

TITLE 405 NURSING FACILITY QUALITY ASSURANCE ASSESSMENT ACT  
CHAPTER 2

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:

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:

Bed-hold day means a day during which a bed is kept open pursuant to the bed-hold 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. Section 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. Sections 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. Section 71-424 ad 471 NAC 31.

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.

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. Section 71-429 ad 471 NAC 31.

State Fiscal Year means the twelve-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 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 assessment shall be three dollars and fifty cents (\$3.50) per day 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 one dollar and ninety-eight cents (\$1.98) per day.

The Department shall exempt the following providers 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

The Department shall prepare and distribute a form on which a nursing facility or skilled nursing facility shall calculate and report the quality assurance assessment. 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:

Patient Days Used to Calculate Quality Assurance Assessment	Deadline for Completing and Submitting Assessment Form	Quality Assurance Assessment Payment Due Date
July 1 <sup>st</sup> - Sept. 30 <sup>th</sup>	October 30 <sup>th</sup>	October 30 <sup>th</sup> *
Oct. 1 <sup>st</sup> - Dec. 31 <sup>st</sup>	January 30 <sup>th</sup>	January 30 <sup>th</sup> *
Jan. 1 <sup>st</sup> - March 31 <sup>st</sup>	April 30 <sup>th</sup>	April 30 <sup>th</sup> *
April 1 <sup>st</sup> - June 30 <sup>th</sup>	July 30 <sup>th</sup>	July 30 <sup>th</sup> *

\* 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 of Tax: A nursing facility or skilled nursing facility that fails to pay the quality assurance assessment within the specified timeframe, shall pay, in addition to the outstanding quality assurance assessment, a penalty of one and one-half 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 a 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 quality assurance assessment 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:

- (a) 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;
- (b) 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;
- (c) 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
- (d) 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.

## 12-011 Rates for Nursing Facility Services

### 12-011.01 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.

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).

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 & 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 based 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.

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)

REV. (6-11-2010)	NEBRASKA DEPARTMENT OF	MEDICAID SERVICES
MANUAL LETTER #	HEALTH AND HUMAN SERVICES	471 NAC 12-011.08

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 12-011.08D) 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 the Medicaid during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of ~~three~~four 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; ~~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.

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.

REV. JUNE 27, 2011

NEBRASKA DEPARTMENT OF

MEDICAID SERVICES

MANUAL LETTER #48-2011

HEALTH AND HUMAN SERVICES

471 NAC 12-011.08D4

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, 2010 through June 30, 2011, the inflation factor is negative 1.54%. For future rate periods, the inflation factor will be calculated using the following formula and will not be specified in the regulations. Once calculated, rates are available for review from the Department.

1. Audited cost and census data following the initial desk audits; and
2. Budget directives from the Nebraska Legislature.

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.