from Per Diem Rates: Items for which payment may be made to Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below.

To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

1. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use;
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

Reimbursement to Nursing Facility providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of nursing facility services. The agency's fee schedule rate was set as of October 1, 2017, and is effective for services provided on or after that date. All fee schedule rates are published on the agency's website at

<http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;

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TN #. NE 17-0009

13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, and handball courts.
15. Revisit fees.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are used. An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year.

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TN #. NE 13-07

Medicaid inpatient days are days for which claims or electronic Standard Health Care Claim: Institutional transaction (ASC X12N 837) from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under 12-011 for these days.

12-011.06C Start-Up Costs: All new providers entering NMAP must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

12-011.06D Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions. (Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

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TN #. MS-07-04

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

12-011.06E Leased Facilities: Allowable costs leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 12-011.06H and J will apply. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

12-011.06F Home Office Costs - Chain Operations: A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to healthcare.

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, are limited to direct patient care services provided at the facility, and must be included in the applicable Cost Category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, are included in the Administration Cost Category. The NMAP does not distinguish between capital related and non-capital related interest expense and interest income (see HIM-15, Section 2150.3E and 2150.3F).

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TN #. MS-07-04

12-011.06G Interest Expense: Interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for nursing facility care. This limitation does not apply to government owned facilities.

12-011.06H Recognition of Fixed Cost Basis: The fixed cost basis of real property (land, land improvements, buildings, and equipment permanently attached to the building) and personal property (furniture, moveable equipment, and vehicles) for facilities purchased on or after July 1, 2020, as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the purchaser; or
2. For facilities purchased as an ongoing operation on or after July 1, 2020, the seller's Medicaid net book value at the time of purchase.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

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TN #. NE 20-0001

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TN #. NE 14-010

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12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6).

Beginning with the following calendar year base numbers for 12/31/2010, the Administrator Compensation Maximum Amounts can be calculated based on the following methodology.

Calendar Year	HIM%	Beds 0-74	Beds 75-99	Beds 100-149	Beds 150-200	Beds 200+
2010	1.5%	81,490	82,954	98,569	99,544	146,388
2011						

To determine the Maximum Amount for State Fiscal Year 2011, for each bed category, add 1 to the Calendar Year 2010 HIM % and multiply this amount by 50% of the Calendar Year 2010 bed total. To this amount add 50% of the Calendar Year 2010 bed total. For future years update the calendar year information above (A) by replacing the HIM % with the updated HIM % from HIM 15 Section 905.6.

Example:  $1 + .015 \times 40,745 = 41,356$                        $41,356 + 40,745 = 82,101$

Administrator Maximum Amounts for Cost Reports:

State Fiscal Year	Beds 0-74	Beds 75-99	Beds 100-149	Beds 150-200	Beds 200+
2011	82,101	83,576	99,308	100,291	147,486
2012					

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

12-011.061L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing and Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing and Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing and Support Services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

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Supersedes  
TN# NE 11-24

Approved \_\_\_\_\_ Effective \_\_\_\_\_

12-011.06M Direct Nursing Costs: Direct nursing costs include cost report lines 94 through 103. The following descriptions cover some of these costs:

1. Salaries of the Director of Nursing and other licensed professionals (RNs & LPNs) who are practicing within the scope of their license;
2. Salaries of other licensed or certified individuals providing routine nursing or routine nursing-related services to residents; and unlicensed, assistive personnel providing nursing-related support for direct nursing care to residents. Nursing-related support includes, but is not limited to: bathing, dressing, transfer, dining assistance, bed mobility, walking, range of motion, bed making, filling water pitchers, personal hygiene, administration of medications, and other activities of daily living; or training/instruction of residents in these services;
3. Salaries related to:
  - a. Nursing staff scheduling;
  - b. Preparation of resident assessments, development of care plans, and other required documentation;
  - c. Instruction of and attendance at nursing inservice training;
  - d. Medical records, including record transcription, file thinning, setup of initial files, and other medical record services; and
  - e. Quality assurance services;
4. The documented nursing portion of multi-purpose and/or universal workers salaries:
  - a. A multi-purpose employee has nursing and non-nursing job duties. For example, medical records (Nursing) and payroll (Administration).
  - b. Universal workers are employees who perform multiple tasks for residents, usually in a distinct unit, pod, or neighborhood. The tasks performed by the universal workers have traditionally been divided between employees of separate departments. Services provided by universal workers may include two or more of the following functions:
    - (1) Nursing;
    - (2) Activities;
    - (3) Laundry;
    - (4) Housekeeping; and
    - (5) Dietary;
  - c. Multi-purpose and/or universal workers who perform services in more than one functional area must identify their time using one of the following approved methods:
    - (1). Maintenance of daily continuous timesheets The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked in each functional area;
    - (2). Maintenance of time studies as defined in Medicare HIM-15 (section 2313.2E);
    - (3). Other methods as pre-approved by the Department;

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TN #. MS-05-02

5. Payroll taxes and employee benefits related to the salaries outlined above. Employee benefits do not include help wanted advertising, pre-employment physicals, background checks, etc;
6. Consulting Registered Nurse;
7. Salary, payroll taxes and employee benefits of home office nursing personnel while performing facility-specific direct care nursing services, if the costs are allocated according to Medicare HIM-15, Section 2150.3B. Related overhead costs, including, but not limited to, travel time, lodging, meals, etc., cannot be reported as Direct Nursing costs. Report overhead costs in the Administration cost category; and
8. Purchased Services - Direct Care (pool nurse labor). Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply.

12-011.06N Plant Related Costs: Plant related costs include cost report lines 129 through 163. The following descriptions cover some of these costs.

1. Costs of routine maintenance services performed by an outside vendor rather than by the provider's maintenance staff. Examples include lawn care, alarm maintenance/monitoring, pest control and snow removal;
2. Costs of incidental supplies and materials used by maintenance personnel and/or maintenance contractors in maintaining or repairing the building, grounds and equipment (excluding business equipment). Examples include paintbrushes, tools, hardware items (screws, nails, etc.), fertilizer, lumber for small projects, and electrical and plumbing supplies. Aviary and other pet supply costs are to be reported in the Activities cost category;
3. Repairs and maintenance applicable to the building, grounds, equipment (excluding business equipment) and vehicles. Report maintenance and repair expenses applicable to business equipment (e.g. computers, copiers, fax machines, telephones, etc.) as an Administration expense.

12-011.06O Equipment Lease and Maintenance Agreements: Costs of equipment lease or maintenance agreements that include or are tied to usage or supplies must be reported in the operating cost category that most closely relates to the equipment.

1. Example 1: The provider has a 5-year copier lease. Monthly lease payments are on the number of copies made. These costs must be reported in the Administration cost category.
2. Example 2: The provider has a maintenance agreement for a dishwasher. A condition of the agreement requires a minimum monthly purchase of dishwasher supplies. These costs must be reported in the Dietary cost category.

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TN #. NE 20-0001

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TN #. MS-05-02

12-011.06P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.06Q Nursing Facility Quality Assessment: The nursing facility quality assessment is an allowable cost addressed through the Nursing Facility Quality Assessment Component.

12-011.07 (Reserved)

12-011.08 Rate Determination: The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Periods: The Rate Periods are defined as July 1 through December 31, and January 1 through June 30. Rates paid during the Rate Periods are determined from base year cost reports (see 12-011.08D and 12-011.08D5). For purposes of this section, "base year cost reports" means full and part-year cost reports filed with a base year Report Period ending date of June 30.

12-011.08B Report Period: Each facility must file a cost report each year for the reporting period of July 1 through June 30 or part-year cost reports, when applicable.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the urban or rural location of the facility.

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the base year Report Period (see 12-011.08D5). The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums and minimums.

Component maximums and minimums are computed using audited data following the initial desk audits, and are not revised based on subsequent changes to the data. Only cost reports with a full year's data are used in the computations. Cost reports from providers entering or leaving Medicaid during the immediately preceding Report Period are not used in the computations.

Each facility's prospective rates are the sum of the following components:

1. The Direct Nursing Component adjusted by the inflation factor, and weighted for level of care;
2. The Support Services Component adjusted by the inflation factor;
3. The Fixed Cost Component;
4. The Nursing Facility Quality Assessment Component;
5. The Quality Measures Component; and
6. For the rate periods July 1 through December 31, 2020, and January 1 through June 30, 2021 only, the Transition Component.

The Direct Nursing Component and the Support Services Component are subject to maximum and minimum per diem payments based on Median/Maximum computations.

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Median: For each Care Classification, the median for the Direct Nursing Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding waived, and/or facilities with partial or initial/final full year cost reports. For each Care Classification, the median for the Support Services Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding hospital based, waived, and/or facilities with partial or initial/final full year cost reports.

The Department will reduce the Direct Nursing Component median by 2% for facilities that are waived from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 105% of the median Direct Nursing Component, and 100% of the median Support Services Component. The Department will reduce the Direct Nursing Component maximum by 2% for facilities that are waived from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Minimum: The minimum per diem is computed as 77% of the median Direct Nursing Component, and 72% of the median Support Services Component.

The Fixed Cost Component is subject to a maximum per diem of \$27.00, excluding personal property and real estate taxes.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the base year allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the base year weighted resident days for each facility (see 12-013.03). The resulting quotient is the facility's computed base year per diem. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the base year allowable costs for support services (lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (lines 203 through 210 from the FA-66), by the total base year inpatient days (see 12-011.06B) for each facility. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's base year allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total base year inpatient days (see 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, plus any prior approved increase under 12-011.08E, or a maximum per diem of \$27.00 excluding personal property and real estate taxes.

12-011.08D4 Nursing Facility Quality Assessment Component: The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset.

For purposes of this section, facilities exempt from the Quality Assurance Assessment are:

1. State-operated veterans homes;
2. Nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and
3. Continuing care retirement communities.

The quality assessment component rate will be determined by calculating the 'anticipated tax payments' during the rate year and then dividing the total anticipated tax payments by 'total anticipated nursing facility/skilled nursing facility patient days,' including bed hold days and Medicare patient days.

For each rate year, July 1 through the following June 30<sup>th</sup>, total facility patient days, including bed hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the 'anticipated tax payments.' Total facility patient days, including bed hold days and Medicare days, for the same four calendar quarters will be used to calculate the 'anticipated nursing facility/skilled nursing facility patient days.'

New providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid:

For the Rate Period beginning on the Medicaid certification date through the following June 30, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from exempt to non-exempt status:

For the Rate Period beginning on the first day of the first full month the provider is subject to the Quality Assurance Assessment through the following June 30, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from non-exempt to exempt status:

For Rate Periods beginning with the first day of the first full month the provider is exempt from the Quality Assurance Assessment, the quality assessment rate component will be \$0.00 (zero dollars).

12-011.08D5 Base Year Report Period and Inflation Factor: For the Rate Periods July 1 through December 31, 2020, and January 1 through June 30, 2021, the base year is the report period ending June 30, 2018; and the inflation factor is positive 1.51%..

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12-011.08D6 Quality Measures Component: This component of the prospective rate is based on the Quality Measures component of the CMS Nursing Facility Star Rating system, published at <https://www.medicare.gov/nursinghomecompare/search.html>. The published rating as of May 1 is used to determine the rate component for the following July 1 through December 31 rate period. The published rating as of November 1 is used to determine the rate component for the following January 1 through June 30 rate period.

Per diem amounts corresponding to the Quality Measures rating are:

5 star rating = \$10.00/day

4 star rating = \$6.75/day

3 star rating = \$3.50/day

1 star, 2 star, or NR (no rating) = \$0.00 (zero)

This component applies to all nursing facility care levels (101-180).

12-011.08D7 Transition Component: This component of the prospective rate is only applicable to the July 1 through December 31, 2020, and January 1 through June 30, 2021 rate periods; and is only applicable to providers with June 30, 2018 base year cost reports. This component will reduce each facility's projected gain or loss in Medicaid payments, due to the change in payment methodology effective July 1, 2020, by 50%.

This component only applies to nursing facility care levels (110-180).

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Medicaid Director or designee, to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. For existing facilities, an exception may only be requested if the facility's total annualized fixed costs (total costs, not per diem rate), as compared to the annualized base year costs, have increased by twenty percent or more. Facilities without a base year cost report, and with 1,000 or more annualized Medicaid days, may only request an exception if the facility's fixed costs per day, computed using an 85% minimum occupancy, exceeds the Care Classification average Fixed Cost Component by twenty percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 20 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

Approved increases from July 1 through December 31, will be effective the following January 1.  
Approved increases from January 1 through June 30, will be effective the following July 1.

12-011.08F Rate Payment for Levels of Care 101, 102, 103, and 104: The payment rate for Levels of Care 101, 102, 103, and 104 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities adjusted to include the Nursing Facility Quality Assessment Component and Quality Measures Component (see 12-011.08D).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08H Rates for Providers Without a Base Year Cost Report:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A provider without a base year cost report is:

1. An individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility due to a change in ownership, or to operate a nursing facility not previously enrolled in Medicaid, after the base year cost report end date; or
2. A provider with 1,000 or fewer Medicaid inpatient days in the base year (see 12-011.03).

For purposes of this definition, "nursing facility" means the business operation, not the physical property.

Prospective Medicaid rates for providers without a base year cost report are the sum of the following components:

1. The applicable Urban or Rural average Direct Nursing base rate component of all other providers in the same Care Classification, adjusted by the inflation factor; and weighted for level of care;
2. The applicable Urban or Rural average Support Services base rate component of all other providers in the same Care Classification, adjusted by the inflation factor;
3. The applicable Urban or Rural average Fixed Cost base rate component of all other providers in the same Care Classification;
4. The Nursing Facility Quality Assessment Component; and
5. The Quality Measures Component.

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12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 12-011.10, Reporting Requirement and Record Retention.

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12-011.08K Special Funding Provisions for Governmental Facilities: City and county-owned and operated nursing facilities are eligible to receive the Federal Financial Participation share of allowable costs exceeding the rates paid for the Direct Nursing, Support Services, and Fixed Cost Components for all Medicaid residents.

The reimbursement is subject to the payment limits of 42 CFR 447.272.

- A. City or county-owned facilities with a 40% or more Medicaid mix of inpatient days are eligible to receive the Federal Financial Participation share of allowable costs exceeding the applicable maximums for the Direct Nursing, Support Services, and Fixed Cost Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current NMAP Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing, Support Services, and Fixed Cost Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.

12-011.08L Special Funding Provisions for IHS Nursing Facility Providers: IHS nursing facility providers are eligible to receive the Federal Financial Participation share of allowable costs exceeding the rates paid for the Direct Nursing, Support Services, and Fixed Cost Components for all Medicaid residents.

- A. IHS providers may receive quarterly, interim Special Funding payments by filing quarterly cost reports (FA-66) for periods ending September 30, December 31 and/or March 31. Quarterly, interim Special Funding payments are retroactively adjusted and settled based on the provider's corresponding annual cost report for the period ending June 30. Quarterly, interim payments and the retroactive settlement amount are calculated in accordance with Section C below. If the average daily census from a quarterly cost report meets or exceeds 85% of licensed beds, this shall be the "final" quarterly cost report filed by the provider. Subsequent quarterly, interim Special Funding payments shall be based on the "final" quarterly cost report. Quarterly, interim Special Funding payments may also be revised based on data from the annual cost reports.
- B. Quarterly, interim Special Funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim Special Funding payments subsequent to the payment for the "final" quarterly cost report shall be made on or about 90-day intervals following the previous payment.

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- C. The Special Funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:
1. The allowable Federal Medical Assistance Percentage for IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all IHS-eligible Medicaid residents and the total amount paid for all IHS-eligible Medicaid residents, if greater than zero: and
  2. The allowable Federal Medical Assistance Percentage for non-IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all non-IHS-eligible Medicaid residents and the total amount paid for all non-IHS-eligible Medicaid residents, if greater than zero.

12-011.08M (Reserved)

12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

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At the time of an asset acquisition, the nursing facility must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 12-011.06H and J.

12-011.09A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset Glass.

12-011.09B Capitalization Guidelines: Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

12-011.09B1 Capitalization Threshold: The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for their facility, but the threshold amount must be at least \$100 and no greater than \$5,000.

12-011.09B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

12-011.09B3 Acquisitions Under \$100: Acquisitions after July 1, 2005 with a per unit cost of less than \$100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the Cost Report in the current period.

Examples:

Item	Per Item Cost	Account
Toaster	\$38	Dietary Supplies
30 Wastebaskets	\$22 (\$660 total)	Housekeeping Supplies
Calculator (bookkeeper)	\$95	Administration Supplies
Pill Crusher	\$62	Nursing Supplies
Wrench Set	\$77	Plant Related Supplies

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12-011.09B4 integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying *the* capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

12-011.09B5 Multiple Items with Per Unit Cost Greater Than or Equal to \$100: Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy must describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

12-011.09B6 Non-Capital Purchases: Purchases of equipment and furnishings over \$100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

12-011.09B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 12011.09B1 through 12-011.09B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

12-011.09B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

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Example A

Provider A's written capitalization policy has a \$5,000 threshold for single item purchases. Multiple item purchases are treated on an item-by-item basis.

Item	Per Item cost	Cost Report Category
5 Computers	\$1,750 (total = \$8,750)	Plant Related - as per item cost is less than \$5,000
Boiler	\$12,500	Capitalize & Depreciate
TV for Day Room	\$1,300	Plant Related
Lawn Mower	\$2,500	Plant Related
Range/Oven	\$4,900	Plant Related
Resident Room Carpet	\$800	Plant Related
10 Resident Beds	\$700 (total = \$7,000)	Plant Related - as per item cost is less than \$5,000
3 Cubicle Walls & for an Office Cubicle	\$300 (total = \$900) (total = \$1,600)	Plant Related - as total Desktop \$700 cost of integrated system is less than \$5,000

Example B

Provider B's written capitalization policy has a \$1,500 threshold for single item purchases. Multiple item purchases are treated as an aggregate single purchase.

Item	Per Item cost	Cost Report Category
5 Computers	\$1,750 (total = \$8,750)	Capitalize & Depreciate
Boiler	\$12,500	Capitalize & Depreciate
TV for Day Room	\$1,300	Plant Related
Lawn Mower	\$2,500	Capitalize & Depreciate
Range/Oven	\$4,900	Capitalize & Depreciate
Resident Room Carpet	\$800	Plant Related
10 Resident Beds	\$700 (total = \$7,000)	Capitalize & Depreciate - as aggregate cost of \$7,000 is more than \$1,500
3 Cubicle Walls & Desktop For an Office Cubicle (total = \$1,600)	\$300 (total = \$900) \$700	Capitalize & Depreciate - as cost of integrated system is greater than \$1,500

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12-011.09C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 12-011.06H);
4. Based on the fair market value at the time of donation for donated assets without a prior Medicaid basis; or based on the donor's Medicaid net book value at the time of the donation for donated assets with a prior Medicaid basis. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

12-011.09D (Reserved)

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12-011.09F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

12-011.09G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

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12-011.10 Reporting Requirements and Record Retention: Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement". Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

Each facility must complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a required cost report has not been filed, the sum of the following is due:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at least five years after receipt from the provider.

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Facilities which provide any services other than certified nursing facility services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. A Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.10A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services, Division of Medicaid and Long-Term Care, Audit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Lincoln State Office Building address; pick up copies at that office; or mail copies). The total fee, based on current Department policy, must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department will perform at least one initial desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Care classification maximums and average base rate components are computed using audited data following the end of the Cost Report Period. Subsequent desk and field audits will not result in a revision of care classification maximums or average base rate components.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

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All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit:

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 12-011.15 #1 or initiating an audit in response to a reopening in accordance with 12-011.15 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.12 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on a remittance advice. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

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12-011.13 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of \$25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than \$25,000, or both.

12-011.14 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Division of Medicaid and Long-Term Care within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis or explanation of each item, or both.

After the Director of the Division of Medicaid and Long-Term Care issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

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12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

“Reopening” means an action taken by the Director of the Division of Medicaid and Long-Term Care to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken:

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director of the Division of Medicaid and Long-Term Care will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Anytime fraud or abuse is suspected.

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A provider does not have the right to appeal a finding by the Director of the Division of Medicaid and Long-Term Care that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under 12-011 must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under 12-011 has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

#### 12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved RUG grouper to assign each resident to a level of care based on information contained on his/her MDS assessment. Each level of care will be assigned the federally-recommended weight. When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

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TN #. 10-19

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care. Each resident's level of care is appropriately updated from each assessment to the next - the admission assessment, a significant change assessment, the quarterly review, the annual assessment, etc., and is effective for payment purposes on the first day of the month of the applicable assessment if it is received by the tenth day of the month of the applicable assessment. A change in resident level of care which results from an audit of assessments is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska Medicaid Case Mix System, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment.

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For each reporting period, the total resident days (per the MDS system) at each care level are multiplied by the corresponding weight. The resulting products are summed to determine the total weighted resident days per the MDS system. This total is then divided by the MDS total resident days per the MDS system. This total is then divided by the MDS total resident days and multiplied by total resident days per the facility's Nebraska Medicaid Cost Report to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.

**12-013.03 Resident Level of Care Weights:** The following weighting factors shall be assigned to each resident level of care, based on the CMS RUG III 5.20 version:

Level of Care	Casemix Index Value	Casemix Index Description	Casemix Index Value
163	RAD	Rehabilitation/ADL = 17-18	1.66
162	RAC	Rehabilitation/ADL = 14-16	1.31
161	RAB	Rehabilitation/ADL = 9-13	1.24
160	RAA	Rehabilitation/ADL = 4-8	1.07
172	SE3	Extensive Services 3/ADL >6	2.10
171	SE2	Extensive Services 2/ADL >6	1.79
170	SE1	Extensive Services 1/ADL >6	1.54
152	SSC	Special Care/ADL = 17-18	1.44
151	SSB	Special Care/ADL = 15-16	1.33
150	SSZ	Special Care/ADL = 4-14	1.28
145	CC2	Clinically Complex w/Depression/ADL = 17-18	1.42
144	CC1	Clinically Complex/ADL = 17-18	1.25
143	CB2	Clinically Complex w/ Depression/ADL = 12-16	1.15
142	CB1	Clinically Complex/ADL = 12-16	1.07
141	CA2	Clinically Complex w/Depression/ADL = 4-11	1.06
140	CA1	Clinically Complex/ADL = 4-11	0.95
133	IB2	Cognitive Impairment with Nursing Rehab/ADL= 6-10	0.88
132	IB1	Cognitive Impairment/ADL = 6-10	0.85
131	IA2	Cognitive Impairment with Nursing Rehab/ADL = 4-5	0.72
130	IA1	Cognitive Impairment/ADL = 4-5	0.67
123	BB2	Behavior Prob w/Nursing Rehab/ADL = 6-10	0.86
122	BB1	Behavior Prob/ADL = 6-10	0.82
121	BA2	Behavior Prob w/Nursing Rehab/ADL = 4-5	0.71
120	BA1	Behavior Prob/ADL = 4-5	0.60
115	PE2	Physical Function w/Nursing Rehab/ADL = 16-18	1.00
114	PE1	Physical Function/ADL = 16-18	0.97
113	PD2	Physical Function w/Nursing Rehab/ADL = 11-15	0.91
112	PD1	Physical Function/ADL = 11-15	0.89
111	PC2	Physical Function w/Nursing Rehab/ADL = 9-10	0.83
110	PC1	Physical Function/ADL = 9-10	0.81
<b>Medicaid Waiver Assisted Living Levels of Care</b>			
104	PB2	Physical Function w/Nursing Rehab/ADL = 6-8	0.65
103	PB1	Physical Function/ADL = 6-8	0.63
102	PA2	Physical Function w/Nursing Rehab/ADL = 4-5	0.62
101	PA1	Physical Function/ADL = 4-5	0.59
<b>Default Rate – Used When No Assessment is Available</b>			
180*	STS	Short-Term Stay	0.59

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\*Level of Care 180 (Short-Term Stay) is used for stays of less than 14 days when a client is discharged and the facility does not complete a full MDS admission assessment of the client. This is effective for admissions on or after July 1, 2010.

12-013.04 Verification: Resident assessment information is audited as a procedure in the Department of Health and Human Services Division of Public Health, Survey and Certification process.

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