

September 26, 2011

National Institutional Reimbursement Team
CMS, CMSO
Attention: Mark Cooley
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

RE: Nebraska TN # 11-29 – Nursing Facility Provider Tax

Dear Mr. Cooley:

Enclosed please find the above referenced amendment to the Nebraska State Plan regarding nursing facility provider tax. Please note that some of these pages are currently in pending status at CMS for NE 11-24. We have also submitted an associated Waiver request to James Scott.

Prior to submitting this State Plan Amendment, the Division of Medicaid and Long-Term Care sought consultation June 30, 2011, from federally recognized Native American Tribes 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 FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 11-29	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, 2011	

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 4,810,480 b. FFY 2012 \$19,241,917
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pages 1, 13, 15,15a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, pages 1, 13, 15

10. SUBJECT OF AMENDMENT:
Implement nursing facility provider tax.

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: Patricia (Pat) Taft Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Vivianne M. Chaumont	
14. TITLE: Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: September 26, 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.

Nursing Facility Quality Assurance Fund means the fund 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 Section 17.

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.

TN# NE 11-29

Supersedes

Approved _____

Effective _____

TN# NE 11-24

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 Assessments: Except for facilities which are exempt, each nursing facility or skilled nursing facility licensed under the Health Care Facility Licensure Act shall pay a quality assurance assessment based on total resident days, including bed-hold days, less Medicare days. The cost of the assessment will be reported on the cost report when paid. 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 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 four components:

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

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

TN# NE 11-29
Supersedes
TN# NE 11-24

Approved _____ Effective _____

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

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 the rate year beginning July 1, 2011, the 'anticipated tax payments' will be determined by annualizing total facility patient days, including bed hold days, less Medicare days from the time period beginning January 1, 2011 and ending June 30, 2011. 'Total anticipated nursing facility/skilled nursing facility patient days' will be determined by annualizing total facility patient days, including bed hold days and Medicare days, from the time period beginning January 1, 2011 and ending June 30, 2011. Nursing Facilities will not be assessed a tax on any patient days prior to July 1, 2011.

For each subsequent rate year, 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.'

12-011.08D45 Inflation Factor: For the Rate Period of July 1, 2011 through June 30, 2012, the inflation factor will be 3.03% with the approval of the waiver of the broad-based and uniformity requirements under 443.68(e)(2) of the applicable Federal regulation. The inflation factor will be a negative 3.91% if the request is not approved.

TN# NE 11-29

Supersedes

Approved _____

Effective _____

TN# NE 11-24

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.

TN# NE 11-29

Supersedes

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