



## State Fiscal Year 2021 Nursing Facility Rates Questions from June 4, 2020, Webinar with the Nebraska Health Care Association and LeadingAge Nebraska

**Q: Is Nebraska Medicaid planning to change from RUG III to RUG IV?**

A: The next change will most likely be to PDP. The timing of this is largely dependent on when the Centers for Medicare and Medicaid Services (CMS) will mandate a change. We do not anticipate a change before July 1, 2021.

**Q: Will the power point be available after the presentation?**

A: Yes. Please see <http://dhhs.ne.gov/Pages/Nursing-Home-Payment-Project.aspx>.

**Q: Based on the changes, it seems like a facility only serves to benefit because of the bed hold policy and the QM star rating add-on, other than those facilities whose direct nursing or support services components were below the minimum, is that correct?**

A: No. Several factors result in changes to facility rates with the new methodology. One example would be the reduction of the Direct Nursing and Support Services maximums, which allowed for a higher inflation factor, benefitting all providers under one or both of those maximums.

**Q: Regarding the frequency of rebasing, now that it is no longer being done annually, what will determine when it will occur?**

A: Medicaid will collaborate with industry groups to review cost reports and other applicable data (e.g. Medicaid days, appropriations, possible conversion to PDP, etc.) to determine the specifics of the next rebasing.

**Q: Although there will no longer be an annual rebasing of rates, there is the potential for the Quality Add-on and the Fixed Costs components of the rate to change every six months, correct? Can you please clarify?**

A: Correct. Each facility's Quality Measures Add-on will be updated each January 1 and July 1 based on the applicable CMS ratings. See #11 on the link below. Fixed Costs components may also change each January 1 and July 1 based on approved increases. See #7 on the following link: <http://dhhs.ne.gov/Documents/NFMethodFacts.pdf>.

**Q: Will the cost reporting instructions change, as far as which costs go in which component?**

A: No.

**Q: For example, will supplies like pencils used by nursing staff be reported under Direct Nursing or under Support Services?**

A: Supplies will continue to be reported on the “Supplies” line in the appropriate cost category on the Medicaid Cost Report. All “Supplies” costs are Support Services costs in rate calculations. Direct Nursing will continue to include only costs from Medicaid Cost Report lines 94-103 (Nursing salaries and related payroll taxes and benefits, Consulting RN, and Purchased Nursing Services – Direct Care).

**Q: Will there be billing code changes?**

A: No.

**Q: Will you cover how bedhold rates will be calculated now, as opposed to how these are currently calculated?**

A: For Medicaid claims for dates of service through June 30, 2020, allowable bedhold days are paid at the Level 105 rate, which is the applicable Rural/Urban Assisted Living rate plus the facility’s QAA component. Beginning July 1, 2020, allowable bedhold days will be paid at the rate associated with the resident’s assessed casemix level of care. For example, if a resident’s assessed level of care for July 2020 is 171, and they have 25 in-house days and six bedhold days in July, the facility will be paid the level of care 171 rate for all 31 days. As in the past, allowable bedhold days are limited to 15 per hospital stay, and 18 annually for therapeutic leaves.

**Q: Will the bedhold rate decrease after a certain number of days or will it remain the same throughout bedhold stay?**

A: It will remain the same for all allowable bedhold days. See the question above for details.

**Q: The Quality Add-On is based on a facility’s Five Star Quality Measure rating, not the Overall rating, correct?**

A: Correct.

**Q: My facility is classified as a rural due to the county, but I am just a few miles from an urban facility. I pay wages like an urban facility but am classified as rural. Would Medicaid consider making changes to the rural-urban classification?**

A: Not at the current time. The Rural/Urban issue was discussed at length by the rate methodology workgroup, with the consensus being to maintain the historic county designations.

**Q: Can you please clarify how the total Medicaid days were projected for the 2020-21 rate calculation?**

A: The number of paid Medicaid claims for each facility, for each level of care, for the 92-day period of October 1 – December 31, 2019, were used to project Medicaid days for the 365-day rate period of July 1, 2020 – June 30, 2021. For example: Oct-Dec 2019 level 171 days for Facility A = 184; 184 divided by 92 days times 365 days = 730 projected level 171 days for Facility A for FYE 6/30/21.

**Q: When there is a rebasing, will this be by individual facility or all facilities at the same time?**

A: All facilities at the same time.

**Q: Can you please clarify how Medicaid will rebase when a facility is in the process of increasing the investment in their physical building (e.g. remodeling, renovation)?**

A: The Fixed Costs Component will be based off the allowable fixed costs reported in base year cost reports. As noted, the Fixed Costs Component is subject to change each January 1 and July 1 based on approved increases to fixed costs (significant remodeling/renovation costs). Please see item #7 on the Fact Sheet at <http://dhhs.ne.gov/Documents/NFMethodFacts.pdf>.

**Q: Can you please clarify whether four years is the maximum amount of time between rebasing the entire rate for all facilities?**

A: Yes. From the Fact Sheet:

14. Subsequent base year periods will be selected by DHHS from cost report periods ending one to four years after the current base year. Specifically, the next base year may be 6/30/19, 6/30/20, 6/30/21, and/or 6/30/22.

**Q: Facilities that accept residents with severe mental health or behavioral needs and Level II PASRR evaluations experience increased costs trying to meet the needs of this special population and an increased likelihood of survey citations and lower quality ratings. Would Medicaid consider a behavioral health add-on rate or similar mechanism to help cover the cost of this special population?**

A: The Department discussed this consideration at length with providers and stakeholders involved in the rate methodology redesign, and while this was not included in the current changes, it is something the department is interested in possibly including in future year enhancements to the methodology.

**Q: What is the Administration's plans for using the COVID-related increased FMAP for nursing facility expenditures?**

A: The Department does not have any plans, at this time, to make any COVID-specific rate increases for nursing facility related expenditures.