TITLE 405 ICF/MR REIMBURSEMENT PROTECTION ACT AND NURSING FACILITY QUALITY ASSURANCE ASSESSMENT ACT

CHAPTER 1 ICF/MR REIMBURSEMENT PROTECTION ACT

1-001 SCOPE OF REGULATIONS: These regulations govern taxes levied against Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The regulations implement provisions of the ICF/MR Reimbursement Protection Act:

1. A process for calculation of the tax;
2. A schedule for remittance of the tax;
3. A penalty for failure to pay the tax;
4. A procedure for claiming a tax overpayment refund; and
5. A list of conditions under which collection of the tax is discontinued.

1-002 DEFINITIONS: As used in these regulations, unless the context otherwise requires:

CMS means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

Department means the Nebraska Department of Health and Human Services.

ICF/MR Reimbursement Protection Fund means the fund created as the repository for provider tax payments remitted by intermediate care facilities for the mentally retarded.

ICF/MR means an intermediate care facility for the mentally retarded as defined in Neb. Rev. Stat. Section 71-421 ad 471 NAC 31.

Medicaid means the medical assistance program established pursuant to Neb. Rev. Stat. Sections 68-901 to 68-949.

Net Revenue mans the revenue paid to an intermediate care facility for the mentally retarded for resident care, room, board, and services less contractual adjustments and does not include revenue from sources other than operations, including, but not limited to, interest and guest meals.

State Fiscal Year means the 12-month period from July 1 through the following June 30.

1-003 CALCULATION OF TAX: The tax amount owed by an ICF/MR provider for a given state fiscal year is the facility's net revenue from the preceding state fiscal year times the applicable percentage(s) listed below, pro-rated for mid-year changes. The ICF/MR provider must report the tax calculation by July 31st of each year on a form approved by the Department.

Percentages:

Prior to January 1, 2008	6.0%
January 1, 2008 through September 30, 2011	5.5%
Beginning October 1, 2011	6.0%

1-003.01 Tax Calculation for State Fiscal Year Ending June 30, 2008: One-half (50%) of the facility's net revenue from the fiscal year ending June 30, 2007 times 6%, plus one-half (50%) of the facility's net revenue from the fiscal year ending June 30, 2007 times 5.5%.

1-003.02 Tax Calculation for State Fiscal Year Ending June 30, 2009: The facility's net revenue from the fiscal year ending June 30, 2008 times 5.5%.

1-003.03 Tax Calculation for State Fiscal Year Ending June 30, 2010: The facility's net revenue from the fiscal year ending June 30, 2009 times 5.5%.

1-003.04 Tax Calculation for State Fiscal Year Ending June 30, 2011: The facility's net revenue from the fiscal year ending June 30, 2010 times 5.5%.

1-003.05 Tax Calculation for State Fiscal Year Ending June 30, 2012: One-fourth (25%) of the facility's net revenue from the fiscal year ending June 30, 2011 times 5.5%, plus three-fourths (75%) of the facility's net revenue from the fiscal year ending June 30, 2011 times 6%.

1-003.06 Tax Calculation for State Fiscal Year Ending June 30, 2013 Forward: The facility's net revenue from the preceding fiscal year times 6%.

1-004 Remittance of Tax: The ICF/MR provider must remit one-twelfth of the tax obligation to the Department for credit to the ICF/MR Protection Fund by the end of each month.

1-005 Penalty for Non-Payment of Tax: An ICF/MR provider that fails to pay the tax in the amount and by the date required is subject to a penalty of $500 per day of delinquency, not to exceed five percent of the annual tax obligation. The Department will assess and collect penalties and remit the funds to the State Treasurer upon receipt.

1-006 Refund of Overpayment of Tax: An ICF/MR provider who has paid an amount in excess of the required tax may request a refund. The ICF/MR provider must request the refund in writing to the Department and must identify the reason why the provider believes an overpayment has occurred and the estimated amount of the overpayment.

1-007 Discontinuation of Tax Obligation: Collection of the tax will be terminated if:

1. The amendment to the State Medicaid Plan is disapproved by CMS;
2. The Department reduces Medicaid rates paid to ICF/MR providers below the rates in effect September 1, 2003; or
3. Money in the ICF/MR Reimbursement Protection Fund is utilized for purposes other than those delineated in the enabling state legislation.

If tax collection is discontinued, the balance of the ICF/MR Protection Fund will be returned to participating facilities in proportion to their contributions to the fund.

TITLE 405 ICF/MR REIMBURSEMENT PROTECTION ACT AND NURSING FACILITY QUALITY ASSURANCE ASSESSMENT ACT

CHAPTER 2 NURSING FACILITY QUALITY ASSURANCE ASSESSMENT

2-001 SCOPE OF REGULATIONS: These regulations govern taxes levied against Nursing Facility (NF) and Skilled Nursing Facility (SNF). The regulations implement provisions of the Nursing Facility Quality Assurance Assessment Act, Neb. Rev. Stat. §§ 68-1901 to 68-1930:

1. A process for calculation of the tax;
2. A schedule for remittance of the tax;
3. A penalty for failure to pay the tax;
4. A procedure for claiming a tax overpayment refund; and
5. A list of conditions under which collection of the tax is discontinued.

2-002 DEFINITIONS: As used in these regulations, unless the context otherwise requires:

Bedhold day means a day during which a bed is kept open pursuant to the bedhold policy of the nursing facility or skilled nursing facility which permits a resident to return to the facility and resume residence in the facility after a transfer to a hospital or therapeutic leave.

CMS means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

Continuing care retirement community means an operational entity or related organization which, under an active life care contract, is currently providing a continuum of services, including, but not limited to, independent living, assisted-living, nursing facility, and skilled nursing facility services within the same or a contiguous municipality.

Department means the Nebraska Department of Health and Human Services.

Gross inpatient revenue means the revenue paid to a nursing facility or skilled nursing facility for inpatient resident care, room, board, and services less contractual adjustments, bad debt, and revenue from sources other than operations, including, but not limited to, interest, guest meals, gifts, and grants.

Good cause is limited to an emergency or natural disaster, preventing the facility from meeting the scheduled requirement and which the facility has taken reasonable steps to communicate to the Department on or before the due date. Staff turnover or a lack of awareness of the requirements is not considered good cause.

Hospital has the meaning as defined in Neb. Rev. Stat. § 71-419 and 471 NAC 31.

Life care contract means a contract between a continuing care retirement community and a resident of such community or his or her legal representative which:

1. Includes each of the following express promises:
   a. The community agrees to provide services at any level along the continuum of care levels offered by the community;
   b. The base room fee will not increase as a resident transitions among levels of care, excluding any services or items upon which both parties initially agreed; and
   c. If the resident outlives and exhausts resources to pay for services, the community will continue to provide services at a reduced price or free of charge to the resident, excluding any payments from Medicare, the medical assistance program, or a private insurance policy for which the resident is eligible and the community is certified or otherwise qualified to receive; and
2. Requires the resident to agree to pay an entry fee to the community and to remain in the community for a minimum length of time subject to penalties against the entry fee.

Medicaid means the medical assistance program established pursuant to Neb. Rev. Stat. §§ 68-901 to 68-949.

Medical assistance program means the medical assistance program established pursuant to the Medical Assistance Act.

Medicare day means any day of resident stay funded by Medicare as the payment source and includes a day funded under Medicare Part A, under a Medicare Advantage or special needs plan, or under Medicare hospice.

Medicare upper payment limit means the limitation established by 42 C.F.R. 447.272 establishing a maximum amount of payment for services under the medical assistance program to nursing facilities, skilled nursing facilities, and hospitals.

Nursing facility has the meaning as defined in Neb. Rev. Stat. § 71-424 and 471 NAC 31.

Nursing Facility Quality Assurance Fund means the fund in Neb. Rev. Stat. § 68-1926 created as the repository for provider tax payments remitted by nursing facilities and skilled nursing facilities.

Quality assurance assessment means the assessment imposed under the Nursing Facility Quality Assurance Assessment Act in Neb. Rev. Stat. § 68-1917.

Resident day means the calendar day in which care is provided to an individual resident of a nursing facility or skilled nursing facility, including the day of admission but not including the day of discharge, unless the dates of admission and discharge occur on the same day, in which case the resulting number of resident days is one resident day.

Skilled nursing facility has the meaning as defined in Neb. Rev. Stat. § 71-429 and 471 NAC 31.

State Fiscal Year means the 12-month period from July 1 through the following June 30.

Total resident days means the total number of residents residing in the nursing facility or skilled nursing facility between July 1 and June 30, multiplied by the number of days each such resident resided in that nursing facility or skilled nursing facility. If a resident is admitted and discharged on the same day, the resident shall be considered to be a resident for that day.

2-003 CALCULATION OF TAX: Except for facilities that are exempt under Neb. Rev. Stat. §68-1918, each nursing facility or skilled nursing facility licensed under the Health Care Facility Licensure Act shall pay a quality assurance assessment of $3.50 per day based on total resident days from the preceding calendar quarter, including bedhold days from the preceding calendar quarter, less Medicare days from the preceding calendar quarter. The Department shall reduce the quality assurance assessment for the two facilities with the highest volume of Medicaid residents. The reduced rate shall be $1.98 per day.

The following providers are exempt from the quality assurance assessment:

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

2-004 REMITTANCE OF TAX: Each nursing facility or skilled nursing facility shall pay the quality assurance assessment to the Department on a quarterly basis.

A nursing facility or skilled nursing facility shall calculate and report the quality assurance assessment on a form prepared and distributed by the Department (see 405-000-1). A nursing facility or skilled nursing facility shall submit the completed form with the quality assurance assessment no later than thirty days following the end of each calendar quarter, or upon the Center for Medicare and Medicaid Services (CMS) formal approval of the Nebraska Nursing Facility and Skilled Nursing Facility Quality Assurance Assessment, whichever is later. The Department will notify affected providers when CMS approval is received. The following table provides an example of data that will be utilized to calculate the tax each calendar quarter, and when the assessment is due and payable to the Department:

Calendar Quarter	Deadline for Completing and Submitting Assessment Form	Quality Assurance Assessment Payment Due Date
July 1st - Sept. 30th	October 30th	October 30th *
Oct. 1st – Dec. 31st	January 30th	January 30th *
Jan. 1st - March 31st	April 30th	April 30th *
April 1st – June 30th	July 30th	July 30th *

* The quality assurance assessment payments are not due and payable until CMS has approved the quality assurance assessment programs and related State Plan Amendment.

2-005 PENALTY FOR NON-PAYMENT OR UNDERPAYMENT OF TAX: A nursing facility or skilled nursing facility that fails to pay the full and accurate amount of the quality assurance assessment within the specified timeframe, shall pay, in addition to the outstanding amount, a penalty of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the assessment is overdue. If the Department determines that good cause is shown for failure to pay the quality assurance assessment, the Department shall waive the penalty or a portion of the penalty.

If the full and accurate amount of the quality assurance assessment has not been received by the Department within thirty days following the quarter for which the assessment is due, the Department shall withhold an amount equal to the outstanding amount and penalty owed from any payment due such nursing facility or skilled nursing facility under the medical assistance program.

The quality assurance assessment shall constitute a debt due the state and may be collected by civil action, including, but not limited to, the filing of tax liens, and any other method provided for by law.

2-006 REFUND OF OVERPAYMENT OF TAX: If the Department determines that a nursing facility or skilled nursing facility has overpaid the quality assurance assessment, the Department shall notify the nursing facility or skilled nursing facility of the refund due. Such refund shall be refunded within thirty days after the issuance of the notice.

A nursing facility or skilled nursing facility provider who has paid an amount in excess of the required tax may request a refund. The nursing facility or skilled nursing facility provider must request the refund in writing to the Department and must identify the reason why the provider believes an overpayment has occurred and the estimated amount of the overpayment.

2-007 DISCONTINUATION OF TAX OBLIGATION: The Department shall discontinue collection of the quality assurance assessments:

1. If the waiver requested or the Medicaid state plan amendment reflecting the payment rates of this act is given final disapproval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services;
2. If, in any fiscal year, the state appropriates funds for nursing facility or skilled nursing facility rates at an amount that reimburses nursing facilities or skilled nursing facilities at a lesser percentage than the median percentage appropriated to other classes of providers of covered services under the medical assistance program;
3. If money in the Nursing Facility Quality Assurance Fund is appropriated, transferred, or otherwise expended for any use other than uses permitted pursuant to the Nursing Facility Quality Assurance Assessment Act; or
4. If federal financial participation to match the quality assurance assessments made under the act becomes unavailable under federal law.

In such case, the Department shall terminate the collection of the quality assurance assessments beginning on the date the federal statutory, regulatory, or interpretive change takes effect. If collection of the quality assurance assessment is discontinued, the money in the Nursing Facility Quality Assurance Fund shall be returned to the nursing facilities or skilled nursing facilities from which the quality assurance assessments were collected on the same basis as the assessments were assessed.

2-008 APPEAL PROCESS: A nursing facility or skilled nursing facility aggrieved by an action of the Department under the Nursing Facility Quality Assurance Assessment Act, may pursuant to Neb. Rev. Stat. §68-1929, file a petition for hearing with the director of the Division of Medicaid and Long-Term Care of the Department. The hearing shall be conducted pursuant to Nebraska Administrative Code Title 465 Chapter 6.