

September 12, 2011

National Institutional Reimbursement Team
CMS, CMSO
Attention: Mark Cooley
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

RE: Nebraska TN #NE 11-²⁴~~26~~ – Rate Reduction for Nursing Facilities and ICF-MR

Dear Mr. Cooley:

Enclosed please find the above referenced amendment to the Nebraska State Plan related to a rate reduction for nursing facilities and ICF-MR. Please note that page 32 is also a pending page for SPA #11-11. In the version submitted with this SPA, we deleted the second paragraph beginning “Additionally, Levels of Care 191,192,193 and 194...”

Prior to submitting this State Plan Amendment, the Division of Medicaid and Long-Term Care sought consultation from federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact that 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 Cindy Kadavy, 402-471-4684, cindy.kadavy@nebraska.gov or for submittal questions, Pat Taft, 402-471-7787, pat.taft@nebraska.gov.

Sincerely,


Vivianne M. Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

cc: James G. Scott
Gail Brown Stevenson

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: NE 11-24	2. STATE Nebraska
FOR: HEALTH CARE FINANCING ADMINISTRATION		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, 2011	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2011 \$(1,247,016)	
		b. FFY 2012 \$(4,988,062)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pp 1,2,10,13,15,16,16a,16b,17,18,25,27,28,31,32, 45,53,61,62,67,69,76		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, pp 1,2,10,13,15,16,17,18,18a,25,27,28,31, 32,45,53,61,62,67,69,76	
10. SUBJECT OF AMENDMENT: Rate reduction for nursing facilities and ICF-MR			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor has waived review	
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED			
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: Vivianne M. Chaumont		Patricia (Pat) Taft Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509	
14. TITLE: Director, Division of Medicaid and Long-Term Care			
15. DATE SUBMITTED: September 12, 2011			
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 471 NAC 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 (see 480 NAC 5).

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 471 NAC 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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Rate Payment means per diem rates paid under provisions of 471 NAC 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 (see 480 NAC 5).

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.

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 July 1, 2009 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 471 NAC 12-011.088) will not file a cost report. The rate paid will be based on the average base rate components, effective July 1 of the rate period of all other providers in the same care classification, following the initial desk audits.

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:

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

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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). See Appendix for Administrator compensation maximums.

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

12-011.07 (Reserved)

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

12-011.08A Rate Period: The Rate Period is defined as July 1 through June 30. Rates paid during the Rate Period are determined (see 471 NAC 12011.08D) from cost reports submitted for the Report Period ending June 30 two years prior to the end of the Rate Period. For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011.

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

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

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 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 Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums 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 computation. Cost reports from providers entering or leaving Medicaid during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of three components:

1. The Direct Nursing Component adjusted by the inflation factor;
2. The Support Services Component adjusted by the inflation factor; and
3. The Fixed Cost Component.

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

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12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 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, or a maximum per diem of \$27.00 excluding personal property and real estate taxes.

12-011.08D4 Inflation Factor: For the Rate Period of July 1, 2011 through June 30, 2012, the inflation factor is negative 3.91%.

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten 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 10 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).

12-011.08F Rate Payment for Levels of Care 101, 102, 103 and 104: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. 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 (see 480 NAC 5).

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.

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12-011.08H Rates for New Providers:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A new provider is 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. For purposes of this definition, "nursing facility" means the business operation, not the physical property. A "new provider" retains that status until the start of the prospective Rate Period corresponding to the provider's first, full twelve-month Report Period.

Example A: A new provider enters the Medicaid program on May 7, 2007. Their first full twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from May 7, 2007 through June 30, 2009.

Example B: A new provider enters the Medicaid program on July 1, 2007. Their first full, twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from July 1, 2007 through June 30, 2009.

Definition: The "Report Period" for a fiscal year determines rates, or interim rates, for a "prospective Rate Period" two years after the Report Period. For example, Report Period 2006-2007 determines prospective rates, or interim rates, for the 2008-2009 Rate Period.

A. Medicaid rates for new providers, except for IHS nursing facility providers are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:

For the Rate Period beginning on the purchase date through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive interim Medicaid rates equal to the rates of the seller in effect on the purchase date, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the purchase date through the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

For the following July 1 through June 30 Rate Period, new providers receive interim rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

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If applicable, for the next July 1 through June 30 Rate Period, new providers receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the purchase date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

2. 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, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive interim Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending on the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

For the following July 1 through June 30 Rate Period, new providers receive initial interim rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits. The initial interim rates are revised based on the provider's audited Medicaid cost report for their first Report Period, subject to maximums and limitations applicable to the Rate Period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report. The revised interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period.

Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

B. Medicaid rates for new IHS nursing facility providers are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:
For the Rate Period beginning on the purchase date through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive Medicaid rates equal to the rates of the seller in effect on the purchase date, subject to maximums and limitations applicable to the Rate Period.

For the following July 1 through June 30 Rate Period, new providers receive rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period.

If applicable, for the next July 1 through June 30 Rate Period, new providers receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the purchase date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

2. 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, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification.

For the following July 1 through June 30 Rate Period, new providers receive rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

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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 471 NAC 12-011.10, Reporting Requirement and Record Retention.

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12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transactions to increase reimbursement. The transaction is subject to the payment limits of 42 CFR 447,272 (payments may not exceed the amount that can reasonable be estimated to be paid under Medicare payment principles), City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

1. 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 and the Support Services 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 and the Support Services 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 who are IHS eligible. This amount is computed after desk audit and determination of allowable costs for a Report Period. The amount is calculated as the NMAP Federal Financial Participation percentage times the difference between allowable costs for all Medicaid IHS eligible residents and the total amount paid for all Medicaid INS eligible 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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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 (<http://www2.dhhs.ne.gov/policies/PublicRecords.pdf>) 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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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. See 471 NAC 2-003 and 465 NAG 2-006 for guidelines for appeals and fair hearings.

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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For each reporting period, the total resident days (per the MDS system) at each care level are multiplied by the corresponding weight (see 471 NAC 12-013.04). 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
Medicaid Waiver Assisted Living Levels of Care			
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
Default Rate – Used for Bedhold Days and When No Assessment is Available			
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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- a. The facility must submit Form FA-66, "Long Term Care Cost Report," to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with 471 NAC 12-012, Completion of Form FA-66, "Long Term Care Cost Report," and 471 NAC 12-011 ff., Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM-15). If the facility provides both nursing facility services and special needs services, direct accounting and/or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department of Health and Human Services, Long Term Care Audit Unit.
- b. The Department shall compute the allowable cost per day from the most recent State fiscal year Form FA-66 or the most recent Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated. Payment for fixed costs is limited to the lower of the individual facility's fixed cost per diem or a maximum per diem of \$54.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to:

- a. Room and board;
- b. Preadmission and admission assessments;
- c. All direct and indirect nursing services;
- d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
- e. All routine equipment, to include suction machine, IV poles, etc.;
- f. Oxygen and related supplies;
- g. Psychosocial services;
- h. Therapeutic recreational services;
- i. Administrative costs;
- j. Plant operations;
- k. Laundry and linen supplies;
- l. Dietary services, to include tube feeding supplies and pumps;
- m. Housekeeping; and
- n. Medical records.

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31-008 Payment for ICF/MR Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/MR services;
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.

31-008.02 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 July 1, 2009) are used in determining the cost for Nebraska ICF/MRs 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.

31-008.03 Allowable Costs: The following items are allowable costs under Medicaid.

31-008.03A 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 in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

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31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department, for the purposes of rate setting, is the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

ICF/MRs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L 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). See Appendix for Administrator compensation maximums.

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".

31-008.05M 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 Personnel Operating and Non-Personnel Operating Cost Components for the facility.

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This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost 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.

31-008.05N Facility Bed Size Exception: Rates for any privately-owned ICF/MR with less than 16 beds that received Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/MRs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period for non-State-operated ICF/MR providers is defined as July 1 through June 30. Rates paid during the Rate Period are determined from cost reports submitted for the Report Period ending June 30, two years prior to the end of the Rate Period (see 471 NAC 31-008.06C1). For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011.

The Rate Period for State-Operated ICF/MR providers is defined as July 1 through June 30..

31-008.06B Report Period: Each facility must file a cost report each year for the reporting period ending June 30.

31-008.06C Rates for Intermediate Care Facility for the Mentally Retarded (ICF/MR) Excluding State-Operated ICF/MR Providers:

31-008.06C1 ICF/MRs with 16 beds or more:

Subject to the allowable, unallowable, and limitation provisions of this system, the Department determines facility-specific prospective per diem rates based on the facility's allowable, reasonable and adequate costs incurred and documented during the Report Period. The rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

1. The ICF/MR Personnel Operating Cost Component adjusted by the inflation factor;
2. The ICF/MR Non-Personnel Operating Cost Component adjusted by the inflation factor;
3. The ICF/MR Fixed Cost Component;
4. The ICF/MR Ancillary Cost Component adjusted by the inflation factor; and
5. The ICF/MR Revenue Tax Cost Component.

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31-008.06C4b ICF/MRs with 4-15 beds:

The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C5 ICF/MR Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C6 ICF/MR Ancillary Cost Component: The ancillary cost component of the rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C7 ICF/MR Inflation Factor: For the Rate Period of July 1, 2011 through June 30, 2012, the inflation factor is 0%.

31-008.06C8 ICF/MR Revenue Tax Cost Component:

31-008.06C8a ICF/MRs with 16 or more beds:

Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06C8b ICF/MRs with 4-15 beds:

Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full year's data.

31-008.06C9 ICF/MR Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten 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 10 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 increases(s).

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs. The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D6 ICF/MR Revenue Tax Cost Component: Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue divided by the prior report period facility resident days. (See 405 NAC 1-003.). The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06E 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 agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.06F Initial Rates for New Providers:

31-008.06F1 Initial Rates for New Providers of ICF/MRs with 16 beds or more: Providers entering Medicaid as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering Medicaid as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

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Facilities that provide any services other than certified ICF/MR 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. Any 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.

31-008.08A 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 Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the ICF/MR 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 from the Department; or mail copies). The total fee, based on current Department policy (<http://www2.dhhs.ne.gov/policies/PublicRecords.pdf>) must be paid in advance. The ICFIMR will receive a copy of a request to inspect its cost report.

31-008.08B Descriptions of Form FA-66, "Long-Term Care Cost Report": All providers participating in Medicaid must complete Form FA-66, consisting of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, .F (Parts 1 and 2) and "Certification by Officer, Owner, or Administrator." (See 471-000-41 and 471-000-42 for an example of all schedules.) For FA-66 must be completed in accordance with regulations found at 471 NAC 12-012. Form FA-66 contains the following schedules, as described:

1. General Data: This schedule provides general information concerning the provider and its financial records.
2. Schedule A, Occupancy Data: This schedule summarizes the licensed capacity and inpatient days for all levels of care. Part 1 identifies the certified days available, and Part 2 identifies the inpatient census data of the facility. This data is used in determining the divisor in computing the facility's per diem rate.
3. Schedule B, Revenue and Costs: This schedule reports the revenues and costs incurred by the provider. The schedule begins with the facility's trial balance, and identifies revenue offsets, adjustments, and/or allocations necessary to arrive at the Medicaid reimbursable costs. Part 1 identifies all revenues from patient services and any necessary offsets to Costs from these revenues. Part 2 identifies other revenues realized by the facility and any necessary offsets to costs from these revenues. Part 3 identifies the facility's costs, summarizes the revenue offsets, summarizes the cost adjustments, and reports any necessary allocation of reimbursable costs. Part 4 summarizes the revenue and costs reported in parts 1, 2, and 3, and reports net income and identifies provision for income tax.

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