STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

COST-SHARING FOR THE CATEGORICALLY NEEDY

Effective October 24, 2011, the Nebraska Medical Assistance Program established the following schedule of copayments:

Service	Amount of copayment
Chiropractic Office Visits	$1 per visit
Dental Services	$3 per specified service
Durable Medical Equipment	$3 per specified service
Generic Drugs	$2 per prescription
Brand Name Drugs	$3 per prescription
Eyeglasses	$2 per eyeglasses
Hearing Aids	$3 per hearing aid
Inpatient Hospital Services	$15 per admission
Mental Health and Substance Abuse Services	$2 per specified service
Occupational Therapy (non-hospital based)	$1 per specified service
Optometric Office Visits	$2 per visit
Outpatient Hospital Services	$3 per visit
Physical Therapy (non-hospital based)	$1 per specified service
Physicians (M.D.'s and D,O's)	
Office Visits (Excluding Primary Care Physicians - Family Practice, General Practice, Pediatricians, Internists, and physician extenders {including physician assistants, nurse practitioners and nurse midwives) providing primary care services)	$2 per visit
Podiatrists Services	$1 per visit
Speech Therapy (non-hospital based)	$2 per specified service

As a basis for determining the copayment amount, the standard copayment amount is determined by applying up to the maximum copayment amounts specified in 42 CFR 447.54(a)(3) to the agency's average or typical payment for that service. For inpatient hospital services, the amount was calculated so as to not exceed one-half of the first day's per diem for each hospital admission.

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State Nebraska

COST-SHARING FOR THE CATEGORICALLY NEEDY

(continued from page 1)

The copayment is collected by the provider at the time the service is provided. If the client is unable to pay the copayment when the service is provided, the provider may bill the client for the amount of the copayment.

An Individual who is unable to pay the copayment is identified by self-declaration to the provider.

Certain individuals and services are excluded from copayments in compliance with 42 CFR 447.53.

Indians are exempt from copayments based on race. Effective August 1, 2012, in compliance with 42 CFR 447.57(c), payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract services for directly furnishing an item or service to an Indian will not be reduced by the amount of the enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

The State will take the following action to meet the requirements of 42 CFR 447.57(c):

Through July 31, 2012, all individuals who have a verified American Indian or Alaska Native (AI/AN) status on their eligibility record will be exempted from cost sharing. Beginning August 1, 2012, for claims processed through the Medicaid Management Information System (MMIS) for those individuals who have a verified AI/AN status on their eligibility record and receive a service or item from an Indian health care provider or a health care provider through referral under contract services will be exempt from cost sharing.

Indian Health Care Providers will be paid in full.

There will not be a cumulative maximum that applies to all charges imposed on a specified time period.

State/Territory: Nebraska

The following enrollment fee, premium or similar charge is imposed on the medically needy:

NONE

Gross Family Income (per mo.)	Charge Family Size 1 or 2	3 or 4	5 or more	Liability Period	Frequency of Charge
(1)	(2)	(3)	(4)	(5)	(6)
$150 or less					
151 - 200					
201 - 250					
251 - 300					
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 650					
651 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than $1000					

State/Territory: Nebraska

Effect on recipient of non-payment of enrollment fee, premium or similar charge: NONE

☐ Non-payment does not affect eligibility

☐ Effect is as described below:

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COST-SHARING FOR THE MEDICALLY NEEDY

Effective October 24, 2011, the Nebraska Medical Assistance Program established the following schedule of copayments:

Chiropractic Office Visits …… $1 per visit
Dental Services ……..... …… $3 per specified service
Durable Medical Equipment……$3 per specified service
Generic Drugs…… $2 per prescription
Brand Name Drugs……$3 per prescription
Eyeglasses……..... $2 per eyeglasses
Hearing Aids……...$3 per hearing aid
Inpatient Hospital Services…… $15 per admission
Mental Health and Substance Abuse Services…….....$2 per specified service
Occupational Therapy (non-hospital based)……..... $1 per specified service
Optometric Office Visits …….. $2 per visit
Outpatient Hospital Services……..... $3 per visit
Physical Therapy (non-hospital based) …… $1 per specified service
Physicians (M.D.'s and D,O's)
Office Visits ……..… $2 per visit
(Excluding Primary Care Physicians -
Family Practice, General Practice,
Pediatricians, Internists, and physician
extenders {including physician assistants,
nurse practitioners and nurse midwives)
providing primary care services)
Podiatrists Services ……..…$1 per visit
Speech Therapy (non-hospital based) ……..$2 per specified service

As a basis for determining the copayment amount, the standard copayment amount is determined by applying up to the maximum copayment amounts specified in 42 CFR 447.54(a)(3) to the agency's average or typical payment for that service. For inpatient hospital services, the amount was calculated so as to not exceed one-half of the first day's per diem for each hospital admission.

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State Nebraska

COST-SHARING FOR THE MEDICALLY NEEDY

(continued from page 1)

The copayment is collected by the provider at the time the service is provided. If the client is unable to pay the copayment when the service is provided, the provider may bill the client for the amount of the copayment.

An Individual who is unable to pay the copayment is identified by self-declaration to the provider.

Certain individuals and services are excluded from copayments in compliance with 42 CFR 447.53.

Indians are exempt from copayments based on race. Effective August 1, 2012, in compliance with 42 CFR 447.57(c), payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract services for directly furnishing an item or service to an Indian will not be reduced by the amount of the enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

The State will take the following action to meet the requirements of 42 CFR 447.57(c):

Through July 31, 2012, all individuals who have a verified American Indian or Alaska Native (AI/AN) status on their eligibility record will be exempted from cost sharing. Beginning August 1, 2012, for claims processed through the Medicaid Management Information System (MMIS) for those individuals who have a verified AI/AN status on their eligibility record and receive a service or item from an Indian health care provider or a health care provider through referral under contract services will be exempt from cost sharing.

Indian Health Care Providers will be paid in full.

There will not be a cumulative maximum that applies to all charges imposed on a specified time period.

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State/Territory: Nebraska

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

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C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

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Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

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It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

A. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:

1. Cost sharing

a. X No cost sharing is imposed.
b. ☐ Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):

Group of Individuals	Item/Service	Type of Charge			
		Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the

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family involved, as applied on a monthly and quarterly basis as specified by the State above.

- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. ☐ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

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2. ☐ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

B. For groups of individuals with family income above 150 percent of the FPL:

1. Cost sharing amounts

a. X No cost sharing is imposed.
b. ☐ Cost sharing is imposed under section 1916A of the Act as follows (specify amounts by groups and services (see below)):

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income (including monthly or quarterly period)
		Deductible	Co-insurance	Co-payment	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

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Attach a copy of the schedule of the cost sharing amounts for specific items and the various eligibility groups.

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

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d. Enforcement

1. ☐ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

2. ☐ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

a. ☐ No premiums are imposed.
b. X Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

Group of Individuals	Premium	Method for Determining Family Income (including monthly or quarterly
Children enrolled in the autism waiver with family income at or above 185% FPL who are: • Optional targeted low income Children under 1902(a)(10)(A)(ii)(XIV). OR • Children receiving home and community based services eligible under 42 CFR 435.217.	For all individuals described, premiums shall begin at 1% of family income for those with family income at or above 185% of FPL on a sliding fee scale as described on Page 5a. Total premiums imposed in a family shall never exceed 5 % of family income.	Different methodology is used for determining family income for premium by program. The premium is imposed monthly. No disregards are allowed. In addition, both the parents' and the child's income are counted when determining the family income available for paying the premium for the 217 children, while only the child's income is counted when determining the child's eligibility.

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Premium Schedule

If gross income is this % of FPL:	Premium is this percent:
185 – 204.99%	1.00% of 185% FPL
205 – 224.99%	1.25% of 205% FPL
225 – 244.99%	1.50% of 225% FPL
245 – 264.99%	1.75% of 245% FPL
265 – 284.99%	2.00% of 265% FPL
285 – 304.99%	2.25% of 285% FPL
305 – 324.99%	2.50% of 305% FPL
325 – 344.99%	2.75% of 325% FPL
345 – 364.99%	3.00% of 345% FPL
365 – 384.99%	3.25% of 365% FPL
385 – 404.99%	3.50% of 385% FPL
405 – 424.99%	3.75% of 405% FPL
425 – 444.99%	4.00% of 425% FPL
445 – 464.99%	4.25% of 445% FPL
465 – 484.99%	4.50% of 465% FPL
485 – 504.99%	4.75% of 485% FPL
505 – 524.99%	5.00% of 505% FPL
525 – 544.99%	5:00% of 525% FPL
545 – 564.99%	5.00% of 545% FPL
565 – 584.99%	5.00% of 565% FPL
585 – 604.99%	5.00% of 585% FPL
Etc.	Etc.

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b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

c. No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.
- American Indians under certain circumstances and other populations excluded in accordance with section 1916A(b)(3)(A) of the Act.

d. Enforcement

1. X Prepayment required for the following groups of individuals who are applying for Medicaid:
   Children receiving services through the Nebraska Autism waiver who are in families with income at or above 185% of the FPL. This includes children receiving home and community based services under 42 CFR 435.217 and optional targeted low income children under 1902(a)(10)(A)(ii)(XIV). (Optional targeted low income children will be terminated from waiver enrollment, but not from Medicaid enrollment, after failure to pay the premium for 60 days).

2. X Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:
   Children receiving services through the home and community based Autism Waiver under 42 CFR 435.217 will be terminated from waiver eligibility and Medicaid eligibility after failure to pay the premium for 60 days.

3. ☐ Payment will be waived on a case-by-case basis for undue hardship.

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State/Territory: Nebraska

C. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

☐ Quarterly

X Monthly

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State/Territory: Nebraska

D Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

The family of a child on the autism waiver will be sent a monthly notice indicating the premium amount due and instructions to remit payment to the Nebraska Department of Health & Human Services. Participants of the autism waiver are exempt from other co-pays and deductibles. If any of the waiver participant's family members have paid a copay under Medicaid, documentation of this payment will be made, and this amount will be deducted from the premium due, so that the family does not pay more than 5% of their total income on premiums and cost sharing.

The family's aggregate premiums, and other cost sharing requirements to which members of the family may be subject under Medicaid and CHIP, will be tracked electronically. This will be done by the State Medicaid program by obtaining monthly ad hoc reports from the Financial and Program Analysis unit of the Department of Health and Human Services. The reports will be based off all family members' Medicaid identification numbers and the amount of Medicaid copays paid under each such Medicaid ID, to ensure the family does not pay more than 5% of their total income on premiums and cost sharing.

10-010 Payment for Hospital Services:

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

This subsection applies to hospital inpatient discharges occurring on or after October 1, 2009.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

For rates effective October 1, 2009, and later, each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

APR-DRG (All Patient Refined Diagnosis Related Group): A Diagnosis Related Group classification system.

Base Year: The period covered by the most recent settled Medicare cost report, which will be used for purposes of calculating prospective rates.

Budget Neutrality: Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B2 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital certified for participation by Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Direct Medical Education Cost Payment: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year.

Disproportionate Share Hospital (DSH): A hospital located in Nebraska is deemed to be a disproportionate share hospital by having -

1. A Medicaid inpatient utilization rate equal to or above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
2. A low-income utilization rate of 25 percent or more.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

DRG Weight: A number that reflects relative resource consumption as measured by the relative costs by hospitals for discharges associated with each DRG and Severity of Illness (SOI).

Hospital Mergers: Hospitals that have combined into a single corporate entity, and have applied for and received a single inpatient Medicare provider number and a single inpatient Medicaid provider number.

Hospital-Specific Base Year Operating Cost: Hospital specific operating allowable cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, but exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Hospital-Specific Cost-to-Charge Ratio: Hospital-Specific Cost-to-Charge Ratio is based on total hospital aggregate costs divided by total hospital aggregate charges. Hospital-Specific Cost-to-Charge Ratios used for outlier cost payments and Transplant DRG CCR payments are derived from the outlier CCRs in the Medicare inpatient prospective payment system.

Indirect Medical Education Cost Payment: Payment for costs that are associated with maintaining an approved medical education program, but that are not reimbursed as part of direct medical education payments.

Low-Income Utilization Rate: For the cost reporting period ending in the calendar year preceding the Medicaid rate period, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues including fee-for-service, managed care, and primary care case management payments (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services including fee-for-service, managed care, and primary care case management payments (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and

2. The total amount of the hospital's charges for hospital inpatient services attributable to indigent care in ending in the calendar year preceding the Medicaid rate period, less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to indigent care does not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Medicaid Allowable Inpatient Charges: Total claim submitted charges less claim non-allowable amount.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Medicaid Inpatient Utilization Rate: The ratio of (1) allowable Medicaid inpatient days, as determined by Nebraska Medicaid, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out–of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

Medical Review: Review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

Medicare Cost Report: The report filed by each facility with its Medicare fiscal intermediary.

National Weights: The 3M APR-DRG National Weights are calculated using the Nationwide Inpatient Sample (NIS) released by the Healthcare Cost and Utilization Project (HCUP).

The Medicare cost report is available through the National Technical Information Service at the following address:

U.S. Department of Commerce
Technology Administration
National Technical Information Service
Springfield, VA 22161

A hospital that does not participate in the Medicare program shall complete the Medicare Cost Report in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Medicare Cost Reports are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;
2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.
   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The base payment amount is the same for all hospitals in a peer group except Peer Group 1 (Children's Hospitals), Peer Group 5 and Peer Group 6.

Reporting Period: Same reporting period as that used for its Medicare cost report.

Resource Intensity: The relative volume and types of diagnostic, therapeutic and bed services used in the management of a particular disease.

Risk of Mortality (ROM): The likelihood of dying.

Severity of Illness level (SOI): The extent of physiologic decompensation or organ system loss of function.

Tax-Related Costs: Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234) or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state or federal government, but not including income taxes.

Uncompensated Care: Uncompensated care includes the difference between costs incurred and payments received in providing services to Medicaid patients and uninsured.

10-010.03B Payment for Peer Groups 1, 2, and 3 (Metro Acute, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis, except hospitals certified as a Critical Access Hospital.

For inpatient services that are classified into a DRG, the total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
   a. Direct Medical Education Cost Payment;
   b. Indirect Medical Education Cost Payment; and
   c. A Cost Outlier Payment.

For inpatient services that are classified into a transplant DRG, the total per discharge payment is the sum of –

1. The Cost-to-Charge Ratio (CCR) Payment amount; and
2. When applicable – Direct Medical Education Cost Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount for discharges that are classified into a DRG is calculated by multiplying the peer group base payment amount by the applicable national relative weight.

10-010.03B1a Calculation of the APR-DRG Weights: For dates of service on or after July 1, 2014, the department will use the All-Patient Refined Diagnosis Related Groups (APR-DRG) grouper to determine DRG classifications. The National Weights published by 3M will be applied to the APR-DRGs. The National Weights are calculated using the Nationwide Inpatient Sample (NIS) released by the Healthcare Cost and Utilization Project (HCUP). The Department will annually update the APR-DRG grouper and national relative weights with the most current available version.

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10-010.03B1b Calculation of Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges with a DRG. Peer Group Base Payment Amounts effective July 1, 2016, are calculated for Peer Group 1, 2 and 3 hospitals based on the Peer Group Base Payment Amounts effective during SFY 2011, adjusted for budget neutrality, calculated as follows:

1. Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2011 Peer Group 1 Base Payment Amount of $4,397.00 by the DRG budget neutrality factor.

2. Children's Hospital Peer Group 1 Base Payment Amounts: Multiply the SFY 2011 Children's Hospital Peer Group 1 Base Payment Amount of $5,278.00 by the DRG budget neutrality factor.

3. Peer Group 2 Base Payment Amounts: Multiply the SFY 2011 Peer Group 2 Base Payment Amount of $4,270.00 by the DRG budget neutrality factor.

4. Peer Group 3 Base Payment Amounts: Multiply the SFY 2011Peer Group 3 Base Payment Amount of $4,044.00 by the DRG budget neutrality factor.

SFY 2007 Nebraska Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B4 in effect on September 1, 2007 and 471 NAC 10-010.03B in effect on July 1, 2001.

Peer Group Base Payment Amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be increased by .5% for the rate period beginning July 1, 2010. The Peer Group Base Payment Amount effective July 1, 2010 will be reduced by 2.5% effective July 1, 2011. The Peer Group Base Payment Amount effective July 1, 2011 will be increased by 1.54% effective July 1, 2012. The Peer Group Base Payment Amount effective July 1, 2012 will be increased by 2.25% effective July 1, 2013. The Peer Group Base Payment Amount effective July 1, 2013 will be increased by 2.25% effective July 1, 2014. The Peer Group Base Payment Amount effective July 1, 2014 will be increased by 2% effective July 1, 2015. The Peer Group Base Payment amount effective July 1, 2015, will be increased by 2% effective July 1, 2016.

10-010.03B2 Calculation of DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a DRG meeting or exceeding Medicaid criteria for cost outliers for each DRG classification. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $30,000 for all neonate and nervous system APR-DRGs at severity level 3 and at severity level 4. For all other APR-DRGs, the outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $51,800. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85% of the difference between the hospital's cost for the discharge and the outlier threshold.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B3 Calculation of Medical Education Costs

10-010.03B3a Calculation of Direct Medical Education Cost Payments:

Direct Medical Education (DME) payments effective October 1, 2009 are based on Nebraska hospital-specific DME payment rates effective during SFY 2007 with the following adjustments:

1. Estimate SFY 2007 DME payments for in-state teaching hospitals by applying SFY 2007 DME payment rates to SFY 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include all APR-DRG discharges except psychiatric, rehabilitation and Medicaid Capitated Plans discharges.
2. Divide the estimated SFY 2007 DME payments for each hospital by each hospital's number of intern and resident FTEs effective in the Medicare system on October 1, 2006.
3. Multiply the SFY 2007 DME payment per intern and resident FTE by each hospital's number of intern and resident FTEs effective in the Medicare inpatient system on October 1, 2008.
4. Divide the DME payments adjusted for FTEs effective October 1, 2008 by each hospital's number of SFY 2007 claims.
5. Multiply the DME payment rates by the stable DRG budget neutrality factor.

SFY 2007 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect September 1, 2007.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection, with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year. The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2010. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through

June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the direct medical education amount shall be reduced by 2.5%. Effective July 1, 2012, the direct medical education amount shall be increased by 1.54%. Effective July 1, 2013, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2014, the direct medical education amount shall be increased by 2.25%. Effective July 1, 2015, the direct medical education amount shall be increased by 2%. Effective July 1, 2016, the direct medical education amount shall be increased by 2%.

10-010.03B3b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from Nebraska Medicaid, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program using the following formula:

$$-[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1] * 1.35$$

On July 1st of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1st of the previous year.

10-010.03B3c Calculation of MCO Medical Education Payments: Nebraska Medicaid will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by NMMCP capitated plans from discharge data provided by the MCO. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the fee-for service direct medical education payment per discharge in effect for the rate year July 1 through June 30.

1. MCO Indirect Medical Education payments will be equal to the number of MCO discharges times the MCO indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows:
    a. Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education prior year payments.
    b. Subtotal each teaching hospital's fee-for-service inpatient covered prior state fiscal year charges.
    c. Divide each teaching hospital's indirect medical education payments, by covered prior state fiscal year charges.
    d. Multiply the ratio described in subsection c. above times the covered charges in MCO paid claims in the base year.
    e. Divide the amount calculated in subsection d. above by the number of MCO paid claims in the base year.

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10-010.03B4 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG. Capital-related payment per diem amounts effective July 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2007, adjusted for budget neutrality, as follows:

1. Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 1 Capital-related payment per diem amount of $36.00 by the Stable DRG budget neutrality factor.
2. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 2 Capital-related payment per diem amount of $31.00 by the Stable DRG budget neutrality factor.
3. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 3 Capital-related payment per diem amount of $18.00 by the Stable DRG budget neutrality factor.

SFY 2007 Capital-Related Cost Payments are described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

Capital-Related Payment Per Diem Amounts effective July, 2010 will be reduced by 2.5% effective July 1, 2011. Capital-Related Payment Per Diem Amounts effective July, 2011 will be increased by 1.54% effective July 1, 2012. Capital-Related payment Per Diem Amounts effective July, 2012 will be increased by 2.25% effective July 1, 2013. Capital-Related payment Per Diem Amounts effective July, 2013 will be increased by 2.25% effective July 1, 2014. Capital-Related payment Per Diem amounts effective July 1, 2014 will be increased by 2% effective July 1, 2015. Capital-Related payment Per Diem amounts effective July 1, 2015, will be increased by 2% effective July 1, 2016.

10-010.03B5 – (RESERVED)

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges. Transplant DRG CCRs are calculated as follows:

1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.
2. Sum the operating and capital outlier CCRs.
3. Multiply the sum of the operating and capital outlier CCRs by the Transplant DRG budget neutrality factor.

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years, before budget neutrality adjustments.

Effective July 1, 2011, the Transplant DRG CCRs will be reduced by 2.5 percent.
Effective July 1, 2012, the Transplant DRG CCRs will be increased by 1.54 percent.
Effective July 1, 2013, the Transplant DRG CCRs will be increased by 2.25%.
Effective July 1, 2014, the Transplant DRG CCRs will be increased by 2.25%.
Effective July 1, 2015, the Transplant DRG CCRs will be increased by 2%.
Effective July 1, 2016, the Transplant DRG CCRs will be increased by 2%.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation, with the exception that in step 4, DME per discharge payment amounts are adjusted by the Transplant DRG budget neutrality factor.

On July 1st of each year, the Department will update Transplant DME payment per discharge rates as described in 10-010.03B3a of this regulation.

On July 1st of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B7 Budget Neutrality Factors: Peer Group Base Payment Amounts, are multiplied by budget neutrality factors, determined as follows:

10-010.03B7a Develop Fiscal Simulation Analysis: The Department will develop a fiscal simulation analysis using Nebraska Medicaid inpatient fee-for-service paid claims data from SFY 2011. The fiscal simulation analysis includes discharges grouped into a DRG and excludes all psychiatric, rehabilitation and transplant discharges.

In the fiscal simulation analysis, the Department will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.

10-010.03B7b Determine Budget Neutrality Factors: The Department will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments, inflated by Peer Group Base Payment Amount increases approved by the Department from the end of the claims data period to the rate year. For rates effective July 1, 2014, the Department will inflate the SFY 2011 base rates by 61.05%.

10-010.03B8 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B8a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A reconciliation will be made within 6 months following receipt by the Department of the facility's settled cost report. Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B9 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B10 Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B11 Readmissions: Nebraska Medicaid adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All Nebraska Medicaid patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

10-010.03B12 Interim Payment for Long-Stay Patients: Nebraska Medicaid's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send a completed Form HCFA-1450 (UB-92) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support.

The hospital will be notified in writing if the request for interim payment is denied.

10-010.03B12a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B13 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the HCFA-1450 (UB-92) claim form.

10-010.03C Non-Payment for Hospital Acquired Conditions (HAC)
Medicaid will not make payment for conditions which are a result of avoidable inpatient hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. This means that Medicaid will, at a minimum, identify as an HAC, those secondary diagnosis codes that have been identified as Medicare HACs when not present on hospital admission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

_X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under
Section 4.19 (A) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

Non-Payment for Hospital Acquired Conditions:

Effective July 1, 2011 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Health Care-Acquired Condition (HCAC).

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges.

Provider Preventable conditions (PPC), which includes Health Care-Acquired Condition (HCAC), with diagnosis codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Providers must identify and report PPC occurrences.

For hospitals reimbursed under a per diem methodology, to the extent that the cost of the hospital acquired condition can be isolated, payment for the cost of the hospital acquired condition will be denied.

Non-Payment for Other Provider Preventable Conditions

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report other provider preventable conditions.

Prohibition on payments for PPC, and HCAC, shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid proportionate share hospital payments.

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

Tiered rates will be used for all acute psychiatric inpatient services. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. Payment for each discharge equals the applicable per diem rate times the number of approved patient days for each tier.

Payment is made for the day of admission, but not the day of discharge.

For payment of inpatient hospital psychiatric services, effective July 1, 2014, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	$715.32
Days 3 and 4	$661.55
Days 5 and 6	$631.18
Days 7 and greater	$601.14

For payment of inpatient hospital psychiatric services, effective July 1, 2015, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	$731.41
Days 3 and 4	$676.43
Days 5 and 6	$645.38
Days 7 and greater	$614.67

For payment of inpatient hospital psychiatric services, effective July 1, 2016, the tiered per diem rate will be:

Days of Service	Per Diem Rate
Days 1 and 2	$747.87
Days 3 and 4	$691.65
Days 5 and 6	$659.90
Days 7 and greater	$628.50

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: The hospital-specific per diem rates will be increased by .5% for the rate period beginning July 1, 2010. Effective July 1, 2011, the transplant DRG DME rates will be reduced by 2.5%. Effective July 1, 2012, the transplant DRG DME rates will be increased by 1.54%. Effective July 1, 2013, the transplant DRG DME rates will be increased by 2.25%. Effective July 1, 2014, the transplant DRG DME rates will be increased by 2.25%. Effective July 1, 2015, the transplant DRG DME rates will be increased by 2%. Effective July 1, 2016, the transplant DRG DME rates will be increased by 2%.

10-010.03E3 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning July 1, 2015, and after payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

10-010.03D5 Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. This rate may be reviewed annually. Effective April 12, 2008, the payment for psychiatric adult subacute inpatient hospital services identified in state regulations was $488.13. Beginning July 1, 2008, the per diem rate was $505.21 and on November 24, 2009 onward the rate is $512.79. On July 1, 2010, there will be a .5% rate increase. On July 1, 2011, there will be a 2.5% rate decrease. On July 1, 2012 there is a 1.54% increase. On July 1, 2013, there will be a 2.25% rate increase. On July 1, 2014, there will be a 2.25% rate increase. On July 1, 2015, there will be a 2.25% rate increase. On July 1, 2016, there will be a 2.25% rate increase. The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
   c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with the Nebraska Medicaid Assistance Program will be considered for eligibility as a Disproportionate Share Hospital.
3. When notified by the Department that the hospital qualifies as a Disproportionate Share Hospital (DSH), each hospital must certify to the Nebraska Medical Assistance Program that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the DSH payment.

10-010.03H1 Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital's Medicaid days, which includes the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the MMIS claims file data will be included.

2. To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease (IMDs). For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

10-010.03H2 Disproportionate Share Hospital Upper Payment Limit and Uncompensated Care Calculation: The Disproportionate Share Hospital upper payment limit and the uncompensated care calculation is the sum of the Medicaid shortfall plus the cost of uninsured care.

1. The Department will calculate the Medicaid shortfall as follows:
   a. The Department will determine the costs of Medicaid fee-for-service and managed care inpatient services by:
      (1) Calculating a hospital's routine cost per day for each cost center (e.g. Adult, Pediatrics, etc) from the CMS 2552 cost report by dividing the total costs by the total days, and
      (2) Multiplying the cost per day times the number of Medicaid allowable days provided during the same fiscal year as the filed cost report, and paid up to 150 days after the end of the fiscal year,
   b. The Department will determine costs of Medicaid fee-for-service and managed care outpatient services by:
      (1) Calculating a hospital's ancillary cost to charge ratio from the CMS 2552 cost report, and
      (2) Multiplying the total Medicaid allowable charges times the ancillary cost to charge ratio.
   c. The total Medicaid cost is the sum of the inpatient and outpatient costs for each hospital.
   d. The Medicaid shortfall is determined by subtracting the total allowable Medicaid payments from the total Medicaid cost.
2. The Department will calculate the cost of uninsured care by using each hospital's charges for services provided to uninsured patients as filed and certified to the Department for the same fiscal year as the CMS cost report used in determining costs. The Department will convert each hospital's charges to cost for uninsured patients by multiplying the charges by the overall cost-to-charge ratio determined using each hospital's CMS 2552 report for the same fiscal year used in determining cost.
3. The Medicaid upper payment limit and the uncompensated care amount shall be the sum of the Medicaid shortfall plus the cost of uninsured care.

10-010.03H3 Disproportionate Share Payments: Disproportionate share payments will be made each federal fiscal year (FFY) following receipt of all required data by the Department. The total of all disproportionate share payments must not exceed the limits on disproportionate share hospital funding as established for this State by the Centers for Medicare and Medicaid Services (CMS) in accordance with the provisions of the Social Security Act, Title XIX, Section 1923. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken.

To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

10-010.03H3a For FFY07 and succeeding years, the Department will make a disproportionate share hospital payment to hospitals that qualify for a payment under one of the following pool distribution methods.

10-010.03H3a(1) Basic Disproportionate Share Payment (Pool 1): Pool 1 consists of eligible hospitals in Peer Groups 2, 3, and 6 that are not eligible under Pool 6.

10-010.03H3a(1)(a) Total funding to Pool 1 will be $1,000,000. In FFY 2008 and following years, this amount will be increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of- state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.
2. Second, the ratio resulting from such division will be multiplied times the total funding for Pool 1 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under section 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals within Pool 1.

10-010.03H3a(2) Basic Disproportionate Share Payment Pool 2:
Pool 2 consists of eligible hospitals in Peer Groups 1, 2, and 3 that are also eligible under Pool 6.

10-010.03H3a(2)(a) Total funding to Pool 2 will be $3,154,000 for FFY 2007, and $2,654,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). The Department will calculate the payment for Pool 2 as follows:

1. First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 2.
2. Second, the ratio resulting from the division will be multiplied times the total funding for Pool 2 to determine each hospital's payment.
3. If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.
4. If payment is reduced to a hospital within Pool 2, the additional funds will be redistributed prorata to eligible hospitals within Pool 2.

10-010.03H3a(3) Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 3): Pool 3 consists of the hospital that both primarily serves children age 20 and under, and has the greatest number of Medicaid days.

10-010.03H3a(3)(a) Total funding for Pool 3 will be $3,138,000 for FFY 2007, and $3,638,000 for FFY 2008. For FFY 2009 and following years, the total funding will be the amount for FFY 2008 with an annual increase by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average). A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.

10-D10.03H3a(4) Disproportionate Share Payment for State Owned Institutions for Mental Disease (IMD) Hospitals and for eligible hospitals in Peer Group 4 (Pool 4): Pool 4 consists of state owned institutions for mental disease and other eligible hospitals in Peer Group 4.

10-010.03H3a(4)a Total funding for Pool 4 will be $1,811,337 annually. The Department will calculate payments as follows:

1. Each eligible hospitals must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospitals cost to charge ratio.
2. Payment to each hospital will be equal to the cost of its uncompensated care.

3. If the total of all disproportionate share payment amounts for Pool 4 exceeds the federally determined disproportionate share hospital limit for Nebraska, the will be reduced prorata.

10-010.03H3a(5) Non-Profit Acute Care Teaching Hospital Affiliated with a State-Owned University Medical College (Pool 5): Pool 5 consists of the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical College owned by the State of Nebraska. A hospital eligible for payment under this pool may be eligible for payment under Pool 6.

10-0103H3a(5)(a) Total funding to Pool 5 will be $15,000,000. For FFY 08 and following years the funding will be increased annually by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) .
The Department will calculate the DSH payment to Pool 4 5 as an amount equal to the cost of its uncompensated care.
If the payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

10-010.03H3a(6) Uncompensated Care Pool (Pool 6): Pool 6 consists of hospitals that provide services to low-income persons covered by a county administered general assistance (GA) program; or hospitals that provide services to low-income persons covered by the state administered public behavioral health system.

10-010.03H3a(6)(a) Total funding to Pool 6 will be the remaining balance of the total (federal and state) DSH funding minus the funding for Pools 1, 2, 3, 4, and 5, The Department will calculate payments as follows:

1. DSH payments to a hospital under all other pools will be subtracted from the hospital's DSH upper payment limit before allocating payments under Pool 6.
2. The costs for uncompensated care resulting from participation in county administered general assistance (GA) program will be reported by the county; and costs for the state administered public behavioral health system will be reported by each hospital. Reported costs will be subject to audit by the Department.
3. A ratio for each hospital will be determined based on the uncompensated cost for each hospital to the total of uncompensated cost for all hospitals in Pool 6.
4. The ratio for each hospital will be multiplied times the available funding to the Pool to yield each hospital' annual payment amount.
5. The total computable payment will be commensurate with the charges for uncompensated care resulting from participation in county administered general assistance (GA) program; or the state administered public behavioral health system.
6. The annual payment amount will be dispersed in twelve monthly payments.
7. If payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(g) of the Social Security Act, the payment will be reduced to the payment limit.
8. If payments to hospitals under this pool exceed the total allotment to Nebraska, the payments will be reduced prorata.

10-010.03H3b Limitations on disproportionate share payments:

(1) No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923 (g)(1)(A) of the Social Security Act.

(2) Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act.

10-010.03H4 Redistribution of DSH Overpayments: As required by Section 1923(j) of the Social Security Act related to auditing and reporting of Disproportionate Share Hospital payments, the Department will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009.

Beginning in DSH State Plan Rate Year 2011, if the results of audits conducted in accordance with the DSH final rule indicate that a hospital has exceeded the hospital specific DSH limit the amount of DSH payment in excess of uncompensated care costs will be recouped. Any funds recouped shall first be recouped from Pool 1 through 5 payments and then from Pool 6 payments and shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds recouped from Pools 1 through 6 shall first be redistributed to each eligible hospital in the Pool in which the hospital payment was recouped. Any recouped funds that are not able to be distributed within the Pool will accumulate and be redistributed to all eligible hospitals. The Department will calculate the redistribution as follows:

1. Pool Redistribution
   a. First, for each Pool in which funds were recouped beginning with Pool 1 and proceeding in Pool numerical order, each hospital's difference between their DSH payment and DSH limit will be calculated. The difference will be divided by the sum of the difference between the DSH payment and DSH limit for all hospitals in the Pool.
   b. Second, the ratio resulting from such division will be multiplied times the total funding recouped for the Pool to determine each hospital's redistribution payment.
   c. If the sum of the original DSH payment and redistribution payment exceeds the DSH payment limit, the payment will be reduced.
   d. If payment is reduced to a hospital within a Pool, the additional funds will be redistributed prorata to eligible hospitals within the Pool. If all hospitals within the Pool have reached their DSH limit, the remaining funds will be carried forward to be redistributed to all eligible hospitals. For Pool 6, each hospital's difference between their DSH payment and DSH limit will include funds redistributed from Pools 1 through 5 above.
2. Final Redistribution
   a. First, for any funds that were not redistributed for each Pool in which funds were recouped, each hospital's (except for Pool 4 IMDs) difference between their DSH payment and DSH limit will be calculated. The difference will be divided by the sum of the difference between the DSH payment and DSH limit for all non-IMD hospitals.
   b. Second, the ratio resulting from such division will be multiplied times the total recouped funding not already distributed to determine each hospital's redistribution payment.
   c. If the sum of the original DSH payment and redistribution payment exceeds the DSH payment limit, the payment will be reduced.
   d. If payment is reduced to a hospital, the additional funds will be redistributed prorata to eligDible non-IMD hospitals within the Pool. If all non-IMD hospitals have reached their DSH limit, the federal portion of remaining funds will be returned to CMS.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day. The cost-to-charge ratio is the peer group average.

Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.

10-010.03J1 Exception: The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that-

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under 471NAC 10-010.03ff.

10-010.03L Free-Standing Psychiatric Hospitals: When a free-standing psychiatric hospital (in Nebraska or out of state) does not have ancillary services on-site, such as pharmacy or laboratory, the provider of the ancillary service shall bill NMAP for the ancillary services provided to inpatients. The hospital shall not include these ancillary costs on its cost report. The hospital's rate is calculated according to 471 NAC 10-010.030, and/or 10-010.03J. This is an exception to policies related to the elimination of combined billing in 471 NAC 10-003.05C and following.

10-010.03M Rate-Setting Following a Change in Ownership: The rate-setting process for facilities with a change in ownership will be the same as the rate-setting process used prior to the change in ownership as described in these regulations.

10-010.03N Rate-Setting Following a Hospital Merger: Hospitals that have combined into a single entity shall be assigned a single combined weighted average for each of the following: direct medical education amount, if applicable, indirect medical education amount, if applicable, cost-to-charge ratio, outpatient percentage, capital amount, and any other applicable rates or add-ons. The weights shall equal each hospital's base year Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the current fiscal year rates which were calculated for each hospital.

10-010.030 Rate-Setting for a New Operational Facility: The Department shall establish a prospective per discharge rate for a new operational facility for Peer Groups 1-5. The rate will be the average peer group rate for the respective peer group for the new facility. For critical access hospitals, the rate will be determined individually for each hospital based on reasonable cost. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as a Regional Rural Referral Center;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year Medicaid discharges;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the Nebraska Department of Health and distinct parts as defined in these regulations.
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

10-010.03P Depreciation: The Department recognizes depreciation as an allowable cost as reported on each facility's Medicare cost report and as determined allowable by the Medicare intermediary through application of Medicare principles of reimbursement.

10-010.03Q Recapture of Depreciation: A hospital which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department; or
2. The product of
   a. The ratio of Medicaid allowed inpatient days to total inpatient days; and
   b. The amount of gain on the sale as determined by the Medicare intermediary.

$\frac{\text{\# of Medicaid Inpatient Days}}{\text{Total \# of Inpatient Days}}$ X Gain on Sale in $ = Recapture Amount

The year(s) for which depreciation is to be recaptured is determined by the Medicare Intermediary according to Medicare principles of reimbursement.

10-010.03R Adjustment to Rate: Changes to Medicaid total allowable costs as a result of error, audit, or investigation may become the basis for adjusting current and/or prior prospective rates. The adjustment will be made back to the initial date of payment for the period affected based on the rate as determined by the Department. Hospitals will receive written notice of any adjustment stating the amount of the adjustment and the basis for the adjustment. If the rate adjustment results in decreasing a hospital's rate, the hospital shall refund the overpayment amount as determined by the Department to the Department. If the rate adjustment results in increasing a hospital's rate, the Department shall reimburse the underpayment amount as determined by the Department to the hospital.

10-010.03S Lower Levels of Care: When the Department determines that a client no longer requires inpatient services but requires skilled nursing care and there are no . skilled nursing beds available when the determination is made, the Department will pay only for authorized medically necessary skilled nursing care provided in an acute care hospital at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year.

When a Medicaid patient no longer requires inpatient hospital services and has requested nursing home admission and is waiting for completion of the pre-admission screening process (PASP), the Department may pay for the PASP days the client remains in the hospital before the pre-admission screening process is completed at a rate equal to the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year. The hospital shall request prior authorization from the Medicaid Division before the PASP days are provided. The Medicaid Division will send the authorization to the hospital. The hospital shall bill for class of care 81 and enter the prior authorization document number from Form MC-9 on Form HCFA-1450 (UB-92). The claim for the PASP days must be separate from the claim for the inpatient days paid at the acute rate. The PASP days will be disallowed as acute care days and NMAP will pay the average rate per patient day paid by the Department to skilled nursing facilities during the previous calendar year for the PASP day. PASP days will not be considered in computing the hospital's prospective rate.

10-010.03T Access to Records: Hospitals shall make all records relating to the care of Medicaid patients and any and all other cost information available to the Department, its designated representatives or agents, and/or representatives of the federal Department of Health and Human Services, upon reasonable notice during regular business hours.

Hospitals shall allow authorized representatives of the Department of Health and Human Services Finance and Support, the federal Department of Health and Human Services, and state and federal fraud and abuse units to review and audit the hospital's data processing procedures and supportive software documentation involved in the production of computer-encoded claims submitted to the Department. The hospital shall allow the authorized representatives access for the purpose of audit and review at any reasonable time during normal working hours upon written notice by the Department at least one working day before the review and audit.

10-010.03U Audits: The Department periodically performs or receives cost report audits to monitor the accuracy of data used to set rates. Audits may be performed by the hospital's Medicare intermediary, the Department, or an independent public accounting firm, licensed to do business in Nebraska and retained by the Department. Audits will be performed as determined appropriate by the Department.

10-010.03V Provider Appeals: A hospital may submit additional evidence and request prompt administrative review of its prospective rate within 90 days of the rate notification date according to the procedures in 471 NAC 2-003 ff. A hospital may also request an adjustment to its rate (see 471 NAC 10-010.03W).

10-010.03W Request for Rate Adjustments: Hospitals may submit a request to the Department for an adjustment to their rates for the following:

1. An error in the calculation of the rate. Hospitals may submit a request for adjustment to their rate if the rate-setting methodology or principles of reimbursement established under the State Plan were incorrectly applied, or if incorrect data or erroneous calculations were used in the establishment of the hospital's rate.
2. Extraordinary circumstances. Hospitals may submit a request for adjustment to their rate for extraordinary circumstances that are not faced by other Nebraska hospitals in the provision of hospital services. extraordinary circumstances are limited to circumstances occurring since the base year that are not addressed by the reimbursement methodology. extraordinary circumstances are limited to -
   a. Changes in routine and ancillary costs, which are limited to -
      (1) Intern and resident related medical education costs; and
      (2) Establishment of a subspecialty care unit;
   b. Extraordinary capital-related costs. Adjustment for capital-related costs will be limited to no more than a five percent increase.
3. Catastrophic circumstances. Hospitals may submit a request for adjustment to their rate if they incur allowable costs as a consequence of a natural or other catastrophe. The following circumstances must be met to be considered a catastrophic circumstance:
   a. One-time occurrence;
   b. Less than twelve-month duration;
   c. Could not have been reasonably predicted;
   d. Not of an insurable nature;
   e. Not covered by federal or state disaster relief;
   f. Not a result of malpractice or negligence.

In all circumstances, requests for adjustments to rates must be calculable and auditable. Requests must specify the nature of the adjustment sought and the amount of the adjustment sought. The burden of proof is that of the requesting hospital.

If an adjustment is granted, the peer group rates will not be changed.

In making a request for adjustment for circumstances other than a correction of an error, the requesting hospital shall demonstrate the following:

1. Changes in costs are the result of factors generally not shared by other hospitals in Nebraska, such as improvements imposed by licensing or accrediting standards, or extraordinary circumstances beyond the hospital's control.
2. Every reasonable action has been taken by the hospital to mitigate or contain resulting cost increases. The Department may request that the hospital provide additional quantitative and qualitative data to assist in evaluation of the request. The Department may require an on-site operational review of the hospital be conducted by the Department or its designee.
3. The rate the hospital receives is insufficient to provide care and service that conforms to applicable state and federal laws, regulations, and quality and safety standards.

Requests for rate adjustments must be submitted in writing to the Administrator, Medicaid Division, Nebraska Department of Health and Human Services Finance and Support. Requests must be received within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rates. Upon receipt of the request, the Department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Department's receipt of the request. Regardless of the Department's decision, the provider will be afforded the opportunity for a conference if requested for a full explanation of the factors involved and the Department's decision. Following review of the matter, the Administrator shall notify the facility of the action to be taken by the Department within 30 days of receipt of the request for review or the date of the conference, except in circumstances where additional information is requested or additional investigation or analysis is determined to be necessary by the Department.

If rate relief is granted as a result of a rate adjustment request, the relief applies only to the rate year for which the request is submitted (except for corrections of errors in rate determination). If the provider believes that continued rate relief is justified, a request in any subsequent year may be submitted.

Under nc circumstances shall changes in rates resulting from the request process result in payments to a hospital that exceed its actual Medicaid cost, calculated in conformity with this Medicaid cost calculation methodology.

10-010.03X Administrative Finality: See 471 NAC 3-001.09.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

INPATIENT PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs) FOR INDIVIDUALS UNDER AGE 19

Reimbursement for inpatient psychiatric services for under age 19 in a PRTF is based on a Medicaid fee schedule established by the State of Nebraska with prospective, statewide per diem rates for each reimbursement category of facility. Payment will be a per diem for active treatment on each child's treatment plan provided by the facility. Medically necessary services and/or supplies, including dental, vision, diagnostic/radiology, prescribed medications, not otherwise included in the PRTF rate when that care is reflected in the individual's plan of care may be billed directly to Medicaid. Physician activities on the treatment plan provided by and in the facility will be paid separately. The reimbursement categories are as follows:

- General hospital-based PRTF;
- General free-standing PRTF; and
- Specialty free-standing PRTF, including facilities treating multiple conditions or sexually deviant behaviors

The fee schedule will be based on modeled costs. Costs for private, in-state facilities consistent with 42 CFR Section 413, Nebraska regulations and policies, OMB Circular A-122 and the Medicare Provider Reimbursement Manual (CMS Publication 15-1), commercial third party payments and market rates will be considered when establishing the fee schedules. For PRTFs, the rates will consider the allowable costs as reported by providers in a standardized expense report. The cost data are adjusted to reflect changes in the service definition, to account for differences in service definitions between the historical reporting period and the period in which the rates will be in effect. In addition, the cost data are adjusted for cost of living increases. DHHS will not pay more than the facility's usual and customary daily charges billed for eligible recipients. Fees will not exceed the Medicare upper limit when applicable. Fees will be consistent with efficiency, economy and quality of care per Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200. Fees will be sufficient to assure the availability of services to clients as required by 42 CFR 447.204. DHHS will not cost settle for services provided to recipients admitted to privately operated PRTFs reimbursed under the above fee schedule prospective payment system. The statewide prospective fee schedule per diems shall constitute full reimbursement for privately operated PRTFs with pharmacy, medically necessary services and/or supplies including dental, vision, diagnostic/radiology, not included in the PRTF rate and physician services being paid separately. Public PRTFs are IMDs and will be cost-settled per Attachment 4.19A, page 18. The PRTF per diem rates are for Medicaid clients under nineteen years of age unless, per 42 CFR 435.1009, the child was receiving PRTF inpatient psychiatric services under 42 CFR 440.160 prior to his 19th birthday, in which case the child may receive services until he is unconditionally released or, if earlier, the date he reaches age 19. Payment rates do not include costs of providing educational services.

INPATIENT PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs) FOR INDIVIDUALS UNDER AGE 19 (cont.)

The PRTF reimbursement is for treatment, provided by and in the facility when it was found during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child's care per 42 CFR 441.155 and address on the active treatment plan. The PRTF per diem includes all care found on the active treatment plan per the assessed needs at 42 CFR 441.155 except for physician, medically necessary services and/or supplies including dental, vision, diagnostic/radiology, prescribed medications, not otherwise included in the PRTF rate, which are reimbursed separately on a fee schedule set consistent with the methodology outlined in Attachment 4.19-B, Item 12. The PRTF reasonable activities are child specific and must be necessary for the health and maintenance of health of the child while he or she is a resident of the facility. The medically necessary care must constitute a need that contributes to the inpatient treatment of the child. The Physician activities in PRTFs will be reimbursed based on a fee schedule set consistent with the methodology outlined in Attachment 4.19-B, Item 5.

The PRTF treatment activities included in the per diem rates that must be provided by the facility are those activities that can reasonably be anticipated and placed on the active treatment plan according to the assessed needs of the child. The prospective per diem rate is considered payment in full for these Medicaid-eligible portions of the payment rate per 42 CFR 447.15, and may not be balance billed to the family or legal guardian.

PRTF Treatment Activities in Per Diem PRTF Fee Schedule Rates

Hospital Based PRTF	**Free-Standing PRTF:**
OT/PT/ST	OT/PT/ST
Laboratory	Laboratory
Transportation	Transportation

Except as otherwise noted in the plan, the state-developed fee schedule are the same for both governmental and private providers of inpatient psychiatric residential treatment facility services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2015, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

- The fee schedule amounts for Clinical Laboratory services are based on 100% Medicare Clinical Laboratory Fee Schedule. The Department shall update the Clinical Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.
- The fee schedule amounts for Injectables are based on 100% Medicare Drug fee schedule. The Department shall update the Injectables Fee Schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.
- Injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the estimated acquisition cost (EAC) used to reimburse pharmacy claims.
- The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date.
- Payment methods for each service are defined in Attachment 4.19B, Methods and Standards for Establishing Payment Rates, as referenced below.

Service	**Attachment**	**Effective Date**
CHIROPRACTORS' SERVICES	ATTACHMENT 4.19-B Item 6c, Page 1 of 2	July 1, 2015
PHYSICIANS' SERVICES	ATTACHMENT 4.19-B Item 5, Page 1 and 2	July 1, 2015
OPTOMETRISTS' SERVICES	ATTACHMENT 4.19-B Item 6b, Page 1	July 1, 2015
MENTAL HEALTH SERVICES	ATTACHMENT 4.19-B Item 9, Page 1 of 4	July 1, 2015
PHYSICAL THERAPY	ATTACHMENT 4.19-B Item 11a, Page 1 of 2	July 1, 2015
OCCUPATIONAL THERAPY	ATTACHMENT 4.19-B Item 11b, Page 1 of 2	July 1, 2015

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Service	Attachment	Effective Date
SPEECH, HEARING, AND LANGUAGE DISORDERS	ATTACHMENT 4.19-B Item 11c, Page 1 of 2	July 1, 2015
DENTURIST SERVICES	ATTACHMENT 4.19-B Item 12b	July 1, 2015
PROSTHETIC DEVICES SERVICES	ATTACHMENT 4.19-B Item 12c	July 1, 2015
OPTOMETRIST'S SERVICES	ATTACHMENT 4.19-B Item 12d	July 1, 2015
EXTENDED SERVICES TO PREGNANT WOMEN	ATTACHMENT 4.19-B Item 20, Page 1 of 2	July 1, 2015
AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN	ATTACHMENT 4.19-B Item 21, Page 1 of 2	July 1, 2015
TRANSPORTATION SERVICES	ATTACHMENT 4.19-B Item 24a	July 1, 2015
TELEHEALTH SERVICES	ATTACHMENT 4.19-B Item 1a	July 1, 2015
CHILDREN'S MENTAL HEALTH & SUBSTANCE ABUSE MST/FFT	ATTACHMENT 4.19-B Item 4b, Page 3	July 1, 2016
FREESTANDING BIRTH CENTER SERVICES	ATTACHMENT 4.19-B Item 27	July 1, 2015
PEDIATRIC FEEDING DISORDER CLINIC	ATTACHMENT 4.19-B Item 9, Page 5	July 1, 2015
OTHER OUTPATIENT SERVICES	ATTACHMENT 4.19-B Item 2a, Page 4	July 1, 2015
PERSONAL ASSISTANCE SERVICES	ATTACHMENT 4.19-B Item 26	July 1, 2015
ANATOMIACL LABORATORY SERVICES	ATTACHMENT 4.19-B Item 3, Page 1 of 3	July 1, 2015
X-RAY SERVICES	ATTACHMENT 4.19-B Item 3, Page 2	July 1, 2015

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Service	Attachment	Effective Date
HOME HEALTH SERVICES	ATTACHMENT 4.19-B Item 7, Page 1 and 2 of 2	July 1, 2015
DENTAL SERVICES	ATTACHMENT 4.19-B Item 10, Page 1 of 2	July 1, 2015
AMBULANCE	ATTACHMENT 4.19-B Item 23a	July 1, 2015
ANESTHESIA	ATTACHMENT 4.19-B Item 6d	July 1, 2015
DURABLE MEDICAL EQUIPMENT – MEDICAL SUPPLIES	ATTACHMENT 4.19-B Item 7c	July 1, 2015
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES	ATTACHMENT 4.19-B Item 4b, Page 1 and 2	July 1, 2015
NURSING SERVICES	ATTACHMENT 4.19-D Page 5	July 1, 2015
ICF/IDD SERVICES	ATTACHMENT 4.19-D Page 55	July 1, 2015
PODIATRISTS' SERVICES	ATTACHMENT 4.19-B Item 6a, Page 1	July 1, 2015
PRTF SERVICES	ATTACHMENT 4.19-A Page 30	July 1, 2015
SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION	ATTACHMENT 4.19-B Item 13d, Page 1a	July 1, 2015

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State Nebraska

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Telehealth services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions (OPPC)

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26, Medicaid agency assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The State can reasonable isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (B) of this State plan, the Medicaid agency will utilize modifiers that are self-reported by providers on claims that indicate if an OPPC occurred. When one of the OPPC modifiers is present on the claim, the Medicaid agency will calculate a non-payment amount to ensure that the services rendered which the OPPC pertains to are not paid by the Medicaid agency.

This provision applies to all providers contracted with the Medicaid agency.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 2015, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Eighty percent (80%) of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-ll, Worksheet C); multiplied by
2. The hospital's submitted charges on Form CMS-1450 (UB-04).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form CMS-1450 (UB-04) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services based on the fee schedule determined by Medicare.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 2015, payment for outpatient services of a CAH is one hundred percent (100%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at one hundred percent (100%) of the reasonable cost of providing the services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made at the rate established by Medicaid for the appropriate group of procedures.

Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (see definition of medical emergency in NAC 10-001.03
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as charges and included in the inpatient per diem); or
3. The patient is referred by a physician or licensed nurse practitioner such as for allergy shots or when traveling (a written referral by the physician or licensed nurse practitioner must be attached to the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly.
When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. All other Medicaid allowable charges incurred in this type visit will be paid at eighty percent (80%) of the ratio of cost-to-charges.

Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as stat fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (an operational facility) will be made at eighty percent (80%) of the statewide average ratio of cost to charges for Nebraska hospitals as of July 1 of that year as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using eighty percent (80%) of the statewide average ratio of cost to charges. The cost settlement will be the lower of cost or charges as reflected on the hospital's cost report (i.e., the Department's payment must not exceed the upper limit of the provider's charges for services).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services.

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges times eighty percent (80%) for all Nebraska hospitals for that fiscal year as of July 1 of that year.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OUTPATIENT HOSPITAL SERVICES

NMAP pays for covered psychiatric partial hospitalization services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of psychiatric partial hospitalization services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

_X_ The payment methodology for RHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

___ The payment methodology for RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

_X_ The payment methodology for RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined methodology will:

1) be agreed to by the State and the center or clinic in a written memorandum form; and
2) will result in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

RURAL HEALTH CLINICS

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the RHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the combined Total Adjusted Visits from the two fiscal year cost reports (Form HCFA - 222-92 Worksheet C, Part 1, Line 6; or Form HCFA - 2552-96 Worksheet M-3, Line 6).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

ALTERNATIVE PAYMENT METHODOLOGY (APM)

For the rate period January 1, 2001, through September 30, 2001 centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the center/clinic must make this selection on the written memorandum form provided by the Department.

Under the Alternative Payment Method, the rate for Rural Health Clinic (RHC) services provided by provider-based RHCs associated with hospitals of 50 beds or less is the lower of cost or charges, as established by Medicare. Rates for the provider-based RHC centers/clinics associated with hospitals of 50 beds or more and Independent Rural Health Clinics are computed at the all inclusive encounter rate established by Medicare. The center/clinic's final rate for January 1, 2001 through September 30, 2001, is the greater of the APM rate or the PPS base rate. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).

For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to Nebraska Medicaid practitioners fee schedule.

RATES FOR NEW RHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new RHCs entering the program after 1999, will be the average PPS rate of all RHC clinic/centers in Nebraska. The RHC's individual PPS base rate will be computed later, using its initial cost report. Once the PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). The interim rate will be retroactively settled based on the RHC clinic/center's initial cost report.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RHC MANAGED CARE PAYMENT

RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly State supplemental payments for the cost of furnishing such services, the difference between the payment the RHC receives from MCE(s) and the payments the RHC would have received under the alternative methodology. At the end of each RHC fiscal year, the total amount of supplemental and MCE payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHCs contract with MCE(s) would have yielded under the alternative methodology. The RHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the RHC if the alternative method is less than the total amount of the supplemental and MCE payments.

Reimbursement for radiology services is included in the encounter rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

It is the responsibility of the centers/clinics to inform and supply the State of Nebraska with necessary documentation regarding changes to types of service, cost reports and any other documentation.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. RHC core services provided via telehealth technologies are not covered under the encounter rate. See Attachment 3.1A, Item 2b.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

_X_ The payment methodology for FQHCs will conform to Section 702 of the BIPA 2000 legislation. (All States should check this one.)

___ The payment methodology for FQHCs will conform to the BIPA 2000 requirements Prospective Payment System.

_X_ The payment methodology for FQHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology will:

1. be agreed to by the State and the center or clinic; and
2. will result in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

FEDERALLY-QUALIFIED HEALTH CENTERS

FQHCs will be reimbursed under one of two methodologies as described below:

a) PROSPECTIVE PAYMENT SYSTEM (PPS)

Effective January 1, 2001, the Prospective Payment System (PPS) base rate will be computed as follows:

1. Combine reasonable costs from the FQHC center/clinic fiscal year 1999 and 2000 cost reports.
2. Divide the costs by the combined Total Adjusted Visits from the two fiscal year cost reports (Form HCFA - 222-92 Worksheet C, Part 1, Line 6; or Form HCFA - 2552-96 Worksheet M-3, Line 6).

This PPS base rate will be the center's final rate for January 1, 2001 through September 30, 2001. Beginning October 1, 2001, the PPS base rate will be updated annually based on the Medicare Economic Index (MEI).
The PPS base rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the FQHC. An adjustment to the base rate upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. A change in the scope of FQHC services shall occur if:

- The center/clinic has added or has dropped any service that meets the definition of FQHC services as provided in Section 1905(a)(2)(B) and (C); and
- The service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

b) ALTERNATIVE PAYMENT METHODOLOGY (APM)

Effective January 1, 2016, the Alternative Payment Methodology (APM) base rate will be computed as follows:

1. Total FQHC Allowable Costs (Line 10 of Part II Determination of Total Allowable Cost) Applicable to RHC/FQHC Services
2. Total FQHC Non-Allowable Costs (Line 11 of Part II Determination of Total Allowable Cost Applicable to RHC/FQHC Services)
3. Total Overhead (Line 14 of Part II Determination of Total Allowable Cost Applicable to RHC/FQHC Services)
4. Total FQHC Visits (Line 8 of Part I Visits and Productivity)
5. Total Physician Visits Under Agreement (Line 9 of Part I Visits and Productivity)
6. Calculate allowable cost percentage by applying the ratio of allowable to total cost
7. Apply allowable cost percentage to total overhead
8. Compute the total allowable cost including overhead
9. Compute the total visits
10. Calculate the cost per visit
11. Trend the cost per visit for each base year to the YE2014 time period using the Medicare Economic Index (MEI).
12. Calculate a blended average cost per visit across the three years of base data for each FQHC. In general, the average weight used for the YE2012/2013/2014 time periods is 10%/25%/65% although this percentage should be determined to give apparent outliers lower weighting.
13. The YE2014 blended rate is then projected to the CY2016 using a three-year average MEI trend of 0.8% per year.

The rate paid to the center or clinic under this methodology will result in payment of an amount which is at least equal to the PPS payment rate. The APM base rate will be updated annually based on the Medicare Economic Index (MEI). The State will periodically rebase the FQHC encounter rates using the FQHC most recent available cost reports and other relevant data. Rebasing will be done only for clinics that are reimbursed under the APM.

A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not constitute a change in the scope of services. Also, a change in the cost of service is not considered in and itself a change in the scope of services.
It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provided the proper documentation to support the rate change. Adjustments to the base rate for the increase or decrease in scope of services will be reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

FQHC MANAGED CARE PPS PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC's fiscal year, the total amount of the supplemental and the MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the supplemental MCE payments.

For Medicaid clients enrolled with a managed care entity (MCE), the State anticipates that the MCE will pay each center/clinic, an encounter rate that is at least equal to the PPS base rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the MCE's data at least quarterly and verify that the payments made by the MCE in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers/clinics reimbursed under the PPS and APM rate methodology.

Effective January 1, 2016 and for date of service on or after January 1, 2016, centers/clinics may choose to have their rate computed under the Alternative Payment Methodology. To choose this method, the FQHC center/clinic must make this selection on the written memorandum form provided by the Department.

The Nebraska Medical Assistance Program (NMAP) makes payment for services provided by federally-qualified health centers (FQHCs) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of 100 percent of reasonable costs attributed to the care of Medicaid-eligible clients, as established by the Nebraska Department of Health and Human Services Finance and Support.

Reasonable costs are determined by the Department on the basis of the FQHCs cost report, submitted as the Medicare cost report (Form HCFA-222). Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

An FQHC paid under this APM in accordance with Section 1902(bb)(6) of the act will receive 100% of their rate in effect as of this date, as determined and described in section (b).
For those non-FQHC services for which no charge has been established by Medicare, NMAP makes payment according to Nebraska Medicaid practitioner fee schedule.

FQHC MANAGED CARE APM PAYMENT

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payment the FQHC receives from MCE(s) and the payments the FQHC would have received under the alternative methodology. At the end of each FQHC fiscal year, the total amount of supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHCs contract with MCE(s) would have yielded under the alternative methodology. The FQHC will be paid the difference between the amount calculated using the alternative methodology and the actual number of visits, and the total amount of the supplemental and MCE payments received by the FQHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC if the alternative method is less than the total amount of the supplemental and MCE payments.

Effective January 1, 2017, for Medicaid clients enrolled with a managed care entity (MCE), the State anticipates that the MCE will pay each center/clinic, an encounter rate that is at least equal to the PPS base rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the MCE's data at least quarterly and verify that the payments made by the MCE in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers/clinics reimbursed under the PPS and APM rate methodology.

RATES FOR NEW FQHC CENTERS/CLINICS

Effective January 1, 2001, initial interim rates for new FQHCs entering the program after 1999, will be the average PPS rate of all FQHC clinic/centers in Nebraska. The FQHC's individual PPS or APM base rate will be computed later, using its initial cost report. Once the PPS/APM base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI). The interim rate will be retroactively settled based on the FQHC center/clinic initial cost report. The State will periodically rebase the FQHC APM rates using the FQHC most recent available cost reports and other relevant data

Payment for Telehealth Services: Payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telehealth encounter) will be equal to what would have been paid without the use of telehealth. If a core service is provided via telehealth and the center/clinic is the distant site, the FQHC will be reimbursed at the PPS or the APM encounter rate (whichever was chosen at the time of the service). Non FQHC services provided via telehealth would not be eligible for PPS/APM payment. Non-FQHC services will be paid according to the Nebraska Medicaid Practitioners Fee Schedule.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Telehealth services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at
http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH-FACILITIES

Indian Health Service facilities or 638 Tribal facilities will be paid at the most current encounter rate established by the Indian Health Service which is published periodically in the Federal Register for established services provided in a facility that would ordinarily be covered services through the Nebraska Medicaid Program. An encounter includes:

a. A practitioner visit which may be a:
   1. physician, doctor of osteopathy, physician assistant, nurse practitioner, or certified nurse midwife,
   2. dentist,
   3. optometrist,
   4. podiatrist,
   5. chiropractor,
   6. speech, audiology, physical or occupational therapist,
   7. mental health provider such as a psychologist, psychiatrist, licensed mental health practitioner, certified drug and alcohol counselor, or a certified nurse practitioner providing psychotherapy or substance abuse counseling or other treatment with family and group therapy, or
   8. Pharmacists.
b. Diagnostic services such as:
   1. radiology
   2. laboratory
   3. psychological testing or
   4. assessment (mental health)
c. Supplies used in conjunction with a visit such as dressings, sutures, etc.
d. Medications used in conjunction with a visit such as an antibiotic injection, and
e. Prescribed drugs dispensed as part of the encounter.

Services not included in the encounter rate will be paid at the Medicaid fee for service allowable rate.

Encounters: Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same day within the IHS or Tribal (638) facility constitute a single visit.

Exceptions:
a. When the patient is seen in the clinic, or by a health professional, more than once in a day for distinctly different diagnosis. Documentation must include unrelated diagnosis codes;
b. When the patient must return to the clinic for an emergency or urgent care situation subsequent to the first encounter that requires additional diagnosis or treatment;
c. When a patient requires a pharmacy encounter in addition to a medical health professional or mental health encounter on the same day. Medicaid covers only one pharmacy encounter per day; and
d. When the patient is seen in the clinic by a clinical social worker or psychologist for a mental health encounter in addition to a medical health professional encounter on the same day.

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service. Tribal Health Clinic Core Services provided via telehealth technologies are not covered under the encounter rate.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, NMAP pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services, including collection of laboratory specimens by venipuncture or catheterization, is paid based on the fee schedule determined by Medicare.

X-Ray Services

For dates of service on or after August 1, 1989, NMAP pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. Updates are adjusted based on the Medicare fee schedule.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

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The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for the professional component only provided to hospital inpatient or outpatient is made according to the Nebraska Medicaid Practitioner Fee Schedule, not to exceed 40 percent of the payment for the total component, as allowed under the fee schedule, for the service provided in a non-hospital setting.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes.

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SKILLED NURSING FACILITIES

See Attachment 4.19-D

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EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, NMAP pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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Medicaid reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
    a. Not appropriate for the service provided; or
    b. Based on errors in data or calculation.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates for the comparable in-person service.

Payment for Telehealth Transmission costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

Medicaid reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission shall be in compliance with the quality standards for real time, two-way interactive audiovisual transmission as set forth in state regulations as amended.

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Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)
Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; ~~and~~ Therapeutic Group Home; Multisystemic Therapy; and Functional Family Therapy

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the agency's website at
http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

The Nebraska Medicaid fee schedule outlined above will be established using the following methodologies:

- If a Medicare fee exists for a defined covered procedure code, then Nebraska will set the Nebraska Medicaid fee schedule for LADC at 95 percent of the licensed Master's level rate paid under Attachment 3.1A, Item 6d for any codes permitted under their scope of practice per Nebraska state law.
- Where Medicare fees do not exist for a covered code, the fee schedule will be set using a market-based pricing methodology as described below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

  The market-based pricing methodology will be composed of provider cost modeling for four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. The analysis includes national compensation studies for Nebraska to determine the appropriate wage or salary expense for the direct care worker providing each service based on the staffing requirements and roles and responsibilities of the worker, published information related to employee related expenses and other notable cost components and cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

  (1) Staffing Assumptions and Staff Wages
  (2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
  (3) Program-Related Expenses (e.g., supplies)
  (4) Provider Overhead Expenses
  (5) Program Billable Units

  The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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FAMILY PLANNING SERVICES

For dates of service on or after August 1, 1989, NMAP pays for family planning services and supplies for individuals of child-bearing age at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
    a. The unit value multiplied by the conversion factor;
    b. The invoice cost (indicated as "IC" in the fee schedule);
    c. The maximum allowable dollar amount; or
    d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
    a. Not appropriate for the service provided; or
    b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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PHYSICIANS' SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for covered physicians' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor (last updated on July 1, 2015);
   b. The invoice cost (indicated as "IC" in the fee schedule); or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement for a negotiated rate with an out-of-state provider which will be based on a percentage of billed charges, not to exceed 100%, only when the Medical Director of the Division has determined that:
   a. The client requires specialized services that are not available in Nebraska; and
   b. No other source of the specialized service can be found.

The following is a listing of specialized physician services that have been previously rendered by out-of-state providers:

a. lung transplants; and
b. pediatric heart transplants.

Note: The above listing is not all-inclusive of the specialized physician services that will be reimbursed via negotiated rates in the future, as it is based on previous experience.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physicians' services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

Physicians and non-physician care providers are subject to a site-of-service payment adjustment. A site-of-service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Nebraska Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service.

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Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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Supplemental Payments

Supplemental payments will be made for services provided by practitioners who are acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices; UNMC Physicians and Nebraska Pediatric Practice, Inc. These payments are made in addition to payments otherwise provided under the state plan to practitioners that qualify for such payments. The supplemental payment applies to services provided by the following practitioners:

- Physicians (MD and DO)
- Advanced Practice Registered Nurses
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Audiologists
- Optometrists
- Licensed Independent Mental Health Practitioners
- Psychologists

All services eligible for supplemental payments are billed under the federal employer number for the public entity.

For practitioners qualifying under this section, a supplemental payment will be made. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider's contracted rates with the commercial insurers for each procedure code from an actual year's data, utilizing the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services; and
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment

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amount. All claims where Medicare is the primary payor will be excluded from the supplemental payment methodology.

4. Calculating the supplemental payments 90 days after the end of each fiscal year quarter. For each fiscal quarter, the public entity will provide a listing of the identification numbers for their practitioner/practitioner groups that are eligible for the supplemental payment to the Department. The Department will generate a report, which includes the identification numbers and utilization data for the affected practitioners/practitioner groups. The amount due is paid to the University of Nebraska Medical Center. In no instance is the sum of the base payment and supplemental payment greater than the practitioner's initial charge for services rendered.
5. Paying initial fee-for-service payments made under this section on a claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four (4) quarterly payments.

With the exception of administrative costs incurred by the single state agency that are associated with calculating and implementing the adjustments, the entire benefit from the supplemental payments will be retained by the University of Nebraska Medical Center as an offset to incurred public expenditures.

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The state reimburses for services provided by physicians or nurse practitioners with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 CFR 447.400(a) remain in effect. The state will pay for these services using the enhanced rates in effect for these providers on January 1, 2014 for the state of Nebraska or if greater, the Medicare payments rates for the applicable year, or the Medicaid rate for the applicable year.

☐ The rates reflect all Medicare site of service and locality adjustments.
☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
☐ The rates reflect all Medicare geographic/locality adjustments.
☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

Method of Payment

☒ Effective January 1, 2015, and thereafter, the state will make payment utilizing the enhanced rates in effect as of January 1, 2014 for the state of Nebraska or, if greater, the Medicare payments rates for the applicable year, or the Medicaid rate for the applicable year.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.
Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

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Primary Care Services Affected by this Payment Methodology (continued)

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2015 and thereafter, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicaid rate for the applicable year.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate established by Medicaid

Documentation of Vaccine Administration Rates

The state uses the rates in effect as of July 1 of the applicable year.

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Documentation of Vaccine Administration Rates

☐ The following codes will be cross walked to the CPT code 90640 for the increased vaccination administration rate:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2015. All rates are published at http://dhhs.ne.gov/medicaid/pages/med_provhome.aspx

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2015. All rates are published at http://dhhs.ne.gov/medicaid/pages/med_provhome.aspx

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PRACTITIONER ADMINISTERED INJECTABLE MEDICATIONS

Practitioner administered injectable medications will be reimbursed at one hundred percent (100%) of the Medicare Drug Fee Schedule; injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the estimated acquisition cost (EAC) used to reimburse pharmacy claims.

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PODIATRISTS' SERVICES

NMAP pays for covered podiatry services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount;
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

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Providers will be notified of changes and their effective dates.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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OPTOMETRISTS' SERVICES

NMAP pays for covered optometrists' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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CHIROPRACTORS' SERVICES

NMAP pays for covered chiropractors' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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CERTIFIED REGISTERED NURSE ANESTHETISTS

The Nebraska Medical Assistance Program calculates payment for CRNA/AA services as follows: The total of the units assigned to the CPT/ASA procedure plus the appropriate number of time units are multiplied by the appropriate conversion factor for medically directed or non-medically directed services. This amount must not exceed the amount allowable for physicians' services for the procedure. These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

When anesthesia services are provided by an anesthesiologist and a CRNA/AA at the same time, NMAP will make payment only for those services provided by the anesthesiologist.

NMAP does not make additional reimbursement for emergency and risk factors.

NMAP does not make payment for CRNA/AA services for secondary procedures. When multiple surgical procedures are performed at the same time, NMAP pays for only the major procedure.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

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HOME HEALTH SERVICES

Medicaid pays for medically prescribed and Department- approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, Medicaid pays for home health agency services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

The Nebraska Home Health Agency Fee Schedule is effective for July 1 through June 30 of each fiscal year.

The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
3. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Home Health Agency Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. Medical supplies not normally carried in the nursing bag are provided by pharmacies or medical suppliers who bill Medicaid directly. Under extenuating circumstances, the home health agency may bill for a limited quantity of supplies.

Medicaid applies the following payment limitations:
Brief Services are performed by a home health or private-duty nursing service provider to complete the client’s daily care in a duration of 15 minutes to two hours per visit, when medically necessary. The services may be divided into two or more trips.

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HOME HEALTH SERVICES

Extended Services are performed by a home health or private-duty nursing service provider when the client's needs cannot be appropriately met within the Brief Service limitation of two hours or less.

Medicaid applies the following payment limitations to nursing services (RN and LPN) for adults age 21 and older:

a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

b. Per diem reimbursement for all other in-home nursing services shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PRIVATE DUTY NURSING SERVICES

Payment for approved nursing services will be the lower of:

1. The submitted charge; or
2. The maximum allowable fee as established by the Department.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CLINIC SERVICES

NMAP pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Psychiatric Day Treatment Services: Payment rates for psychiatric day treatment services for individuals age 19 and older will be on a unit basis. Rates are set annually for the period July 1 through June 30. Rates are set prospectively for this period and are not adjusted during the rate period. Providers are required to report their costs on an annual basis. Providers desiring to enter the program who have not previously reported their costs or that are newly operated are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on the required form based on the timeframes in 471 NAC 20-003.08. Providers shall compile data based on generally accepted accounting principles and the actual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will inform the provider via letter that no further payment will be made until a proper cost report is filed. In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per diem, per monthly, or DRG rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Ambulatory Surgical Centers:

Payment of facility fees for services provided in an ambulatory surgical center (both free-standing and hospital-affiliated) is made at the rate established by Medicaid for the appropriate group of procedures.

If one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure.

Insertion of intraocular lens prosthesis with cataract extration is considered two procedures; payment is made at 150 percent of the applicable group rate. If this procedure is performed bilaterally, payment is made at 150 percent of the group rate for the first procedure (first eye) and 100 percent for the second procedure (second eye).

The ambulatory surgical center may also provide services which are not directly related to the performance of a surgical procedure, such as durable medical equipment, medical supplies, and ambulance services. Payment for these services will be made according to the methods and standards elsewhere in the Title XIX Plan for the appropriate service.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Pediatric Feeding Disorder Clinic Intensive Day Treatment: Reimbursement for pediatric feeding disorder clinic intensive day treatment for medically necessary services will be a bundled rate based on the sum of the fee schedule amounts for covered services provided by Medicaid enrolled licensed practitioners. This service is reimbursed via a daily rate.

Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for Pediatric Feeding Disorder Clinic Outpatient Treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation. This service is reimbursed via an encounter rate.

An encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, psychologist, speech therapist, physical therapist, or dietician during which services are rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTAL SERVICES

For dates of service on or after August 1, 1989, NMAP pays for dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee - Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Effective July 1, 2010, NMAP will provide a supplemental payment for covered dental services when services are provided or supervised by a faculty or staff member of the University of Nebraska Medical Center (UNMC) College of Dentistry and who is providing or supervising the treatment as part of an approved program of the University.

For dentists qualifying under this section, a supplemental payment will be made. These payments are made in addition to payments otherwise provided under the state plan to dentists that qualify for such payments. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Calculating annually an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider's contracted rates with the commercial insurers for each procedure code. The rate used will be the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services. Supplemental and fee schedule/base payment may not in the aggregate exceed this reimbursement ceiling; and
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment amount.

The supplemental payments will be calculated 30 days after the end of each FY quarter. The amount due is paid to the UNMC College of Dentistry. No payments are made with the expectation or requirement that some or all of the payment be transferred to another party. A final reconciliation of payments is made one year after the end of each quarter.

Initial fee-for-service payments made under this section will be paid on a claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four (4) quarterly payments.

For each fiscal quarter, the University of Nebraska Medical Center College of Dentistry will provide a listing of the identification numbers for their dentists that are affected by the payment adjustment to the Division of Medicaid and Long-Term Care. The Division will generate a report, which includes the identification numbers and utilization data for the affected dentists. This report will be provided to University of Nebraska Medical Center College of Dentistry.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The University of Nebraska Medical Center College of Dentistry must review and acknowledge the completeness and accuracy of the report. After receipt of confirmation, the Division will approve the supplemental payment amount.

Assurances. The Department hereby assures that payment for dental services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICAL THERAPY

For dates of service on or after August 1, 1989, NMAP pays for physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICAL THERAPY

Reimbursement rates for Medicaid-covered physical therapy services provided to students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with physical therapy. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OCCUPATIONAL THERAPY

NMAP pays for occupational therapy services provided by independent providers at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule - as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" – by report or "RNE" - rate not established in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OCCUPATIONAL THERAPY

Reimbursement rates for Medicaid-covered occupational therapy services provided to students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with occupational therapy. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the providers submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST)

For dates of service on or after August 1, 1989, NMAP pays for services for individual with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST) (cont'd)

Reimbursement rates for Medicaid-covered services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) provided students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with the services. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PRESCRIBED DRUGS

Federal Upper Limit (FUL): Certain multiple source drug products will have an upper limit of reimbursement assigned by the Federal Government.

State Maximum Allowable Cost (SMAC): Certain drug products will have a state maximum allowable cost designated by the Division of Medicaid and Long-Term Care. The SMAC value is the cost at which the drug is widely and consistently available to pharmacy providers in Nebraska. The determination of which products are designated SMAC products is the direct responsibility of the Division of Medicaid and Long-Term Care. A pricing evaluation is done on all coverable generic products for a drug strength and dosage form. Outliers are eliminated and the average Wholesale Acquisition Cost (WAC) is derived as the base SMAC value. A review of Medicaid prices paid by other states is done as well as consultation with the Nebraska Pharmacists Association Medicaid Advisory Committee and a buying group to verify marketplace pricing prior to establishment of the final SMAC value. Any individual or organization may at any time request a revision in a SMAC value directly from the Department.

The Department notifies all pharmacies of products which have been designated as SMAC products and the respective SMAC values via the NE-POP system and on the Department's website.

Estimated Acquisition Cost (EAC): All drug products, including the FUL/SMAC products, will be assigned an estimated acquisition cost. The EAC of any product will be the average wholesale price (AWP) as published by the drug reference file utilized by the NE-POP system less eleven percent, or Wholesale Acquisition Cost (WAC) as published by the drug reference file utilized by the NE-POP system plus 6.8 percent. The Division of Medicaid and Long-Term Care will be responsible for assigning the EAC values to all drugs.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PRESCRIBED DRUGS (Continued)

Cost Limitations: The Nebraska Medicaid Drug Program is required to reimburse product cost at the lowest of:

1. Product cost (EAC or FUL or SMAC) plus the appropriate dispensing fee(s);
2. The pharmacy's usual and customary charge to the general public; or
3. Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal code or regulation.

The FUL or SMAC limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the EAC will be the maximum allowable cost.

Dispensing Fees

"Assigned" Dispensing Fee: A dispensing fee of $4.45 is assigned by the Department to each individual pharmacy. The fee is calculated from the information obtained through the Department's prescription survey. The Department notifies each pharmacy of its dispensing fee. If a pharmacy accepts a lesser fee from any other third party program, the Department may adjust its assigned dispensing fee to reflect this variance in total charge.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTURES

For dates of service on or after August 1, 1989, NMAP pays for dentures at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSTHETIC DEVICES

NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CRT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EYEGLASSES

NMAP pays for covered eyeglasses at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" by report or "RNE" rate not established in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SCREENING SERVICES

NMAP pay for covered screening services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable among for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

COMMUNITY-BASED COMPREHENSIVE PSYCHIATRIC REHABILITATION AND SUPPORT SERVICES PROGRAM

The Department pays separate rates for each community-based psychiatric rehabilitation and support service.

For Community Support, the unit of service is a client month.
For Day Rehabilitation, the unit of service is a day of participation (five or more hours).
Note: Providers may bill for 1/2 unit of service when at least three hours of service but less than five hours are provided.
For Psychiatric Residential Rehabilitation, the unit of service is a day in residence (room and board is not included in the rate).

Rates are reviewed annually based on audits and actual cost information submitted by each provider. The review is used as the basis for establishing a statewide fee schedule for each of the four services. Rates will not exceed the average statewide actual cost of providing rehabilitation services.

The State assures that rehabilitative services are not provided in institutions for mental diseases (IMD).

Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per monthly rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION

Medicaid has researched the cost of an existing similar service to develop a comparable rate. Costs for treatment and rehabilitation services are contained in the Medicaid rate. The rate does not include room and board. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Secure Psychiatric Residential Rehabilitation Services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

The State Medicaid agency will have an agreement with each entity receiving payment under Secure Psychiatric Residential Rehabilitation services that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate,
- Cost information by practitioner type and by type of service actually delivered within the services unit,
- Provider's annual utilization data and cost information shall support that the required type, quantity and intensity of treatment services are delivered to meet the medical needs of the clients served. Medicaid Agency or its designee may further evaluate through on site or post pay review of the treatment plans and the specific services delivered as necessary to assure compliance.

COMMUNITY SUPPORT SERVICES

Community Support Services shall be reimbursed on a direct service by service basis and billed in 15 minute increments up to a maximum of 144 units per 180 days.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of community support services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

This rate will be the same for quasi-governmental and private providers of community support service.

The rate includes all indirect services and collateral contacts that are medically necessary rehabilitative related interventions.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

ASSERTIVE COMMUNITY TREATMENT

For Assertive Community Treatment, the unit of service is a client day. The services will be paid on a fee-for-service basis for each day that services are performed, including face-to-face contact with the client, or on behalf of the client, and conducting daily organization staff meetings to review the status of the team's clients and the schedule of upcoming interventions. Providers cannot bill for a day during which no service was performed.

Payment Rates: The payment rate for Assertive Community Treatment is in accordance with the Nebraska Behavioral Health System statewide rates adopted by the Department, that are determined as follows.

Rates are established effective October 1 each year. Government providers submit cost information to the Department as of June 30 of each year. Rates for the following period of October 1 through September 30 are determined based upon the providers' costs of allowable personnel and indirect costs divided by the estimated number of client service days. Rates paid to non-government providers are fee-based and established for the period of October 1 through September 30 of each year. Rates are set to reimburse the reasonable costs of providing services, but are not a guarantee that a provider's costs will be fully met.

Rates paid to government providers will be retroactively settled to actual cost within ninety days following receipt of the June 30 cost report. Rates paid to non-government providers are prospective and considered final payment for services provided.

Provider payment is fee for service. Providers, who are subcontractors of Regional Governing Boards, submit claims directly to MMIS for payment. The Department, through MMIS, will issue payment to the Regional Governing Boards per Neb. Rev. Stat. §83-158.01 to §83-169 and §71-5001 to §71-5052 who then distribute the MMIS payments to providers. Regional Governing Boards are regional consortiums/quasi governmental entities consisting of 93 counties organized into six (6) regional areas of the state for the purpose of planning and contracting for mental health services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payments made by Regional Governing Boards are based upon the established statewide rates for service. None of the MMIS payments issued to Regional Governing Boards are taken for operating expenses. Regional Governing Boards receive separate administrative funding from the Department.

HCPCS Codes

The following HCPCS Codes will be used to identify ACT services:

H0039	Assertive Community Treatment, face to face, per 15 minutes.
H0040	Assertive Community Treatment program, per diem.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR TUBERCULOSIS

Not provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES

1. Inpatient Hospital Services

   See Attachment 4.19-A

2. Skilled Nursing Facility Services

   See Attachment 4.19-D

3. Intermediate Care Facility Services

   See Attachment 4.19-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INTERMEDIATE CARE FACILITY SERVICES

See Attachment 4.19-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INPATIENT PSYCHIATRIC FACILITIES FOR INDIVIDUALS AGE 21 OR YOUNGER

NMAP pays for inpatient psychiatric facility services for individuals age 21 or younger provided by hospitals at the rates established under the reimbursement plan for hospital services in Attachment 4.19-A.

NMAP pays for inpatient psychiatric facility services for individuals age 21 or younger provided by residential treatment centers and treatment group homes as follows:

Payment rates for these services are established on a unit (per day) basis. Rates are set annually. Rates are set prospectively for the annual rate period and are not adjusted during the rate period. Providers are required to submit annual cost reports on a uniform cost reporting form. In determining payment rates, the Department will consider those costs that are reasonable and necessary for the active treatment of the clients being served. Those costs include costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning.

The Department does not guarantee that all costs will be reimbursed. The submitted cost reports are used only as a guide in the rate-setting process. Payment rates do not include the costs of providing educational services.

Payment for services provided by facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, the American Osteopathic Association, or by any other accrediting organization with comparable standards, that is recognized by the State will include payment for room and board.

Services provided by inpatient psychiatric facilities that are state-operated are reimbursed at a rate that includes all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NURSE MIDWIFE SERVICES

Payment for nurse-midwife services is made to the nurse-midwife or the physician with whom the nurse-midwife has a practice agreement; the physician is then responsible for payment to the nurse-midwife. Payment for nurse-midwife services is made at the lower of:

1. The provider's submitted charge; or
2. A percentage, determined by the Department, of the amount allowable under Item 5 of Attachment 4.19-B for the physician with whom the nurse-midwife has a practice agreement.

NMAP covers pre-natal care, delivery, and postpartum care as a "package" service. Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State Nebraska

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR PAYMENT RATES-OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION	Medical and Remedial Car and Services Item 18	**Hospice Care**
42 CFR Part 418 Subpart G		**Method of Payment**
State Medicaid Manual, Chapter 4, Section 4306 &4307		Hospice care is reimbursed utilizing the principles of reimbursement as detailed in the State Medicaid Manual, Chapter 4, Sections 4306 and 4307 as amended by Public Law 105-33, "Balanced Budget Act of 1997". Note: Medicaid pays all costs for hospital services provided when a client receiving tile Medicaid Hospice benefit is hospitalized for an acute medical condition that is not related to the terminal diagnosis. For dual-eligible, residing in IMD/NF settings hospice bills Medicare for hospice services and bills Medicaid for room and board. Medicaid will pay 95% of the NF rate to the hospice and the hospice is responsible to reimburse the facility. However, in the case of the IMD, room and board may not be billed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State Nebraska

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

P.L. 105.33

Payment Rates

Only one is applicable for each day of routine home care, continuous home care, inpatient respite care and general inpatient care.
For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the client on that day.
Payment rates are adjusted for regional differences in wages. The Bureau will compute the adjusted rate based on the geographic location at which the service was furnished to allow for the differences in area wage levels, using the same method used under Part A of Title XVIII.
The hospice will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for Medicaid clients residing in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). When a client resides in a Center for Developmental Disabilities (CDD) or Assisted Living Facility (ALF), room and board is not reimbursed.

Refer to the Annual Medicaid Bulletins for the most current rates.
www.cms.hhs.gov/medicaid/services/hospice.asp

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CASE MANAGEMENT SERVICES

The Department pays for case management services at the lower of:
1. The provider's submitted charge; or
2. The maximum allowable fee established by the Department.

All claims for reimbursement of case management services shall contain the name of the client served, the provider name and identification number, the type of service, date of service and cost.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EXTENDED SERVICES TO PREGNANT WOMEN

For dates of service on or after August 1, 1989, NMAP pays for extended services to pregnant women at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year, and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN FURNISHED DURING A PRESUMPTIVE ELIGIBILITY PERIOD

For dates of service on or after August 1, 1989, NMAP pays for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a Medicaid-enrolled provider at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PAYMENT FOR PEDIATRIC OR FAMILY NURSE PRACTITIONERS

Payment for certified pediatric nurse practitioners or certified family nurse practitioners is made at the lower of:

1. The provider's submitted charge; or
2. A percentage, determined by the Department of Health and Human Services Finance and Support, of the amount allowable under the Nebraska Medicaid Practitioner Fee Schedule if the services was provided by a physician.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

AMBULANCE

Payment for ambulance services will be the lowest of -

1. The provider's submitted charges;
2. The provider's customary charge as determined by Medicare or Medicaid;
3. The prevailing charge for providers of like specialty and locality as determined by Medicare or Medicaid; or
4. Maximum allowable fees established by the Department.

Medicare customary and prevailing charge determinations used by the Nebraska Department of Social Services are those calculated by Medicare and defined as follows for purposes of the limits described above:

1. Medicare customary charges are those established on the basis of the provider's billed charges in the appropriate base period; and
2. Medicare prevailing charges are the unadjusted prevailing charges established on the basis of billed charges.

Medicaid customary and prevailing charge determinations are those established by the Department.

The new Medicare charges will become effective on the same date as the updated Medicaid charges.

OTHER MEDICAL TRANSPORTATION

Payment for other medical transportation is based on the authorized rate per trip.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TRANSPORTATION SERVICES

For dates of service on or after May 1, 2011, Medicaid pays for emergency and non-emergency medical transportation services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
    a. The unit value multiplied by the conversion factor;
    b. The invoice cost (indicated as "IC" in the fee schedule);
    c. The maximum allowable dollar amount; or
    d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-emergency transportation services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SKILLED NURSING FACILITY SERVICES FOR PATIENTS UNDER 21 YEARS AGE

See Attachment 4.19-0.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EMERGENCY HOSPITAL SERVICES

See Item 2a of this Attachment.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PERSONAL CARE AIDE SERVICES

For services provided on or after July 1, 1998. NMAP pays for personal care aide services at the lower of:

1. The provider's submitted charge: or
2. The allowable amount for that procedure code the Nebraska Medicaid Care Aide Fee Schedule.

The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure: or
3. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is not appropriate.

Personal Assistance Services will be reimbursed at rates established and published by Nebraska Health and Human Services. Rates are based on experience or training of the Personal Assistance provider.

For purpose of establishing the provider payment rate. NMAP considers a provider of personal assistance services to be "specialized" the provider meets one of the following criteria and presents a copy of the certificate or license to the worker. The provider must:

1. Have successfully completed the American Red Cross Home-Bound Care Course or a basic aide training course that has been approved by the Nebraska Health and Human Services System;
2. Have passed the Nurse Aide Equivalency test;
3. Be a licensed R.N. or L.P.N: or
4. Have a total of 4160 hours of experience as a personal assistance service provider.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FREESTANDING BIRTH CENTER SERVICES

Nebraska Medicaid providers of birthing center services are reimbursed based on a fee schedule as follows:

a. Payment for birthing center services provided by a participating, licensed birthing center is limited to the allowable rates established by Nebraska Medicaid.
b. The fee schedule established by Nebraska Medicaid is based upon a review of Medicaid fees paid by other states;
c. The birthing center and the birth attendant must bill separately for the services provided by each. The birthing center may bill only for facility services outlined elsewhere in this state plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Freestanding Birthing Center Services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ____ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters “MR.”

3. Payments are up to the amount of special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item 1 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
Other Medicaid Beneficiaries	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
Dual Eligible (QMB Plus)	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment of Medicare Part A and Part B Deductible/Coinsurance

Item 1

Special Rate Method

For nursing facility services, except for Skilled Nursing Units in Small Rural Hospitals ("Swing Beds"), covered under Medicare Part A, payments are limited to State plan rates and payments according to the following method:

1) If the Medicare payment amount for a claim exceeds or equals the State plan rate or payment for that claim, Medicaid reimbursement will be zero (0).

2) If the State plan rates and payments for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

   a) the difference between the Medicaid State plan rates and payments minus the Medicare payment amount; or

   b) the Medicare coinsurance and deductible, if any, for the claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

BEDHOLDING

The Nebraska Medical Assistance Program makes payments to reserve a bed in a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF/MR) during a client's absence due to hospitalization for an acute condition and for therapeutically-indicated home visits. Therapeutically-indicated home visits are overnight visits with relatives and friends or visits to participate in therapeutic or rehabilitative, programs. Payment for bedholding is subject to the following conditions:

1. A held bed must be vacant and counted in the census. The census must not exceed licensed capacity;
2. For ICF/MR residents, hospital bedholding is limited to full per diem reimbursement for 15 days per hospitalization (hospital bedholding does not apply to hospital NF-swing-beds or to hospitalization following a Medicare-covered (SNF) stay);
3. For NF residents, except for the months of April and May of 2012 in which payment is at full per diem reimbursement, hospital bedholding is limited to reimbursement at the applicable rate in effect for assisted living services under the Home and Community-Based Waiver for Aged Persons and Adults or Children with Disabilities for 15 days per hospitalization (hospital bedholding does not apply to hospital NF-swing-beds or to hospitalization following a Medicare-covered (SNF) stay);
4. For ICF/MR residents, therapeutic bedholding is limited to full per diem reimbursement for 36 days per calendar year.
5. For NF residents, except for the months of April and May of 2012 in which payment is at full per diem reimbursement, therapeutic leave bedholding is limited to the applicable rate in effect for assisted living services under the Home and Community-Based Waiver for Aged Persons and Adults or Children with Disabilities for 18 days per calendar year. Bedholding days are prorated when a client is admitted after January 1;
6. A transfer from one facility to another does not begin a new 18-day or 36-day period;
7. The client’s comprehensive care plan must provide for therapeutic leave; and
8. Facility staff shall work with the client, the client's family and/or guardian to plan the use of the allowed 18 days of therapeutic leave for the calendar year.

When the limitation for therapeutic leave interferes with an approved therapeutic or rehabilitation program, the facility may submit a request for special limits of up to an additional six days per calendar year to the Medical Services Division.

ASSURANCES FOR ATTACHMENT 4.19-C, pages 1 and 2

Assurances associated with payment rate for reserve bed days for skilled nursing facilities effective May 1, 1987 required by 42 CFR 447.253-255.

Payment to a skilled nursing facility (SNF) to reserve a bed while a resident is absent over night for visitation or hospitalization is available only if the person has required care in a skilled nursing facility for at least three (3) consecutive months and subject to the following limitations:

1. This percentage is comparable to the percentage paid to an intermediate care facility for reserve bed days.

2. Payment rates at 75% of the usual Medicaid rate are reasonable to maintain for on-going expenses of a facility while a resident is absent.

3. Public Notice requirements. In accordance with 42 CFR 447.205 the Department gave public notice before May 1, 1987. A copy of the notice is attached.

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 ill 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.

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, 104 and 105 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) adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

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 waivered 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 the beginning of each applicable cost report period 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 12-011.08B) 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:

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

1. Comply with the standards prescribed by the Secretary of the Federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
2. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health standards, under 42 CFR 431.610; and
3. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:

1. General nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician or licensed nurse practitioner, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff must aid the client as necessary, under the client's therapy program, with programs intended to maintain the function(s) being restored; to include but not limited to augmentative communication devices with related equipment and software
3. Items which are furnished routinely and relatively uniformly to all clients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, bandaids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stockings with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);
5. Items which are used by individual clients which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs. traction equipment, alternating pressure pad and pump, other durable medical equipment, etc. not listed in 12-009.05 and 12-009.06;
6. Nutritional supplements and supplies used for oral, parenteral or enteral feeding.
7. Laundry services, including personal clothing;
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
9. Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance;
10. Injections and supplies: including syringes and needles, but excluding the cost of the drug(s) not listed in 12-009.05 and 12-009.06.

12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility must contract for ancillary services not readily available in the facility.

If ancillary services are provided by a licensed provider or another licensed facility, e.g., physician, dentist, physical/occupational/speech/etc., therapists, etc., the ancillary service provider must submit a separate claim for each client served.

Allowable costs paid to Physical, Occupational and Speech Therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services and seminars.

Respiratory therapy is an allowable cost.

Department-required independent QMRP assessments are considered ancillary services.

12-011.04D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses (see 471 NAC 24-000), hearing aids (see 471 NAC 8-000), etc.;
3. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
4. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7-000;
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000;
   a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP will not make payment for ambulance service.
   b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy enter are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonable be expected to be provided at the client's residence (including the Nursing Facility).

12-011.04E Payments to Nursing Facility Provider SEPARATE from Per Diem Rates: Items for which payment may be made to -Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below.

To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

1. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use (see 471 NAC 7-000);
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000); and
3. Negative Pressure Wound Therapy, See 471 NAC 7-000).

Reimbursement to Nursing Facility providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of nursing facility services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;

13. Carry-over of costs “lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts.
15. Revisit fees.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are used. An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year.

Medicaid inpatient days are days for which claims or electronic Standard Health Care Claim: Institutional transaction (ASC X12N 837) from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under 471 NAC 12-011 for these days.

12-011.06C Start-Up Costs: All new providers entering NMAP must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest. employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

12-011.06D Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions. (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); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

12-011.06E Leased Facilities: Allowable costs leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation. interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 12-011.06H and J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

12-011.06F Home Office Costs - Chain Operations: A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to healthcare.

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, are limited to direct patient care services provided at the facility, and must be included in the applicable Cost Category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, are included in the Administration Cost Category. The NMAP does not distinguish between capital related and non-capital related interest expense and interest income (see HIM-15, Section 2150.3E and 2150.3F).

12-011.06G Interest Expense: Interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for nursing facility care. This limitation does not apply to government owned facilities.

12-011.06H Recognition of Fixed Cost Basis: The fixed cost basis of real property (land, land improvements, buildings, and equipment permanently attached to the building) for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation of or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 12-011.09E, Recapture of Depreciation, will apply to this part.

The fixed cost basis of personal property (furniture, moveable equipment and vehicles) for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the seller's Medicaid net book value at the time of purchase.

471 NAC 12-011.09E, Recapture of Depreciation, does not apply to personal property.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

12-011.06J Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 12-011, 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 are 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.

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).

Beginning with the following Calendar year base numbers for 12/31/2010, the Administrator Compensation Maximum Amounts can be calculated based on the following methodology.

Calendar Year	HIM%	Beds 0-74	Beds 75-99	Beds 100-149	Beds 150-200	Beds 200+
2010	1.5%	81,490	82,954	98,569	99,544	146,388
2011						

To determine the Maximum Amount for State Fiscal Year 2011, for each bed category, add 1 to the Calendar Year 2010 HIM % and multiply this amount by 50% of the Calendar Year 2010 bed total. To this amount add 50% of the Calendar Year 2010 bed total. For future years update the Calendar Year information above (A) by replacing the HIM % with the updated HIM % from HIM 15 Section 905.6.

Example: 1 + .015 X 40,745 = 41,356 41,356 + 40,745 = 82,101

Administrator Maximum Amounts for Cost Reports:

State Fiscal Year	Beds 0-74	Beds 75-99	Beds 100-149	Beds 150-200	Beds 200+
2011	82,101	83,576	99,308	100,291	147,486
2012					

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.

12-011.06M Direct Nursing Costs: Direct nursing costs include cost report lines 94 through 103. The following descriptions cover some of these costs:

1. Salaries of the Director of Nursing and other licensed professionals (RNs & LPNs) who are practicing within the scope of their license;
2. Salaries of other licensed or certified individuals providing routine nursing or routine nursing-related services to residents; and unlicensed, assistive personnel providing nursing-related support for direct nursing care to residents. Nursing-related support includes, but is not limited to: bathing, dressing, transfer, dining assistance, bed mobility, walking, range of motion, bed making, filling water pitchers. personal hygiene, administration of medications and other activities of daily living; or training/instruction of residents in these services;
3. Salaries related to:
   a. Nursing staff scheduling;
   b. Preparation of resident assessments, development of care plans, and other required documentation;
   c. Instruction of and attendance at nursing inservice training;
   d. Medical records, including record transcription, file thinning, setup of initial files, and other medical record services; and
   e. Quality assurance services;
4. The documented nursing portion of multi-purpose and/or universal workers salaries:
   a. A multi-purpose employee has nursing and non-nursing job duties. For example, medical records (Nursing) and payroll (Administration).
   b. Universal workers are employees who perform multiple tasks for residents, usually in a distinct unit, pod, or neighborhood. The tasks performed by the universal workers have traditionally been divided between employees of separate departments. Services provided by universal workers may include two or more of the following functions:
      (1) Nursing;
      (2) Activities;
      (3) Laundry;
      (4) Housekeeping; and
      (5) Dietary;
   c. Multi-purpose and/or universal workers who perform services in more than one functional area must identify their time using one of the following approved methods:
      (1). Maintenance of daily continuous timesheets The daily timesheet must document, for each day, the person's start time, stop time, total hours worked, and the actual time worked in each functional area;
      (2). Maintenance of time studies as defined in Medicare HIM-15 (section 2313.2E);
      (3). Other methods as pre-approved by the Department;

5. Payroll taxes and employee benefits related to the salaries outlined above. Employee benefits DO NOT include help wanted advertising, pre-employment physicals, background checks, etc;
6. Consulting Registered Nurse;
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.

12-011.060 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 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 Assessment: 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.

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 waivered, 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, waivered, and/or facilities with partial or initial/final full year cost reports.

The Department will reduce the Direct Nursing Component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 125% of the median Direct Nursing Component, and 115% of the median Support Services Component. The Department will reduce the Direct Nursing Component maximum by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

The Fixed Cost Component is subject to a maximum per diem of $27.00, excluding personal property and real estate taxes.

Each facility's base prospective rate is computed as the sum of the facility-specific Direct Nursing and Support Services components adjusted by the inflation factor and the Fixed Cost Component, subject to the rate limitations and component maximums of this system. The Direct Nursing, Support Services, and Fixed Cost components are expressed in per diem amounts.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the allowable costs for support services (lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (lines 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Rate determination for the Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

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.

For purposes of this section, facilities exempt from the Quality Assurance Assessment are:
1. State-operated veterans homes;
2. Nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and
3. Continuing care retirement communities.

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 each 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.'

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, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from exempt to non-exempt status:
For the Rate Period beginning on the first day of the first full month the provider is subject to the Quality Assurance Assessment through the following June 30, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from non-exempt to exempt status:
For Rate Periods beginning with the first day of the first full month the provider is exempt from the Quality Assurance Assessment, the quality assessment rate component will be $0.00 (zero dollars).

12-011.08D5 Inflation Factor: For the Rate Period of July 1, 2015 through June 30, 2016, the inflation factor is positive .46%.

12-011.08D6 Durable Medical Equipment (DME) Rate Add-on: Effective August 1, 2013, nursing facilities are responsible for costs of certain durable medical equipment. To account for these increased costs on prospective rates only:
1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.90/day.

3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.08/day.
4. For the rate period June 30, 2016 prospective rates will not be increased by a DME rate add-on.

The DME rate add-on does not apply to Levels of Care 101-105.

Retroactive rate settlements computed according to 471 NAC 12-011.08H1 will not include a DME component as actual DME costs will be included in the reported Support Services – Other Nursing costs. To account for these increased Support Services costs on retroactive rate settlements only:

1. For the rate period August 1, 2013 through June 30, 2014, The Support Services Maximum will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, the Support Services Maximum will be increased by $.90/day.
3. For the rate period July 1, 2015 through June 30, 2016, the Support Services Maximum will be increased by $.08/day.

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, 104 and 105: 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. Level of Care 105 is used for payment of qualifying bedhold days. The payment rate for Levels of Care 101, 102, 103,104 and 105 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) adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

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.

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 July1, 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.

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.

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.

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.

A. IHS providers may receive quarterly, interim Special Funding payments by filing quarterly cost reports (FA-66) for periods ending September 30, December 31 and/or March 31. Quarterly, interim Special Funding payments are retroactively adjusted and settled based on the provider's corresponding annual cost report for the period ending June 30. Quarterly, interim payments and the retroactive settlement amount are calculated in accordance with Section C below. If the average daily census from a quarterly cost report meets or exceeds 85% of licensed beds, this shall be the "final" quarterly cost report filed by the provider. Subsequent quarterly, interim Special Funding payments shall be based on the "final" quarterly cost report. Quarterly, interim Special Funding payments may also be revised based on data from the annual cost reports.

B. Quarterly, interim Special Funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim Special Funding payments subsequent to the payment for the "final" quarterly cost report shall be made on or about 90-day intervals following the previous payment.

C. The Special Funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:

1. The allowable Federal Medical Assistance Percentage for IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all IHS-eligible Medicaid residents and the total amount paid for all IHS-eligible Medicaid residents, if greater than zero: and
2. The allowable Federal Medical Assistance Percentage for non-IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all non-IHS-eligible Medicaid residents and the total amount paid for all non-IHS-eligible Medicaid 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.

At the time of an asset acquisition, the nursing facility must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 12-011.06H and J.

12-011.09A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset Glass.

12-011.09B Capitalization Guidelines: Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

12-011.09B1 Capitalization Threshold: The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for their facility, but the threshold amount must be at least $100 and no greater than $5,000.

12-011.09B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

12-011.09B3 Acquisitions Under $100: Acquisitions after July 1, 2005 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the Cost Report in the current period.

Examples:

Item	Per Item Cost	Account
Toaster	$38	Dietary Supplies
30 Wastebaskets	$22 ($660 total)	Housekeeping Supplies
Calculator (bookkeeper)	$95	Administration Supplies
Pill Crusher	$62	Nursing Supplies
Wrench Set	$77	Plant Related Supplies

12-011.09B4 integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying *the* capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

12-011.09B5 Multiple Items with Per Unit Cost Greater Than or Equal to $100: Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy must describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

12-011.09B6 Non-Capital Purchases: Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

12-011.09B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 471 NAC 12-011.09B1 through 12-011.09B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

12-011.09B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

Example A
Provider A's written capitalization policy has a $5,000 threshold for single item purchases. Purchases of multiple items are treated on an item-by-item basis.

Item	Per Item cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Plant Related - as per item cost is less than $5,000
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Plant Related
Range/Oven	$4,900	Plant Related
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Plant Related - as per item cost is less than $5,000
3 Cubicle Walls & Desktop for an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Plant Related - as total cost of integrated system is less than $5,000

Example B
Provider B's written capitalization policy has a $1,500 threshold for single item purchases. Multiple item purchases are treated as an aggregate single purchase.

Item	Per Item cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Capitalize & Depreciate
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Capitalize & Depreciate
Range/Oven	$4,900	Capitalize & Depreciate
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Capitalize & Depreciate - as aggregate cost of $7,000 is more than $1,500
3 Cubicle Walls & Desktop For an Office Cubicle	$300 (total = $900 $700 (total = $1,600)	Capitalize & Depreciate - as cost of integrated system is greater than $1,500

12-011.09C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 12-011.06H and J);
4. Based on the fair market value at the time of donation for donated assets without a prior Medicaid basis; or based on the donor's Medicaid net book value at the time of the donation for donated assets with a prior Medicaid basis. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

12-011.09D (Reserved)

12-011.09E Recapture of Depreciation: Depreciation in 471 NAC 12-011.08E refers to real property only. A nursing facility which converts all nursing facility beds to assisted living beds is not subject to recapture provisions. A nursing facility which is sold for a profit and has received NMAP payments for depreciation must refund to the Department the lower of:

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times (\text{Sales Price - Book Value})$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture. In the above calculations of the recapture of depreciation, if a facility has been limited to the maximum payment for the fixed cost component (see 471 NAC 12-011.08D3), then that facility's allowable individual expense categories of the fixed cost component must be proportionately prorated to determine the amount that is attributable to depreciation.

Examples:		Data
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4-2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

12-011.09F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will *be* reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

12-011.09G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

12-011.10 Reporting Requirements and Record Retention: Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

Each facility must complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a required cost report has not been filed, the sum of the following is due:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at least five years after receipt from the provider.

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.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit:

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 12-011.15 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 12-011.15 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.12 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on a remittance advice. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

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.

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.

A provider does not have the right to appeal a finding by the Director of the Division of Medicaid and Long-Term Care that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under 471 NAC 12-011 must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated • settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under 471 NAC 12-011 has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved RUG grouper to assign each resident to a level of care based on information contained on his/her MDS assessment. Each level of care will be assigned the federally-recommended weight (see 471 •NAC 12-013.04). When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care per 471 NAC 12-013.01. Each resident's ievei of care is appropriately updated from each assessment to the next - the admission assessment, a significant change assessment, the quarterly review, the annual assessment, etc., and is effective for payment purposes on the first day of the month of the applicable assessment if it is received by the tenth day of the month of the applicable assessment. A change in resident level of care which results from an audit of assessments (see 471 NAC 12-013,05) is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska Medicaid Case Mix System, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment.

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 When No Assessment is Available			
180*	STS	Short Term Stay	0.59

105 is not a level of care, it is a payment rate for bedhold days on the above levels of care.

*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.

Reserved for Future Use

12-014 Services for Long Term Care Clients with Special Needs

12-014.01 The term "Long term care clients with special needs" means those whose medical/nursing needs are complex or intensive and are above the usual level of capabilities of staff and exceed services ordinarily provided in a nursing facility as defined in 471 NAC 12-003.

12-014.01A Ventilator-Dependent Clients: These clients are dependent on mechanical ventilation to continue life and require intensive or complex medical services on an on-going basis. The facility shall provide 24-hour R.N. nursing coverage.

12-014.01A1 Criteria for Care: The client must-

1. Require intermittent (but not less than 10 hours in a 24-hour period) or continuous ventilator support. S/he is dependent on mechanical ventilation to sustain life, or is in the process of being weaned from mechanical ventilation. (This does not include individuals using continuous positive airway pressure (C-PAP) or Bi-level positive airway pressure (Bi-PAP) nasally; patients requiring use of Bi-PAP via a tracheostomy will be considered on a case-by-case basis);
2. Be medically stable and not require intensive acute care services;
3. Have care needs which require multi-disciplinary care (physician, nursing, respiratory therapist, psychology, occupational therapy, physical therapy, pharmacy, speech therapy, spiritual care, or specialty disciplines);

4. Require daily respiratory therapy intervention and/or modality support (for example: oxygen therapy, tracheostomy care, chest physiotherapy, deep suctioning. etc.); and
5. Have needs that cannot be met at a lesser level of care (for example: skilled nursing facility. nursing facility, assisted living, private home).

12-014.01B Clients with Brain Injury:

12-014.01 B1 Clients Requiring Specialized Extended Brain Injury Rehabilitation: These clients must require and be capable of participating in an extended rehabilitation program. Their care must be -

1. Primarily due to a diagnosis of acute brain injury (see 471 NAC 12-001.04); or
2. Primarily due to a diagnosis of chronic brain injury following demonstration of significant improvement over a period of six months while receiving rehabilitative services based on approval by NMAP.

12-014.01B1a Criteria for Care: The client must:

1. Require physician services that exceed those described in 471 NAC 12-007.09;
2. Have needs that exceed the nursing facility level of care (that is, needs that cannot be met at a lower level of care such as a traditional nursing facility, assisted living, or a private home), as evidenced by:
   a. Complex medical needs as well as extended training or rehabilitation needs that together exceed the criteria for nursing facility level of care;
   b. Combinations of extended training or rehabilitative needs that together exceed the criteria for nursing facility level of care;
   c. Extended training or rehabilitation needs that require multi-disciplinary care including but not limited to those provided by a psychologist. physician, nurse, occupational therapist, physical therapist, speech and language pathologist, cognitive specialist, rehabilitation trainer. etc.; or
   d. Complex combinations of needs from various domains such as behavior, cognitive, medical, emotional and physical.

3. Be capable of participating in an extended training or rehabilitation program evidenced by:
   a. Ability to tolerate a full rehabilitation schedule daily;
   b. Being medically stable and free from complicating acute major medical conditions that would prohibit participation in an extended rehabilitation program;
   c. Possessing the cognitive ability to communicate some basic needs, either verbally or non-verbally;
   d. Being able to respond to simple requests with reasonable consistency, not be a danger to themselves or others, but may be confused, inappropriate, engage in non-purposeful behavior in the absence of external structure, exhibit mild agitation, or have severe attention, initiation, and/or memory impairment (minimum Level IV on the Rancho Los Amigos Coma Scale; and
   e. Being absent of addictive habits and/or behaviors that would inhibit successful participation in the training or rehabilitation program;
4. Have potential to benefit from an extended training or rehabilitation program resulting in reduced care needs, increased independence, and a reasonable quality of life as evidenced by:
   a. Possessing a current documented prognosis that indicates that s/he has the potential to successfully complete an extended training or rehabilitation program;
   b. Possessing the ability to learn compensatory strategies for, or to acquire skills of daily living in areas including, but not limited to transportation, money management, aide management, self medication, social skills, or other self cares which may result in requiring residency in a lower level of residential care; and
   c. Documentation supporting that s/he is making continuous progress in an extended training or rehabilitation program including transitional training for successful discharge or transfer.

12-014.01 B2 Criteria for Care of Clients Requiring Long Term Care Services for Brain Injury: The client must:

1. Have needs that exceed the nursing facility level of care (that is, needs cannot be met at a lower level of care such as traditional nursing facility, assisted living, or a private home), as evidenced by:

a. Combinations of medical, care and/or rehabilitative needs that together exceed the criteria for nursing facility level of care;
b. Care that requires a specially trained, multi-disciplinary team including but not limited to physician, nurse, occupational therapist. physical therapist, speech and language pathologist, psychologist, cognitive specialist, adaptive technologist, etc.;
c. Complex care needs occurring in combinations from various domains such as behavior, cognitive, medical, emotional, and physical that must be addressed simultaneously; or
d. Undetermined potential to benefit from extended training and rehabilitation program;

2. Be capable of participating in clinical program as evidenced by:
   a. Being non-aggressive and non-agitated;
   b. Being absent of addictive habits and/or behaviors that would inhibit participation in clinical program;
3. Have potential to benefit from clinical program as evidenced by:
   a. Being cognitively aware of surroundings and/or events;
   b. Being able to tolerate open and stimulating environment;
   c. Being able to establish/tolerate routines;
   d. Being able to communicate verbally or non-verbally basic needs; and
   e. Requiring moderate to extensive assistance to preserve acquired skills.

12-014.01C Other Special Needs Clients: These clients must require complex medical/rehabilitative care in combinations that exceed the requirements of the nursing facility level of care. These clients may also use excessive amounts of supplies. equipment, and/or therapies. The client must meet the criteria for one of the two following categories:

12-014.01C1 Criteria for Care of Clients with Rehabilitative Special Needs: The client must -

1. Be medically stable and require physician visits or oversight activities two to three times per week;
2. Require multi-disciplinary care (for example, physician, nursing, psychology, respiratory therapy, occupational therapy, physical therapy, speech therapy, pharmacy, spiritual care, or specialty disciplines);
3. Require care in multiple body organ systems;
4. Require a complicated medical/treatment regime, requiring observation and intervention by specially trained professionals, such as:

a. Multiple stage 2, or at least one stage 3 or stage 4 decubiti with other complex needs;
b. Multiple complex intravenous fluids, or nutrition with other complex needs;
c. Tracheostomy within the past 30 day with other complex care needs;
d. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex care needs;
e. Respiratory therapy treatments/interventions more frequently than every six hours with other complex care needs;
f. Initiation of Continuous Abdominal Peritoneal Dialysis (CAPD) or established CAPD requiring five or more exchanges per day with other complex care needs; or
g. In room hemodialysis as required by a physician with other complex care needs;

5. Require extensive use of supplies and/or equipment;
6. Have professional documentation supporting that s/he is making continuous progress in the rehabilitation program beyond maintenance goals; and
7. Have care needs that cannot be met at a lesser level of care (for example, skilled nursing facility, nursing facility, assisted living or private home.)

12-014.01C2 Criteria for Care of Pediatric Clients with Special Needs: The client must-

1. Be underage 21 ;
2. Be medically stable;
3. Require multidisciplinary care (physician, nursing, respiratory therapy, occupational therapy, physical therapy, psychology, or specialty disciplines); and
4. Require a complex medical/treatment regimen requiring observation and intervention by specially trained professionals, such as:
   a. Tracheostomy care/intervention with other complex needs;
   b. Intermittent ventilator use (less than ten hours in a 24-hour period) with other complex needs;
   c. Respiratory therapy treatments/interventions more than every six hours with other complex care needs; or

d. Multiple complex care needs that in combination exceed care needs usually provided in a nursing facility (for example, variable gastrostomy/nasogastric/ jejunostomy feedings with documented aspiration risk; complicated medication regimen requiring titration of meds and/or frequent lab monitoring to determine dosage; multiple skilled nursing services such as intermittent urinary catheterizations, sterile dressing changes, strict intake/output monitoring, intravenous medications, hyperalimentation or other special treatments).

12-014.01D: The revised admission criteria does not apply to clients admitted before the effective date of these regulations.

12-014.01E Exception: Under extenuating circumstances, the Director of the Division of Medicaid and Long-Term Care may approve an exception to the criteria for care of long term care clients with special needs based on recommendations of HHSS staff.

12-014.02 Facility Qualifications: To be approved as a provider of services for LTC clients with special needs, a Nebraska facility providing services to special needs clients must be licensed by the Nebraska Department of Health and Human Services as a hospital or a nursing facility and be certified to participate in the Nebraska Medical Assistance Program (42 CFR 483. Subpart B). Out-of-state facilities must meet licensure and certification requirements of that state's survey agency. Out-of-state placement of clients will only be considered when their special needs services are not available within the State of Nebraska (see 471 NAC 1-002.02G).

The facility must demonstrate the capacity/capability to provide highly skilled multi-disciplinary care. The facility must ensure that its professional nursing staff have received appropriate training and have experience in the area of care pertinent to the individual client's special needs (such as ventilator dependent). The facility must have the ability to provide the necessary professional services as the client requires (such as respiratory care available 24 hours per day, seven days a week).

The facility must-

1. Demonstrate the capability to provide highly skilled multidisciplinary care;
2. Ensure that its staff have received appropriate training and are competent to care for the identified special needs population that is being served (for example, ventilator dependent, brain injury, complex medical/rehabilitation, complex medical pediatrics);

3. Be able to provide the necessary professional services that the special needs clients require (for example, respiratory therapy 24 hours a day, 7 days a week);
4. Have the physical plant adaptations necessary to meet the client's special needs (for example, emergency electrical back-up systems);
5. Establish admission criteria and discharge plans specific to each special needs population being served;
6. Have a separate and distinct unit for the special needs program;
7. Establish written special program criteria with policy and procedures to meet the needs of an identified special needs group as defined in 471 NAC 12-014.01;
8. Have written policies specific to the special needs unit regarding:
   a. Emergency resuscitation;
   b. Fire and natural disaster procedures;
   c. Emergency electrical back-up systems;
   d. Equipment failure (e.g.: ventilator malfunction);
   e. Routine and emergency laboratory and/or radiology services; and
   f. Emergency transportation.
9. Maintain the following documentation for special needs clients:
   a. A comprehensive multidisciplinary and individualized assessment of the client's needs before admission. The client's needs dictate which disciplines are involved with the assessment process. The assessment must include written identification of the client's needs that qualify the client for the special program as defined in 471 NAC 12-014.01. The initial assessment and the team's review and decisions for care must be retained in the client's permanent record. (see 471 NAC 12-014.03A);
   b. A copy of the admission MDS (Minimum Data Set), admission assessment and, PASRR Level 1 identification screen and the Level II determination if applicable. These are to be maintained as part of the client's permanent record;
   c. A minimum of daily documentation or assessment and/or intervention by a Registered Nurse or other professional staff as dictated by the client's needs (e.g., Respiratory Therapy, Occupational or Physical therapy);
   d. A record of physician's visits; and
   e. A record of interdisciplinary team meetings to evaluate the client's response and success toward achieving the identified program goals and the team's revisions/additions/deletions to the established program plan (see 471 NAC 12-014.03D);
10. Maintain financial records in accordance with 471 NAC 12-011 and 12-012; and
11. Provide support services necessary to meet the care needs of each individual client and these must be provided under existing contracts or by facility staff as required by Medicare/Medicaid (42 CFR 483. Subpart B) for nursing facility certification (for example, respiratory, speech, physical or occupational therapies, psychiatric or social services).

12-014.03 Approval Process: NMAP pays for a special need nursing facility service as defined in 471 NAC 12-014 when prior authorized by the designated program specialist in the Central Office. Each admission shall be individually prior authorized.

12-014.03A Prior to Admission: A written comprehensive and individualized assessment completed by the facility must be sent to the Central Office. The assessment and accompanying documentation must address how the client meets the criteria for special needs care as defined in 471 NAC 12-014.01. It is the facility's responsibility to assess, gather and obtain this information and submit it to the Central Office for prior authorization and before admission.

Initial approval/denial will be given after Medicaid staff reviews the submitted information. It is the facility's responsibility to obtain and provide any missing or additional information requested by the Central Office. The initial approval will be delayed until all information is received by the Central Office staff. The Pre-Admission Screening Level I Evaluation (see 471 NAC 12-004.04) and Level II Evaluation, when applicable (see 471 NAC 12-004.08), must be completed before admission and the Level II findings/reports must accompany the packet of information sent to the Central Office for funding authorization.

12-014.03A1 Facilities serving the needs of individuals who are ventilator-dependent and other special needs clients (see 471 NAC 12-014.01A and 12-014.01 C) must include the individualized admission assessment completed by the facility and other documentation which must include but is not limited to:

1. Current medical information that documents the client's current care needs;
2. Historical information that impacts the client's care needs;
3. Discharge summary(ies) of any facility stay(s) within the past 6 months;
4. Current physical/cognitive/behavioral status;
5. Justification for special needs level of care; and
6. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03A2 Facilities serving the needs of clients with brain injuries (see 471 NAC 12-014.01B) shall submit the individualized admission assessment completed by the facility and the following documentation which must include but is not limited to:

1. Current medical information that documents the client's current care needs, including a letter from the client's primary care physician indicating the potential for successful rehabilitation;
2. Historical information that impacts the client's care needs;
3. Discharge summaries of any facility stay(s) within the past year;
4. All discharge/service summaries of any rehabilitative (inpatient and outpatient) services received since the qualifying injury;
5. An Individualized Educational Plan (IEP) of any client under age 21 if one exists;
6. An Individual Program Plan and discharge statement/meeting for any client receiving or who has received services from the Developmental Disabilities System since the qualifying injury;
7. The written plan from Vocational Rehabilitative services if the client is receiving or has received since the qualifying injury;
8. Current physical/cognitive/behavior status; and
9. Identification of major areas of preliminary care planning (an estimate of services needed to reach the proposed goals).

12-014.03B Initial Approval: Based on the pre-admission assessment, initial approval/denial will be given by the Central Office staff for a 90-day admission, for assessment and development of a special needs plan of care. During this 90-day period, the individual will be receiving special needs care for the purposes of determining the potential for benefit from longer-term participation in the special needs program. At the end of 30 days, the Central Office will be provided a special needs formal plan of care, developed by the full interdisciplinary team. By the end of the 60th day, a report will be provided to the Central Office establishing demonstrated potential to benefit from the additional special needs programming, and estimating the time needed to complete the special needs plan of care, or recommendations to a lesser level of care.

12-014.03B1 In-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007)-

1. Complete an admission Form MC-9-NFas required by 471 NAC 12-006.02C (the facility is responsible for verifying the client's Medicaid eligibility before completion of the MC-9-NF);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of PASRR Level I identification screen and Level II determination if applicable; and
4. Submit all information to the Central office.

Facility staff must make a comprehensive assessment of the resident's needs within 14 days of admission using the Minimum Data Set (MDS), and transmit it electronically to CMS in accordance with 42 CFR 483.20.

The Department review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time limited.

12-014.03B2 Out-of-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date Medicaid eligibility is determined, facility staff shall (see 471 NAC 12-007)

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C (the facility is responsible for verifying the client's Medicaid eligibility prior to completion of the MC-9-NF);
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form PASRR Level I identification screen and Level II determination (where applicable);
4. Attach a copy of their state-approved MDS; and
5. Submit all information to the Central Office.

The Department review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.04 Utilization Review: The Department will review records and programs established for authorized Medicaid client stays in a Special Needs program on a quarterly basis. These reviews can be conducted on-site or by submitting requested documentation to the Department. Upon completion of a review, Department staff may determine that a client no longer meets the criteria as established in 471 NAC 12-014.01. The Department will notify the facility in writing of this finding. Examples of conditions for termination of special needs payment include but are not limited to:

1. The client has medically, physically, or psychologically regressed and cannot participate in the established program documented for at least one month duration;
2. The client refuses to participate in the established program for a documented time of at least one month;
3. The client no longer has documented progress toward established program goals and/or the client's progress has reached a plateau with no documented progress for at least three months (maintenance goals do not qualify the client to continue the program);
4. The client no longer meets criteria as defined in 471 NAC 12-014 that pertains to his/her specific program needs (for example, ventilator use, complex care needs are resolved, pediatric client turns 22).

12-014.04A Comprehensive Plan of Care: The facility must submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings (see 471 NAC 12-014.02, item 9e) that document the client's progress/lack of progress toward the client's established program outcomes/goals to the Medicaid Central Office quarterly.

12-014.04B: NMAP will require monthly reviews for extended brain injury rehabilitation stays beyond two years.

12-014.04C Right to Contest a Decision: See 471 NAC 2-003.01.

12-014.05 Payment for Services for Long Term Care Clients with Special Needs: Payment for services to all special needs clients must be prior authorized by Department staff in the Central Office.

12-014.05A Nebraska Facilities: To establish a Nebraska facility's payment rate for care of special needs clients:

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.

Services not commonly included in the per diem (unless specifically provided via the facility's provider agreement addendum,) include, but are not limited to:

a. Speech therapy;
b. Occupational therapy;
c. Physical therapy;
d. Pharmacy;
e. Audiological services;
f. Laboratory services;
g. X-ray services;
h. Physician services; and
i. Dental services;

These services are reimbursed under the Department's established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. If the facility has no prior cost experience in providing special needs services, the facility must submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience.
4. An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;
5. After a rate is agreed upon, the provider must sign a provider agreement addendum. The addendum originated by the Department, must include:
    a. The rate and its applicable dates;
    b. A description of the criteria for care;
    c. A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately;

6. Reimbursement must reflect the facility's actual reasonable cost of providing services to special needs clients and must be updated annually using an appropriate inflation adjustment.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the establishment of the Nebraska Medicaid provider agreement. The payment is not subject to any type of adjustment.

12-014.05C Payment for Bedhold: The Medicaid payment rate for hospital and therapeutic leave days will be negotiated between the service provider and the Department based on the costs of operating a special needs unit (e.g. required medical equipment, staffing levels). The rate will be no lower than the Level 105 rate, as defined in 471 NAC 12-011.08F, and will not exceed the per diem inpatient unit rate.

12-014.06: The requirements of 471 NAC 12 apply to services provided under 471 NAC 12-014 unless otherwise specified in 471 NAC 12-014.

12-014.08 INTERMEDIATE SPECIALIZED SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

12-014.08A Introduction: The Nebraska Medical Assistance Program (NMAP) covers "intermediate specialized services (ISS) for persons with serious mental illness". ISS are covered for those individuals who have been identified by the Level II Preadmission Screening Process (PASP) evaluation and through the ISS evaluation process as needing services to maintain or improve their behavioral or functional levels above and beyond services that nursing facilities normally provide, but who do not require the continuous and aggressive implementation of an individualized plan of care, as "specialized services" is defined by PASP regulations in 471 NAC 12-004. These individuals need more support than nursing facilities would normally provide, but not at a "specialized services" level.

12-014.08B The requirements of 471 NAC 12 apply to ISS provided under 471 NAC 12-014.08 thru 12-014.08M unless otherwise specified.

12-014.08C Definition: Intermediate Specialized Services (ISS) for Individuals with Serious Mental Illness means services necessary to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest practicable level of functional and psycho-social well being. Services are characterized by:

1. The client's regular participation, in accordance with his/her comprehensive care plan, in professionally developed and supervised activities, experiences, and therapies;
2. Activities, experiences, and therapies that reduce the client's psychiatric and behavioral symptoms, improve the level of independent functioning. and achieve a functional level that permits reduction in the need for intensive mental health services.

12-014.08D Program Components: ISS is designed to:

1. Provide and develop the necessary services and supports to enable clients to reside successfully in a nursing facility without the need of more intensive specialized services;
2. Maximize the client's participation in community activity opportunities, and improve or maintain daily living skills and quality of life;
3. Facilitate communication and coordination between any providers that serve the same client;

4. Decrease the frequency and duration of hospitalization and inpatient mental health (MH) services;
5. Provide client advocacy, ensure continuity of care, support clients in time of crisis, provide and procure skill training, ensure the acquisition of necessary resources, and assist the client in achieving social integration;
6. Expand the individual's comprehensive care plan to assure that it includes interventions to address: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related areas necessary for successful living in the community;
7. Provide the individualized support and rehabilitative interventions as identified through the comprehensive care planning process to address client needs in the areas of: community living skills, daily living skills, interpersonal skills, psychiatric emergency and relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related services necessary for successful living in the community;
8. Monitor client progress in the services being received and facilitate revision to the comprehensive care plan as needed;
9. Provide therapeutic support and intervention to the client in time of crisis and, if hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client's transition back into the client's place of residence upon discharge;
10. Establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client, including scheduled services that include evening and weekend hours; and
11. Provide or otherwise demonstrate that each client has on call access to a mental health provider on a 24 hour, 7 days per week basis.

12-014.08E Criteria for ISS: For ISS, the client must have been evaluated through the PASP process and the ISS evaluation process, and been determined to not need specialized services based on the outcomes of the Level II evaluation and the ISS Evaluation Process. The ISS Evaluation Process must include, but is not limited to, evaluation by a team which must consider an individual's long term residence in a mental health facility, higher levels of aggression, and higher levels of medical need. The client must be currently diagnosed with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of DSM or ICD-9-CM equivalent (and subsequent revisions) except DSM "V" codes, substance use disorders, developmental disorders, and dementia which are excluded, unless they co-occur with another diagnosable serious mental illness.

12-014.08F Comprehensive Care Plan Development: The Department or its designee will refer clients authorized for ISS to the most appropriate provider(s), consistent with client choice. The ISS provider must work with the client to complete a comprehensive care plan that includes:

1. An assessment of the client's strengths and needs in that service domain according to the requirements of the Level l evaluation found at 471 NAC 12-004.09 and 12-004.13C and the ISS evaluation process; and
2. The Resident Assessment in accordance with 471 NAC 12-007.06 and 12-007.07.

12-014.08G Movement Between Specialized Services, ISS, and Regular Nursing Facility Services: Individuals' needs change over time and level of service intensity must change to appropriately meet those needs. Nursing facility staff and other service providers must identify changes in level of need as they occur. Such changes would include a decline in psychiatric stability that requires specialized services or marked decrease in the need for ISS. See 471 NAC 12-004.02.

12-014.08G1 Increase in Service Needs: Nursing facility staff must request review by the consulting psychiatrist when ISS are not sufficient to meet a client's needs (i.e, escalation in behavioral challenges, marked decreases in functional level, decreases in mental stability that might require inpatient stays). Based on the findings of the consulting psychiatrist, the client may be moved to an inpatient facility for receipt of specialized services.

12-014.08G1a Returning from Receiving Specialized Services for Mental Illness: For ISS clients, this process must follow procedures at 471 NAC 12-004.09A and 12-014.08E.

12-014.08G2 Decrease in Service Needs: When the need for ISS decreases. regular services that the nursing facility would normally provide may be sufficient. In addition to the normal discharge planning process under 471 NAC 12-007.19, ISS facility staff must request review by the ISS evaluation team. With the team's approval, the client may be transferred to regular nursing facility services.

12-014.08H Transfers: For ISS clients, transfers between nursing facilities will not require a Level I or Level II PASARRP evaluation. See 471 NAC 12-004.04. A Tracking Form must be completed and faxed to the PASP contractor for clients with a PASP determination.

12-014.08I Standards for Provider Participation: ISS providers may be any nursing facility certified to participate in Medicaid and Medicare. If the ISS provider subcontracts with service providers, they must be Medicaid enrolled providers. All providers of ISS must be approved and meet all applicable requirements under Title 471, Chapter 2-000, Provider Participation and other applicable sections of the NAC. However, for the purposes of effectiveness and efficiency in delivering these services, the Department approves ISS providers through a proposal process, and certifies all or part of a facility to provide ISS services. The Department will announce, through public notice, when it will entertain facility proposals. These announcements will detail to potential ISS providers the primary locations, number of beds, architectural standards, staffing requirements, and any other information to assist facilities with their proposals.

12-014.08J Staff Requirements: The facility must maintain a sufficient number of staff with the required training, competencies, and skills necessary to meet the client's needs. Training must be approved by the Department and specific to the delivery of ISS and related mental health services. At a minimum, the ISS facility must have a consulting psychiatrist. It must develop and implement a comprehensive care plan for each ISS client, ensure necessary monitoring and evaluation and must modify the care plan when appropriate. Staff must have the skills to care for the clients, know how to respond to emergency and crisis situations and fully understand client rights. The facility must provide care and treatment to clients in a safe and timely manner and maintain a safe and secure environment for all residents.

12-014.08J1 Staff Credentialing: The facility must ensure that:

1. Any staff person providing a service for which a license, certification, registration, or credential is required holds the license, certification, registration, or credential in accordance with applicable state laws;
2. The staff have the appropriate license, certification, registration, or credential before providing a service to clients including training specific to the delivery of ISS and related mental health services; and
3. It maintains evidence of the staff having appropriate license, certification, registration, or credential.

12-014.08J2 Initial Orientation: The facility must provide staff with orientation before the staff person having direct responsibility for care and treatment of clients receiving ISS provides services to clients. The training must include:

1. Client rights;
2. Job responsibilities relating to care and treatment programs and client interactions;
3. Emergency procedures including information regarding availability and notification;
4. Information on any physical and mental special needs of the clients of the facility;
5. Information on abuse, neglect, and misappropriation of money or property of a client and the reporting procedures;
6. De-escalation techniques;
7. Crisis intervention strategies;
8. Behavior management planning and techniques;
9. The role of medication in psychiatric treatment;
10. CPR and medical first aid; and
11. Strength-based services and the recovery model.

The facility must maintain documentation of staff initial orientation and training.

12-014.08J3 Ongoing Training: The facility must provide each staff person ongoing training in topics appropriate to the staff person's job duties, including meeting the needs, preferences, and protecting the rights of the clients in the facility.

12-014.08K Client Rights: The facility must ensure that clients rights are ensured in accordance with 42 CFR 483.10 and 175 NAC 12-006.05.

12-014.08L Utilization Review: The Department or its designee will provide utilization review for ISS. This includes assessing the appropriateness of the intensity of services and providing ongoing utilization review of the client's progress in relation to the comprehensive care plan. At least annually, the Department or its designee will reassess clients receiving ISS, and will review and approve new service recommendations and continued eligibility for ISS.

12-014.08M Payment: The Department pays for ISS services as specified in 471 NAC 12-014.05.

31-008 Payment for ICF/IID 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/IID 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 of the beginning of each applicable cost report period) are used in determining the cost for Nebraska ICF/IIDs 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:

1. Routine Services: Routine ICF/MR services include regular room, dietary, and nursing services; social and active treatment program as required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are:
   a) All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b) Active treatment: The facility must provide a continuous active treatment program as determined necessary by each client's Interdisciplinary team, including physical therapy, occupational therapy, speech therapy, recreational therapy, and pre-vocational services and supplies to include but limited to augmentative communication devices with related equipment and software, as described in each client's Individual Plan of Care (see 42 CFR 483.440 and 471 NAC 31-001.02);
   c) Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins. bedpans, etc.;
   d) Items stocked at nursing stations or on each floor/home in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, Band Aids, incontinency care products, oxygen and oxygen equipment, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, supports (e.g. trusses and compression stocking with related components), hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
   e) Items which are used by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, standard wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, and all other durable medical equipment, not listed in 31-007-06B;
   f) Nutritional supplements and supplies used for oral, enteral, or parenteral feeding;
   g) Laundry services, including personal clothing; and
   h) Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.
   i) Repair of medically necessary facility owned/purchased durable medical equipment and their maintenance.
2. Injections: The resident's physician must prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility must provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.03C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/IDD and are not properly classified as "routine services." The ICF/IDD must contract for ancillary services not readily available in the ICF/IDD.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider must submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for ICF/IDDs.

Department-required independent QMRP assessments are considered ancillary services.

31-008.03D Payment to ICF/IDD Provider SEPARATE from Per Diem Rates: Items for which payment may be made to ICF/IDD Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in 471 NAC 7-000.

1. Non-standard wheelchairs and components;
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

Reimbursement to ICF/IDD providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ICF/IDD services. The agency's fee schedule rate was set as of July 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

31-008.03E Payments to Other Providers: Items for which payment may be authorized to non-ICF/IDD providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Orthoses (e.g. lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7-000;

5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000.
   a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP does not make payment for ambulance service.
   b. Non-emergency ambulance transports to physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the ICF/MR).

31-008.04 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15;
5. Travel and entertainment, other than for professional meetings and direct operations of the facility. Costs of motor homes, boats, and other recreational vehicles including operation and maintenance are not allowable expenses;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts. charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;

11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of persons with mental retardation in ICF/MR's will be allowed.

31-008.05 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs that are not State-operated.

31-008.05A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

31-008.05B Total Inpatient Days: Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.05B1 For ICF/MRs with 16 beds or more: In computing the provider's allowable cost per day for determination of the rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days.

31-008.05B2 For ICF/MRs with 4-15 beds: In computing the provider's allowable cost per day for determination of the rate, total inpatient days for fixed costs are the greater of actual inpatient days or 85% of licensed beds. For computing the non-fixed costs per day the actual patient days are utilized.

31-008.05C New Construction Reopening and Certification Changes: For new construction (entire facility or bed additions), facility reopening, or a certification change from Nursing Facility to (CF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering Medicaid after July 31, 1982, must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months. Start-up costs include, for example, administrative and nursing' salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding).

Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05E1 ICF/MRs with 16 beds or more:
An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, adjusted by the Inflation Factor (see 471 NAC 31-008.06C7) for the most recent report period.

31-008.05E2 ICF/MRs with 4-15 beds:
An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's average customary charge to the general public for the same retroactively settled payment period, for the same level of care services, except for public facilities providing services at a nominal charge,

31-008.05F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with others than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions; (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.); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

31-008.05G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-008.05J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

31-008.05H Interest Expense: For rate periods beginning January 1, 1985, interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for ICF/MR care. This limitation does not apply to government owned facilities.

31-008.05J Recognition of Fixed Cost Basis: The fixed cost basis of real property (land, land improvements, buildings and equipment permanently attached to the building) for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Department of Health and Human Services, Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 31-008.07E, Recapture of Depreciation, will apply to this part.

The fixed cost basis of personal property (furniture, moveable equipment and vehicles) for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the seller's Medicaid net book value at the time of purchase.

471 NAC 31-008.07E, Recapture of Depreciation, does not apply to personal property.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

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 12-011.06K for Administrator compensation maximum amounts.

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.

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.

An ICF/IID facility's prospective rate is the sum of the five components.

31-008.06C1a Durable Medical Equipment (DME) Rate Add-on: Effective August 1, 2013, facilities are responsible for costs of certain durable medical equipment. To account for these increased costs:

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.28/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.28/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.02/day.
4. For the rate periods after June 30, 2016, prospective rates will not be increased by a DME rate add-on.

31-008.06C2 ICF/IIDs with 4-15 beds:

31-008.06C2a Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06C2b Final Rate: The Department pays each ICF/IID with 4-15 beds a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/IID Revenue Tax Cost Component. This component is not retroactively settled (see 31-008.06C8b).

The final rate is the sum of the above five components.

31-008.06C3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry and housekeeping, property and plant, and administrative services.

31-008.06C3a ICF/MRs with 16 or more beds:
Both the resident care services and the support services portions of the personnel operating cost component of the prospective rate are the lower of:

1. The allowable personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7, or
2. The facility's Personnel Operating Cost Model, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7.

31-008.06C3b Personnel Operating Cost Model: The personnel operating cost model cost per day for each facility is determined based on each facility's average actual occupancy per day limited to an average occupancy of not less than 15 residents per day, level of care resident mix, staffing standards, and reasonable wage rates as adjusted for reasonable fringe benefits.

31-008.06C3b(1) Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in 471 NAC 31-008.06C3b(2), are used to determine each facility's efficient and adequate personnel cost. The 19 staff categories and respective standards are used to determine total efficient and adequate personnel cost and are not intended to be required staffing levels for each staff category. All standard hours per resident day are paid hours and, therefore, include vacation, sick leave, and holiday time.

The staff categories and standards are as follows:

Hours per Resident Day

Staff Categories	All
Direct Care Staff -Aides, attendants, houseparents, counselors, house managers	6.5160
Direct Care Admin. -QMRPs, residential service/ program coordinators, direct care supervisors	0.9105

Hours per Resident Day

Active Treatment Services	All
-Physical therapists & assistants	0.0620
-Occupational therapists & assistants	0.0830
-Psychologists	0.0940
-Speech therapists & audiologists	0.0700
-Social workers	0.1390
-Recreation therapists	0.1460
-Other professional & technical staff	0.4330
Medical Services	
-Health services supervisor	see description following
-Registered nurses	see description following
-LPN or vocational nurses	0.1975
Dietary	
-Dietitian, nutritionists	0.0230
-Food service staff	0.5540
Laundry & Housekeeping	
-Laundry & housekeeping personnel	0.3940
Property & Plant	
-Maintenance personnel	0.3000
Administration	
-Administrator	see description following
-Assistant administrators	see description following
-Other support personnel	see description following

The standard for the Health Services Supervisor position is one full-time equivalent employee, which will result in a varying number of standard hours per resident day depending upon the number of resident days. The standard hours per resident day for registered nurses are 0.1885 reduced by the Health Services Supervisor hours per resident day. However, these standard hours may not reduce the facility below one full-time equivalent for the combined Health Services Supervisor and R.N. positions.

The standard for the Administrator position is one full-time equivalent employee. The standard for assistant administrators is based on facility size and is as follows:

Number of Residents	Number of Assistant Administrators
1 to 100	None
101 to 200	1
201 to 300	2
301 to 400	3
401 to 500	4
501 and over	5

For other support personnel, the standard hours per resident day are 0.608, reduced by the assistant administrators' hours per resident day.

31-008.06C3b(2) Standard Wage Rates: Wage rates for each personnel category will be determined annually based on the actual average wage rates of the Beatrice State Developmental Center for the current cost report period.

31-008.06C3c ICF/MRs with 4-15 beds:
Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C4 ICF/MR 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.

31-008.06C4a ICF/MRs with 16 beds or more:
The nonpersonnel operating cost component of the prospective rate is the lower of:

1. The allowable non-personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC31-008.06C7;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/MR facilities, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC31-008.06C7; or
3. 30 percent of the weighted mean for all ICF/MR facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under 471 NAC31-008.06C7. The mean will be weighted by the Nebraska Medicaid ICF/MR days.

31-008.06C4b ICF/IIDs 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/IID provider's most recent cost report period.

31-008.06C5 ICF/IID 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/IID 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/IID Inflation Factor: The Inflation Factor is determined from spending projections computed using:

1. Audited cost and census data following the initial desk audits;
2. Budget directives from the Nebraska Legislature; and
3. Effective for the rate period beginning July 1, 2015 and for subsequent rate periods, proceeds from the ICF/DD Reimbursement Protection Fund as specified in Nebraska Revised Statute 68-1804(4)(e).

For the Rate Period of July 1, 2015 through June 30, 2016, the inflation factor is positive 12.23%.

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

31-008.06C8a ICF/IIDs with 16 or more beds:
Under the ICF/DD Reimbursement Protection Act, the ICF/IID revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentages(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 fiscal year's data.

31-008.06C8b ICF/IIDs with 4-15 beds:
Under the ICF/DD Reimbursement Protection Act, the ICF/IID 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/IID 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).

31-008.06D Rates for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR): The Department pays State-operated ICF/MR providers an amount equivalent to the reasonable and adequate costs incurred during each Reporting Period. An interim per diem rate is paid during the fiscal year Rate Period, based on financial and statistical data as submitted by the ICF/MR for the most recent Reporting Period. The interim rate is settled retroactively to the facility's actual costs, which determine the Final Rate. The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and

The ICF/MR Revenue Tax Cost Component.

The rate is the sum of the above five components. Rates cannot exceed the amount that can reasonably be estimated to have been paid under Medicare payment principles.

31-008.06D1 Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06D2 Final Rate: The Department pays each ICF/MR a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

31-008.06D3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry, and housekeeping, property and plant, and administrative services. Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

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 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 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.

31-008.06F2 Initial Interim Rates for New Providers of ICF/MRs with 4-15 Beds: All new providers entering the NMAP will be required to submit a proposed budget covering census, revenues, operating expenses and fixed expenses as detailed on the Medicaid Cost Report. The Department will review and, if necessary, adjust the proposed budget amounts based on reasonableness and allowability. The Department will calculate an initial interim rate based on the adjusted budget amounts. The initial interim rate will be retroactively adjusted based on the provider's actual, audited costs for the rate period, according to 471 NAC 31-008.06C2b.

31-008.07 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreement (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the ICF/MR must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the ICF/MR determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 31-008.05J and 31-008.05K.

31-008.07A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

31-008.07B Capitalization Guidelines: Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

31-008.07B1 Capitalization Threshold: The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for its facility, but the threshold amount must be at least $100 and no greater than $5,000.

31-008.07B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has a historical cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

31-008.07B3 Acquisitions Under $100: Acquisitions after July 1, 2004 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are to be included in the applicable operating cost category on the Cost Report in the current period.

Examples:

Item	Per Item Cost	Account
Toaster	$38	Dietary Supplies
30 Wastebaskets	$22 ($660 total)	Housekeeping Supplies
Calculator (bookkeeper)	$95	Administration Supplies
Pill Crusher	$62	Nursing Supplies
Wrench Set	$77	Plant Related Supplies

31-008.07B4 Integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

31-008.07B5 Multiple Items: Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy should describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

31-008.07B6 Non-Capital Purchases: Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

31-008.07B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 471 NAC 31-008.07B1 through 31-008.07B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

31-008.07B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

Example A
Provider A's written capitalization policy has a $5,000 threshold for single item purchases. Purchases of multiple items are treated on an item-by-item basis.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Plant Related – as per item cost is less than $5,000
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Plant Related
Range/Oven	$4,900	Plant Related
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Plant Related – as per item cost is less than $5,000
3 Cubicle Walls & Desktop for an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Plant Related – as total cost of integrated system is less than $5,000

Example B
Provider B's written capitalization policy has a $1,500 threshold for single item purchases. Multiple item purchases are treated as an aggregate single purchase.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Capitalize & Depreciate
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Capitalize & Depreciate
Range/Oven	$4,900	Capitalize & Depreciate
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Capitalize & Depreciate – as aggregate cost of $7,000 is more than $1,500
3 Cubicle Walls & Desktop For an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Capitalize & Depreciate – as cost of integrated system is greater than $1,500

31-008.07C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines; 008.05J and 31-008.05K);

3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 31-008.05J and K)
4. Based on the fair market value at the time of donation for donated assets without a prior Medicaid basis; or based on the donor's Medicaid net book value at the time of the donation for donated assets with a prior Medicaid basis. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

31-008.07D (reserved)

31-008.07E Recapture of Depreciation: Depreciation in 471 NAC 31-008.07E refers to real property only. An ICF/DD which is sold for a profit and has received NMAP payments for depreciation must refund to the Department the lower of:

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times (\text{Sales Price} - \text{Book Value})$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:	Data	
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4/2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

31-008.07F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

31-008.07G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

31-008.08 Reporting Requirements and Record Retention: Providers must submit cost and statistical data on Form FA-66, “Report of Long Term Care Facilities for Reimbursement” (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

Each facility must complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All interim payments made during the rate period to which the cost report applies;
2. All interim payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department retains all cost reports for at least five years after receipt from the provider.

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.

31-003.09 Audits: The Department will perform at least one 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. Payment rates are determined after the initial desk audit is completed.

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.

All cost reports, including those previously desk-audited but excluding those previously field- audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department, The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit:

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 31-008.13 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 31-008.13 #2 or when grounds exist to suspect that fraud or abuse has occurred.

31-008.10 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. If an audit is completed during the applicable rate period, the Department will adjust the rate for payments made after the audit completion.

The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is recovered.

The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

31-008.11 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.

31-008.12 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 Department 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 and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director 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.

31-008.13 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 that 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 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. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

31-008.14 Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments as outlined in 471 NAC 2-002, except that the Department is not required to give 30 days notice.

31-008.15 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

The Nebraska Medical Assistance Programs use the following definitions for a claim to meet the requirements for timely claims payment under 42 CFR 447.45:

1. For inpatient hospital services, a total claim is a single Form HCFA-1450;
2. For long term care services, a total claim is a unique document number;
3. For outpatient hospital services, a total claim is a unique document number on Form HCFA-1450;
4. For physicians' services, a total claim is each single line item on Form HCFA-1500;
5. For dental services, each single line on Form MC-13 is a total claim;
6. For other practitioner services, a total claim is each single line item on Form HCFA-1500;
7. For clinic services, a total claim is each single line item on Form HCFA-1500;
8. For home health services, a total claim is a unique document number on Form HCFA-1450;
9. For family planning services, a total claim is -
   a. A unique document number on Forms HCFA-1450 and MC-3; and
   b. Each single line item on Form HCFA-1500;
10. For laboratory and radiology services, a total claim is each line item on Form HCFA-1500;
11. For prescribed drugs, a total claim is a unique document number on Form MC-3;
12. For EPSDT services, a total claim is each line item on Form MC-5;
13. For sterilization services, a total claim is -
    a. A unique document number on Form HCFA-1450 and
    b. Each line item on Form HCFA-1500; and
14. For personal care aide services, a single line on Form MC-82; and
15. For other care, a total claim is -
    a. A unique document number on Form MC-3; and
    b. Each line item on Form HCFA-1500.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

REQUIREMENTS FOR THIRD PARTY LIABILITY - DETERMINING LIABILITY OF THIRD PARTIES

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1. FREQUENCY OF DATA EXCHANGES:

a. State Wage Information Collection Agency, SSA Wage and Earnings Files, and Title IV-A Program

The Department conducts a data exchange with the state wage information collection agency, the Nebraska Department of Labor, on a quarterly basis with updates nightly; this exchange includes the Title IV-A program. SSA wage and information files are part of the Department's integrated wage data base, and matches are conducted twice a month on new applicants and approvals.

b. Workers' Compensation

The Department is not conducting a data exchange with the Nebraska Workers' Compensation Court. Although discussions were held and the Workers' Compensation Court was amenable to the match, critical data elements for the success of an exchange are not key elements within the computer system for the Compensation Court. Names are not normalized or spellings verified, dates of birth are not available and individual social security numbers are not verified. Because a reliable match can not be produced, the Department has no plans to pursue the match unless or until the key elements become verified data elements.

c. State Motor Vehicle Agency

The Nebraska Department of Roads who has the responsibility over the motor vehicle accident reports has not been able to provide a data file which could be used for TPL purposes. The accident file does not contain verified SSNs, dates of birth, or names of other accident victims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

REQUIREMENTS FOR THIRD PARTY LIABILITY - DETERMINING LIABILITY OF THIRD PARTIES

However, the Department has been able to secure terminal access to the Department of Road's accident records file which includes a menu screen and accident summary page. The accident records file permits the State to enter the driver's name and date of accident (information often received from the county office) and thus obtain information as to the location of the accident, and available insurance information.

d. The Department receives, on a quarterly basis, a report identifying those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (ICDCM) International Classification of Disease. 9th Revision, Clinical Modification, Volume 1).

2. FOLLOW-UP PROCEDURES

a. SWICA, SSA wage and earnings files, and Title IV-A Data Exchanges

The IV-A agency identifies and reports to the Medicaid agency third party resources within 30 days via the insurance file.

b. Health insurance information and Workers' Compensation Date Exchange

Local office staff report health insurance information to the TPL Unit within 60 days after it is obtained from the Medicaid applicants/recipients.

The Department does not conduct a data exchange with the Workers' Compensation Court. However, when workers' compensation coverage is identified from information provided by sources such as clients, local office staff, medical providers, etc. an indicator is placed on the client's eligibility record within 60 days of receipt so that future claims will edit and be reviewed for potential TPL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

REQUIREMENTS FOR THIRD PARTY LIABILITY - DETERMINING LIABILITY OF THIRD PARTIES

c. State Motor Vehicle Accident Report File Data Exchange

The Department does not conduct a data exchange with the State Department of Motor Vehicles. However, when information provided by sources such as clients, local office staff, medical providers, etc. indicates an injury due a motor vehicle accident, the Department has on-line access to the accident report files. Information is obtained and, when applicable, an indicator is placed on the client's eligibility record within 60 days of receipt so that future claims will edit and be reviewed for potential TPL.

d. Diagnosis and Trauma Code Edits

After review of the quarterly report of paid trauma code claims and subsequent investigation, if a liable third party is identified and the third party is a currently available resource, recovery is pursued within 60 days. When appropriate, an indicator is added to the recipient's eligibility record within 60 days so that future claims will edit and be reviewed for potential TPL.

To determine the trauma codes that yield the highest third party collections for purposes of prioritizing follow-up activities on those codes, the Department receives a quarterly report of recovery activity. The report lists those claims in descending order from the highest recovered amounts for each trauma code to the least recovered amounts.

The Department uses a $250.00 threshold in determining whether to pursue recovery after a liable third party has been identified.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

REQUIREMENTS FOR THIRD PARTY LIABILITY - PAYMENT OF CLAIMS

1. PROVIDER BILLING

Providers are not required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the the State IV-D agency. However, the provider must indicate on the claims form or by attachment whether or not the third party was billed. Compliance with billing requirements is monitored by manual review of documentation.

2. THRESHOLD FOR SEEKING RECOVERY

Health Insurance - Most recovery activity for health insurance is for services covered under the cost avoidance waiver. The Department uses a $250 accumulated threshold as the waivered services, if covered, are generally subject to deductibles/coinsurance under the health insurance plan. These reductions to anticipated recoveries do not make it cost effective to pursue amounts under this threshold.

Casualty Coverage - The Department uses a $250 threshold in determining whether to pursue recovery after a liable third party party has been identified.

3. CLAIM ACCUMULATIONS

Health Insurance - Claims generally accumulate for one year for purposes of determining whether to pursue recovery. However, the Department has the capability to continue to accumulate claims for the two calendar years prior to the current year and file for reimbursement of paid claims over one year old when appropriate.

Casualty Coverage - For purposes of the paid claim trauma code follow-up only, claims accumulate for a quarter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

State Methodology on Cost Effectiveness of
Employer-Based Group Health Plans

The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of employer-based group health plans using the following methodology:

1. Obtain information on the group health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the employee.

2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.

3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.

4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.

5. Determine the administrative cost to Medicaid for processing the group health plan information by determining the average increase in cost per client for the six-month period.

6. Determine the cost to Medicaid with insurance by adding the following:
   a. The administrative cost determined under item 5;
   b. The coinsurance and deductible cost determined under item 4;
   c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska's costs being based on "per client" data instead of "per eligible" data.); and
   d. The cost of non-covered services (subtract item 3 from item 2);

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

State Methodology on Cost Effectiveness of
Employer-Based Group Health Plans

7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the group health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the group health plan is not cost effective.

   If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (item 2), NMAP may determine that the group health plan is cost effective.

   NMAP has determined that payment of premiums for a group health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

   NMAP has determined that payment of premiums for a group health plan is not cost effective for the eligibility category of Aged.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

State/Territory: Nebraska

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1),)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: Nebraska

Citation	Sanctions for MCOs and PCMs
1932(e) 42 CFR 428.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the Provisions in 42 CFR 438 Subpart I, in manner Specified below:

Intermediate Sanctions. The State may impose Intermediate Sanctions when the MCO acts or fails to act as follows:

A. Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to a client covered under the contract.
B. Imposes on clients premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
C. Acts to discriminate among clients on the basis of their health status or need for health care services.
D. Misrepresents or falsifies information that it furnishes to CMS or to the State.
E. Misrepresents or falsifies information that it furnishes to a client, potential client, or health care provider.
F. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
G. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
H. Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
I. Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

Intermediate Sanctions: Types. The State may impose the following types of intermediate sanctions:

A. Civil monetary, penalties in the following specified amounts:

State Nebraska

1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to clients, potential clients or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
3. A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
4. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program.

The State must deduct from the penalty the amount of overcharge and return it to the affected clients(s).

- Appointment of temporary management for the MCO as provided in 42 CFR 438.706.
- Granting clients the right to terminate enrollment without cause and notifying the affected clients of their right to disenroll.
- Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Special Rules for Temporary Management. Temporary management only be imposed by the State if it finds that:

State: Nebraska

A. There is continued egregious behavior by the MCO, including, but not limited to behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
B. There is substantial risk to clients' health; or
C. The sanction is necessary to ensure the health of the MCO's clients while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the MCO.

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The State of Nebraska has an eligibility system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States.

The information that is requested will be exchanged on at least a quarterly basis with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

The PARIS match collects data from three separate data matches: Federal, Veterans Affairs (VA) and Interstate. The Federal match provides information about recipients military and civil service benefits. The VA match provides information about veteran's pension and compensation benefits. The Interstate match provides information about recipient's possible receipt of duplicative Medicaid, benefits issued by the 50 states, Washington D.C. and Puerto Rico.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Department sends the Medicaid eligibility card for a homeless individual to the client's local Social Services office, where the client is able to pick it up.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

REQUIREMENTS FOR ADVANCE DIRECTIVES FOR STATE PLANS
FOR MEDICAL ASSISTANCE

The following pages contain the written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Note: Two bills dealing with advance directives were passed by the Nebraska State Legislature in 1992. LB 671 deals with living wills; LB 696 deals with power of attorney for health care. The required information on definitions, witnesses, forms, and conscience provisions are addressed in the written description. In 1993, the Nebraska Legislature amended the power of attorney for health care law by passage of LB 782. This change is reflected in the description.

In addition, Section 30-2668, Neb. Rev. State., defines durable power of attorney as "a power of attorney by which a principal designates another his or her attorney in fact in writing and the writing contains the words The power of attorney shall not be affected by subsequent disability or incapacity of the principal or This power of attorney shall become effective upon the disability or incapacity of the principal or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent disability or incapacity." This state law on power of attorney does not specifically address health care issue; however, section 49-1549 of the Nebraska Short Form Act seems to allow a durable power of attorney for health care decisions under the General Power for Domestic and Personal Concerns.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

REQUIREMENTS FOR ADVANCE DIRECTIVES FOR STATE PLANS
FOR MEDICAL ASSISTANCE

Page 1

ADVANCE DIRECTIVES

THE PATIENT'S RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW IN NEBRASKA

A federal law requires the Nebraska Department of Social Services to prepare a written description of Nebraska's law concerning Advance Directives. The federal law also requires Medicaid-participating hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, and health maintenance organizations to give this description to adult patients. The following material is a general description of Nebraska's law concerning Advance Directives.

In Nebraska, adults who are capable of making health care decisions generally have the right to say yes or no to medical treatment. As a result, you have the right to prepare a document, known as an "Advance Directive." The document says in advance what kind of treatment you do or do not want under special, serious medical conditions - conditions that would prevent you from telling your doctor how you want to be treated. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know your specific wishes about the kind of medical treatment that you do and do not want to receive?

The information in this description can help you understand your right to make decisions in advance of treatment. Because this is an important matter, you may wish to talk to family, close friends or personal advisors, your doctor, and your attorney before deciding whether you want an Advance Directive.

1. WHAT IS AN ADVANCE DIRECTIVE?

An Advance Directive is a written statement which reliably shows that you have made a particular health care decision or have appointed another person to make that decision on your behalf. The two most common forms of Advance Directives are -

- A "Living Will"; and
- A "Power of Attorney for Health Care."

However, an Advance Directive can take other forms or be called other things.

An Advance Directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an Advance Directive can enable you to make decisions about your future medical treatment. You can say "Yes" to treatment you want or say "No" to treatment you do not want.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

REQUIREMENTS FOR ADVANCE DIRECTIVES FOR STATE PLANS
FOR MEDICAL ASSISTANCE

Page 2

2. WHAT IS A LIVING WILL?

A Living Will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a "Living Will" because it takes effect while you are still living. The Nebraska Legislature has adopted laws governing living wills. This law is known as the Rights of the Terminally Ill Act. An adult of sound mind may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the individual or another person at the individual's direction and witnessed by two adults or a notary. No more than one witness to a declaration can be an administrator or employee of a health care provider who is caring for or treating the individual. An employee of a life or health insurance provider cannot be a witness for the individual. Under the law, life-sustaining treatment cannot be withheld or withdrawn under a declaration from an individual who is pregnant if it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment. A Living Will should clearly state your choice with regard to health care.

3. WHAT IS A POWER OF ATTORNEY FOR HEALTH CARE?

A "Power of Attorney for Health Care" is a legal paper naming another person, such as a husband, wife, daughter, son, or close friend, as your "agent" or "representative" to make medical decisions for you if you should become unable to make them for yourself. Your agent, or representative, is guided by your instructions, and you can provide instructions about any treatment you do or don't want. In general, the power of attorney can give to the agent or representative the same powers an individual may have or could enforce on his/her own behalf. Nebraska has laws on Powers of Attorney for Health Care which allow an agent to make medical decisions for the person giving the power of attorney.

A power of attorney for health care must be in writing; identify yourself, your agent, and your successor agent, if any; specifically authorize the agent to make health care decisions on behalf of yourself in the event you are incapable; show the date of its execution; and be witnessed and signed by two adults, each of whom witnesses the signing and dating of the power of attorney for health care by you or your acknowledgment of the signature and date, or be signed and acknowledged by you before a notary public who is not the attorney in fact or successor attorney in fact.

Your power of attorney for health care can grant authority for health care decisions as described in the law. However, the authority to consent to withholding or withdrawing a life-sustaining procedure or artificially administered nutrition or hydration is effective only when -

1. You are suffering from a terminal condition or are in a persistent vegetative state; AND
2. Your power of attorney for health care explicitly grants the authority to your agent or your intention to withhold or withdraw life-sustaining procedures or artificially administered nutrition or hydration is established by clear and convincing evidence. Clear and convincing evidence may be a living will, clearly documented medical record, refusal to consent to treatment, or other evidence.

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State: Nebraska

REQUIREMENTS FOR ADVANCE DIRECTIVES FOR STATE PLANS
FOR MEDICAL ASSISTANCE

Page 3

4. MUST A HEALTH CARE PROVIDER FOLLOW AN ADVANCE DIRECTIVE?

The federal law requires hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations (HMO's) to have written policies concerning Advance Directives. The health care provider you choose must inform you in writing of its written policy regarding Advance Directives. Therefore, you should review and discuss the provider's policy on following your Advance Directive with the provider and others.

Your health care provider must follow your Advance Directive unless the health care provider has informed you that it is unwilling to do so. If the health care provider is unwilling to follow your living will, the health care provider or physician must assist in transferring your care to another provider who is willing to follow your living will. If the health care provider is unwilling to follow your power of attorney for health care, your agent or representative must make arrangements to transfer you to another provider who is willing to follow your power of attorney for health care.

5. WHEN DO ADVANCE DIRECTIVES TAKE EFFECT?

Your Advance Directive generally takes effect only after you no longer can make personal decisions. As long as you can make personal decisions on your own behalf, your health care givers will rely on you, not on your Advance Directive.

6. DO I HAVE TO WRITE AN ADVANCE DIRECTIVE?

No. It is entirely up to you whether you want to prepare an Advance Directive. Questions may arise about the kind of medical treatment that you do and do not want to receive. An Advance Directive may help to solve these important questions.

Your health care provider cannot require you to have an Advance Directive as a condition of receiving care; nor can your health care provider prohibit you from having an Advance Directive.

7. CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

Yes. To change or cancel an Advance Directive, simply destroy the original or take some other action to notify those who might rely on your Advance Directive that you are changing it or no longer want to have it effective. If you have given the Advance Directive to your doctor, notify your doctor of your change of mind. If you have given it to another health care provider, such as a hospital, nursing home, or home health agency, or a relative, notify them that you have changed your mind. If you have written a new document, you should give a copy of the new document to your doctors, other health care providers, and anyone else who may be involved in your care.

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REQUIREMENTS FOR ADVANCE DIRECTIVES FOR STATE PLANS
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8. DO I HAVE TO HAVE A WRITTEN DOCUMENT TO EXPRESS MY WISHES TO MY DOCTOR?

No. If you are able to communicate your wishes to your doctor, they will carry more weight than an Advance Directive. But if you state your wishes in a written document, your doctor will know what you want if you are not able to make decisions and communicate them on your own behalf.

9. WHAT CHOICES SHOULD I INCLUDE IN MY ADVANCE DIRECTIVE?

If you choose to write an Advance Directive, the content of the Advance Directive is entirely your own choice. If you have questions, you may talk with family members, close personal advisors, your doctor, your attorney, or others who could help you understand your choices. Your Advance Directive should be personal to you and should reflect your own personal choices.

10 IF I EXECUTED AN ADVANCE DIRECTIVE IN ANOTHER STATE, WILL IT BE FOLLOWED IN NEBRASKA?

If you have executed an Advance Directive in another state and it is valid under the laws of that state or of Nebraska, it is valid in Nebraska.

11. WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that someone, such as a family member, knows that you have an Advance Directive and knows where it is located. You might also consider the following:

- If you have a power of attorney for health care, give a copy or the original to your "agent" or "representative:"
- Tell your health care provider that you have an Advance Directive and ask the provider to make it part of your medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet, which states that you have an Advance Directive and where it is located and who your "agent" or "representative" is, if you have named one.

This paper provides general information about Advance Directives. It is not intended to provide specific advice in a particular case. If you have additional questions about your legal rights, you should seek the professional advice of a lawyer.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NOT APPLICABLE

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice
requirements specified in the regulation.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NOT APPLICABLE

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DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The Department of Health currently verifies whether an individual meets the requirements. Effective 1-2-92, there will also be a summary attachment regarding substantiated abuse.

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COLLECTION OF ADDITIONAL REGISTRY INFORMATION

N/A

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DEFINITION OF SPECIALIZED SERVICES

For the preadmission screening and annual resident review process (PASARR), the Nebraska Medical Assistance Program defines Specialized Services as follows:

Specialized Services for Individuals with Mental Illness: Services which result in the continuous and aggressive implementation of an individualized plan of care that -

1. Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional, and as appropriate, other professionals;
2. Prescribed specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
3. Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his/her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

These services are commonly provided in an IMD facility, inpatient psychiatric facility, or an equally intensive facility, e.g., crisis unit.

Specialized Services for Individuals with Mental Retardation or a Related Condition: A continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards -

1. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and
2. The prevention or deceleration of regression or loss of current optimal functional status.

These services are commonly provided in an ICF/MR or a community-based developmental disability services (CBDDS) program.

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CATEGORICAL DETERMINATIONS

The Nebraska Medical Assistance Program applies the following categorical determinations:

A categorical determination applies when an individual -

1. Is being admitted to a nursing facility for a period of time not to exceed 120 days for convalescent care for an acute physical illness which required hospitalization;
2. Is certified by a physician to be terminally ill;
3. Is documented to have a severe physical illness such as coma, ventilator- dependent, etc., that is so severe that the individual's medical needs are the predominant treatment issue and the individual could not be expected to benefit from or participate in mental health or mental retardation services or specialized services;
4. Is being admitted pending further assessment in emergency situations requiring protective services, for a period not to exceed seven days;
5. Is being admitted to provide respite for in-home caregivers to whom the individual is expected to return, for a period not to exceed 30 days per stay; or
6. Has a diagnosis of mental retardation or a related condition and Alzheimer's, dementia, or a related disorder, and the determination is made that the diagnosis of dementia is primary and predominant and the individual could not be expected to benefit from or participate in mental health or mental retardation services or specialized services.

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State/Territory: Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Surgery and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The Department of Health and Human Services (DHHS) conducts provider meetings as needed. At these meetings, DHHS staff present information on the Omnibus Budget Reconciliation Act of 1987 (OBRA). There is also a question and answer session.

When requested, DHHS staff speak at meetings of health care associations and other advocacy or educational groups.

Whenever Title XIX regulations change significantly, information will be provided to the appropriate groups.

DHHS surveyors meet the residents during the survey to explain the survey process

DHHS staff are available, on request, to speak to any facility's staff and residents (and their representatives).

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. 1919(g)(1)(c)

When the Department of Health and Human Services (DHHS) receives an allegation of abuse, neglect, and/or mistreatment of a resident or misappropriation of resident property, the Division of Public Health Licensure Unit reviews the allegation. If it is determined that the allegation should be handled as a complaint, reasonable efforts are made to conduct the investigation within timeframes established by policies. A report of the finding is sent to the complainant when the survey results become public information. A report is sent to Adult Protective Services (APS) and if it meets the APS criteria for abuse, they complete an investigation. The Division of Developmental Disabilities conducts investigations for ICF/MR's and their Medicaid waivers.

The complaint investigation report must include or reference, at a minimum —

1. A clear, chronological account of what has occurred.
2. Interviews with --
   a. The victim;
   b. The alleged perpetrator;
   c. Witnesses;
   d. Other residents;
   e. Persons outside the facility, if involved;
3. Copies of information relevant to the incident —
   a. Any signed admission;
   b. In-facility investigative reports and personnel records that indicate disciplinary actions;
   c. Applicable DHHS reports and/or Long Term Care Ombudsman reports;
   d. Resident records pertaining to the incident, any injury, or residual effect of the incident;
   e. Incident reports pertaining to the incident;

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

f. Physician exams or hospitals records related to the incident;
g. Death certificates, coroner or autopsy reports, if available and applicable;
h. Police reports, if applicable; and
i. Pictures and observation of injury and illness resulting from the alleged incident; and
j. Lab and X-ray report.

4. Other information, including —
   a. Statements regarding the victim's and any resident witness's level of awareness and their temperament or demeanor;
   b. If the incident involves conflict, any information regarding previous conflicts;
   c. When applicable, a description of the room or scene of the incident;
   d. A listing of all persons mentioned in the report;
   e. Any documentation that demonstrates that the alleged neglect was caused by factors beyond the control of the perpetrator.
5. Identification of the perpetrator, including full name, last known address, social security number or registry identifier, and place of employment.

The Division of Public Health evaluates the report and determines if the evidence obtained is sufficient to provide a reason to believe that the perpetrator did neglect, abuse, or mistreat a resident, or misappropriate resident property while employed in any certified nursing facility.

If the perpetrator was convicted in a court of law of abuse, neglect, mistreatment, and/or misappropriation of resident property, a certified copy of the conviction is obtained from the court.

If the determination is made that there is reason to believe that a violation has occurred, the results of the complaint investigation are reviewed by DHHS Legal Services. If Legal Services determine that there is sufficient evidence to warrant adding the aide's name to the Nurse Aide Abuse Registry or Medication Aide Abuse Registry, a letter is sent to the aide at the last known address via certified mail within five calendar days of the decision. The letter must include the following information:

1. An allegation has been made against the aide and the substance of the allegation:

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

2. An investigation has been conducted which substantiates the allegation;
3. The aide's name will be included in the Nurse Aide Abuse Registry or Medication Aide Abuse Registry;
4. The consequences of being listed in the registry; and
5. The aide's rights to appeal.

If a request for a hearing is received within 15 calendar days of the mailing of the notice, the hearing will be conducted according to DHHS regulations.

An individual name is put on the Nurse Aide Abuse Registry or the Medicaid Aide Abuse Registry only after —
1. The individual has not appealed the decision; or
2. The individual has appealed the decision and all appeals have been resolved in favor of DHHS.

When an individual whose name is in the Nurse Aide Abuse Registry or the Medication Aide Abuse Registry disputes the decision of DHHS, a brief statement of the dispute will be entered in the registry. If an inquiry is made to the registry, any information disclosed concerning the individual's name being listed on the registry must also include disclosure of any such dispute.

Individuals with Court or Department substantiated abuse are also listed on the DHHS Central Adult Abuse Registry.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Nebraska Department of Health and Human Services (DHHS) has issued the following policy on survey scheduling for Medicare and Medicaid certification purposes.

All initial surveys and scheduled re-surveys for all providers are conducted unannounced, or are announced consistent with CMS instructions per State Operations Manuals 2700A.

Initial surveys for Medicare/Medicaid certified facilities are to be conducted within 90 days from the date of notification from the facility that it is in full operation (SOM 2008A), if possible.

Life Safety Code surveys should be scheduled to coincide with the health survey. In no instance should the Life Safety Code survey precede the health survey. The State Fire Marshall's office conducts the Life Safety Code survey during or after the health survey. It must be scheduled so that all certification actions are completed timely.

It may be necessary to conduct a complete formal survey at an earlier date than planned, due to a complaint about deteriorating standards of care, substantial changes in management or ownership, a significant change in the type of treatment involved, etc. These surveys are not announced in advance.

It may be appropriate to make an unannounced visit between regular survey visits to determine the status of a previously identified problem area or to monitor progress on corrections.

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State/Territory: Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Department of Health and Human Services conducts periodic staff meetings (with all surveyors) to ensure consistency. The Office of Health Facilities Administrators meet monthly and as needed and conduct periodic unit/office meetings.

Supervisors conduct onsite supervisory visits.

The Department has an in-house training program for new surveyors, with a trainer on staff. The Department also conducts ongoing training for current staff.

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State/Territory: Nebraska

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance and verification of continued compliance is indicated; or
(iii) the State has reason to question the compliance of the facility with such requirements.

The Nebraska Department of Health and Human Services (DHHS) conducts complaint investigations of nursing facilities licensed and/or certified by the DHHS as mandated by state law, using the following process:

1. Intake of Complaints: Complaints may be submitted in writing, by telephone, or in person. They may come from individuals receiving services, their responsible parties or other interested persons, or may be referred from the Regional Office, other State agencies, Federal agencies, or private organizations.

2. A central log is maintained by Health Facilities Investigations listing all complaints received by the Division of Public Health. Complaints are logged by support staff and allegations are written by the Complaint Intake staff or Office Administrators. These are assigned to the surveyors. The surveyors schedule the date of the complaint investigation based on the complaint prioritization.

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Process for Investigations of Complaints and Monitoring

3. The investigation proceeds as follows:
    a. The investigation is NOT pre-announced to the facility.
    b. Surveyors identify themselves to the person in charge of the facility and announce the purpose of the visit before beginning the visit.
    c. The identity of the complainant is not revealed unless the complainant has given specific consent.
    d. The surveyors conduct a partial survey focusing on the specific licensure and/or certification requirements(s) related to the allegation. This includes reviewing appropriate samples of residents, rooms, records, etc., to adequately assess compliance with applicable requirements (See SOM 3281).
4. A written report of the visit is submitted on each complaint investigated. If deficiencies are written, surveyors may schedule a follow-up visit after receipt of an acceptable plan of correction.

Section 6032 State Plan Preprint
ATTACHMENT 4.42-A

State/Territory: NEBRASKA

Nebraska requires all entities as defined under section 4.42(a)(1)(A) of this state plan to comply with the requirements of 1902 (a)(68) of the Social Security Act, P.L. 109-171, section 6032. Nebraska will monitor this requirement by identifying entities by provider number or contract number who have received or made payments, in any federal fiscal year, of at least $5,000,000 and annually monitor their compliance with the requirements of section 6032.

Entities will be identified for FFY 2006, contacted and required to submit a compliance report form by July 1, 2007. Annually, thereafter, at the close of each federal fiscal year, Nebraska will identify entities, contact them and require submission of a compliance report by January 1 of the following year, beginning 1-1-2008. Nebraska will validate compliance by sampling the identified entities annually.

COMPLIANCE REPORT - DEFICIT REDUCTION ACT OF 2005, SECTION 6032
EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

Entity/Provider: _____
Address: _____
_____

Medicaid Provider Number(s): _____
_____
_____

This document is a verification that the above entity is in compliance with the requirements of Public Law 109-171, Section 6032, as indicated below:

1. The above entity has written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following:

    - The Federal False Claims Act under title 31 of the United States Code, Sections 3729 through 3733;
    - Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;
    - The State laws pertaining to civil or criminal penalties for false claims and statements (Nebraska Revised Statutes Sections 68-934 to 68947, False Medicaid Claims Act);
    - The provider or provider entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

2. The above entity includes as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

3. The above entity includes in any existing employee handbook for the entity, a specific discussion of the laws described above and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

On behalf of the above entity, I verify compliance with the above requirements and will make them available upon request.

SIGNATURE: _____
(name) (title) (date)

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State Nebraska

NON-DISCRIMINATION

The following is a description of administration used to assure that each service for which Federal Assistance is received is operated in accordance with Title VI of the Civil Rights Act and section 504 of the Rehabilitation Act of 1973:

1. All staff members of the Nebraska Department and county divisions of Social Services are responsible for implementation of Title VI and section 504 of the Rehabilitation Act of 1973.

2. Our Civil Rights handbook is used to inform state and local agency staff of responsibilities and obligations with regard to Title VI and section 504.

3. Pamphlets, application forms, and notice forms include information for applicants and beneficiaries regarding Title VI and section 504.

4. Provider agreement forms and claim forms include information for providers regarding Title VI and section 504.

5. Continued compliance is maintained through surveys and by quality control staff.

6. Policies for handling civil rights related complaints are included in the Nebraska Public Welfare Manual, IX-8200 ff.