Rates for Nursing Facility Services

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.

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 regulation.

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.

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.

Physician Services means the physician must see the client whenever necessary, but at least once every 30 days for the first 90 days following admission, and at least once every 60 days thereafter. At the time of each visit, the physician must: (1) Review the client's total program of care, including medications and treatments; (2) Write, sign, and date progress notes at each visit; and (3) Sign all orders.

Physician Tasks mean in accordance with 42 CFR 483.40(f), the Department will allow all but the following required physician tasks in a nursing facility to be satisfied when performed by a nurse practitioner or physician's assistant who is not an employee of the facility but who is working in collaboration with a physician according to Nebraska statute and designation of duties: (i) Initial certification; (ii) Admission orders; and (iii) Admission plan of care.

Rate Determination means per diem rates calculated under provisions of the Nebraska Administrative Code. These rates may differ from rates actually paid for nursing facility services for Levels of 201 and 202.

Rate Payment means per diem rates paid under provisions of the Nebraska Administrative Code. The payment rate for Levels of Care 201 and 202 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 adjusted to include the Nursing Facility Quality Assessment Component and the Quality Measures Component.

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. Rural means all other Nebraska 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, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

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 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 Indian Health Services nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year report period will not file a cost report.

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

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;

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

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.;
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).

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 QIDP assessments are considered ancillary services.

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. 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 (lower and upper limb, foot and spinal);
4. Prostheses (breast, eye, lower and upper limb);
5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care;
    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, Nebraska Medicaid 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 reasonably be expected to be provided at the client's residence (including the Nursing Facility).

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;
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

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 October 1, 2017, and is effective for services provided on or after that date. All fee schedule rates are published on the agency's website at https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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, and handball courts.
15. Revisit fees.

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

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 Nebraska Medicaid. 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 Nebraska Medicaid.

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 Total Inpatient Days for these days.

Start-Up Costs: All new providers entering Nebraska Medicaid 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.

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.

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 Recognition of Fixed Cost Basis will apply. 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.

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. Nebraska Medicaid does not distinguish between capital related and non-capital related interest expense and interest income (see HIM-15, Section 2150.3E and 2150.3F).

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.

Recognition of Fixed Cost Basis: The fixed cost basis of real property (land, land improvements, buildings, and equipment permanently attached to the building) and personal property (furniture, moveable equipment, and vehicles) for facilities purchased on or after July 1, 2020, 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 purchaser; or
2. For facilities purchased as an ongoing operation on or after July 1, 2020, the seller's Medicaid net book value at the time of purchase.

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.

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".

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.

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.

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 and 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.

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.

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

Nursing Facility Quality Assessment: The nursing facility quality assessment is an allowable cost addressed through the Nursing Facility Quality Assessment Component.

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

Rate Periods: The Rate Periods are defined as July 1 through December 31, and January 1 through June 30. Rates paid during the Rate Periods are determined from base year cost reports (see Prospective Rates and Base Year Report Period and Inflation Factor). For purposes of this section, "base year cost reports" means full and part-year cost reports filed with a base year Report Period ending date of June 30.

Report Period: Each facility must file a cost report each year for the reporting period of July 1 through June 30 or part-year cost reports, when applicable.

Care Classifications: A portion of each individual facility's rate may be based on the urban or rural location of the facility.

Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of Allowable Costs, Unallowable costs and Limitations for Rate Determination, 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 base year Report Period (see Base Year Report Period and Inflation Factor). The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums and minimums.

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

Each facility's prospective rates are the sum of the following components:

1. The Direct Nursing Component adjusted by the inflation factor, and weighted for level of care;
2. The Support Services Component adjusted by the inflation factor;
3. The Fixed Cost Component;
4. The Nursing Facility Quality Assessment Component;
5. The Quality Measures Component; and
6. For the rate periods July 1 through December 31, 2020, and January 1 through June 30, 2021 only, the Transition Component.

The Direct Nursing Component and the Support Services Component are subject to maximum and minimum 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 105% of the median Direct Nursing Component, and 100% 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.

Minimum: The minimum per diem is computed as 77% of the median Direct Nursing Component, and 72% of the median Support Services Component.

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

Direct Nursing Component: This component of the prospective rate is computed by dividing the base year allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the base year weighted resident days for each facility (see Resident Level of Care Weights). The resulting quotient is the facility's computed base year per diem. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

Support Services Component: This component of the prospective rate is computed by dividing the base year 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 base year inpatient days (see Total Inpatient Days) for each facility. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's base year allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total base year inpatient days (see 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, plus any prior approved increase under Exception Process, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

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, July 1 through the following June 30th, 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).

Base Year Report Period and Inflation Factor: For the Rate Periods July 1 through December 31 and January 1 through June 30, the base year is updated no less frequently than every 5 years. The inflation factor is updated annually. For the Rate Period of July 1, 2024 through June 30, 2025, the inflation factor is a positive 6.67%.

Quality Measures Component: This component of the prospective rate is based on the Quality Measures component of the CMS Nursing Facility Star Rating system, published at https://www.medicare.gov/nursinghomecompare/search.html. The published rating as of May 1 is used to determine the rate component for the following July 1 through December 31 rate period. The published rating as of November 1 is used to determine the rate component for the following January 1 through June 30 rate period.

Per diem amounts corresponding to the Quality Measures rating are:
5 star rating = $10.00/day
4 star rating = $6.75/day
3 star rating = $3.50/day
1 star, 2 star, or NR (no rating) = $0.00 (zero)

This component applies to all nursing facility care levels (101-180).

Exception Process: An individual facility may request, on an exception basis, the Medicaid Director or designee, to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. For existing facilities, an exception may only be requested if the facility's total annualized fixed costs (total costs, not per diem rate), as compared to the annualized base year costs, have increased by twenty percent or more. Facilities without a base year cost report, and with 1,000 or more annualized Medicaid days, may only request an exception if the facility's fixed costs per day, computed using an 85% minimum occupancy, exceeds the Care Classification average Fixed Cost Component by twenty 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 20 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).

Approved increases from July 1 through December 31, will be effective the following January 1. Approved increases from January 1 through June 30, will be effective the following July 1.

Rate Payment for Assisted Living Levels of Care: The payment rate for Levels of Care 201 and 202 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 adjusted to include the nursing facility quality assessment component and quality measures component.

Out-Of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at the rates established by that state's Medicaid program for nursing facility days, bed hold days and therapeutic leave days at the time of establishment of the Medicaid provider agreement. The rates are periodically updated to align with the current and applicable rates assigned by the out-of-state facility's State Medicaid program.

Rates for Providers Without a Base Year Cost Report:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A provider without a base year cost report is:

1. 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, after the base year cost report end date; or
2. A provider with 1,000 or fewer Medicaid inpatient days in the base year (see General Information).

For purposes of this definition, "nursing facility" means the business operation, not the physical property.

Prospective Medicaid rates for providers without a base year cost report are the sum of the following components:

1. The applicable Urban or Rural average Direct Nursing base rate component of all other providers in the same Care Classification, adjusted by the inflation factor; and weighted for level of care;
2. The applicable Urban or Rural average Support Services base rate component of all other providers in the same Care Classification, adjusted by the inflation factor;
3. The applicable Urban or Rural average Fixed Cost base rate component of all other providers in the same Care Classification;
4. The Nursing Facility Quality Assessment Component; and
5. The Quality Measures Component.

Providers Leaving the Nebraska Medicaid: Providers leaving the Nebraska Medicaid program as a result of change of ownership or exit from the program shall comply with provisions of Reporting Requirements and Record Retention.

Special Funding Provisions for Governmental Facilities: City and county-owned and operated nursing facilities 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.
The reimbursement is subject to the payment limits of 42 CFR 447.272.

A. 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, Support Services, and Fixed Cost Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current Nebraska Medicaid Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing, Support Services, and Fixed Cost Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.

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.

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 Recognition of Fixed Cost Basis.

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.

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.

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.

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.

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

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.

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.

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.

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 Capitalization Guidelines 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.

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. Multiple item purchases 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 &	$300 (total = $900)	Plant Related - as total Desktop $700 cost of integrated system
for an Office Cubicle	(total = $1,600)	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 &	$300 (total = $900	Capitalize & Depreciate - as cost of integrated
Desktop	$700	system is greater than
For an Office Cubicle (total = $1,600)		$1,500

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 Recognition of Fixed Cost Basis);
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.

Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under Nebraska Medicaid. 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.

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.

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". 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 Nebraska Medicaid. 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.

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, must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

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 Medicaid. 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 opening or reopening an audit in accordance with Administrative Finality.

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.

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.

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.

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.

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.

Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under 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 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.

Classification of Residents and Corresponding Weights

Resident Level of Care: The Department will use a federally approved patient driven payment-model grouper to assign a level of care using the information from the minimum data set. Each level of care will be assigned the federally-recommended weight. When no minimum data set assessment is available, the resident will be assigned to a default level of care, Level 280.

Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care. Each resident's level 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 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. 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.

Resident Level of Care Weights: The following weighting factors must be assigned to each resident level of care, based on the Centers for Medicare and Medicaid Services Patient Driven Payment Model Nursing classifications:

(A) Level of care: 272; Case Mix Group: ES3; Description: Extensive Services 3, Tracheostomy and Ventilator; Case Mix Index Value: 4.06;
(B) Level of care: 271; Case Mix Group: ES2; Description: Extensive Services 2, Tracheostomy or Ventilator; Case Mix Index Value: 3.07;
(C) Level of care: 270; Case Mix Group: ES1; Description: Extensive Services 1, Infection Isolation; Case Mix Index Value: 2.93;
(D) Level of care: 263; Case Mix Group: HDE2; Description: Special Care High, Depressed, Function Score 0-5; Case Mix Index Value: 2.40;
(E) Level of care: 262; Case Mix Group: HDE1; Description: Special Care High, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.99;
(F) Level of care: 261; Case Mix Group: HBC2; Description: Special Care High, Depressed, Function Score 6-14; Case Mix Index Value: 2.24;
(G) Level of care: 260; Case Mix Group: HBC1; Description: Special Care High, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.86;
(H) Level of care: 253; Case Mix Group: LDE2; Description: Special Care Low, Depressed, Function Score 0-5; Case Mix Index Value: 2.08;
(I) Level of care: 252; Case Mix Group: LDE1; Description: Special Care Low, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.73;
(J) Level of care: 251; Case Mix Group: LBC2; Description: Special Care Low, Depressed, Function Score 6-14; Case Mix Index Value: 1.72;
(K) Level of care: 250; Case Mix Group: LBC1; Description: Special Care Low, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.43;
(L) Level of care: 245; Case Mix Group: CDE2; Description: Clinically Complex, Depressed, Function Score 0-5; Case Mix Index Value: 1.87;
(M) Level of care: 244; Case Mix Group: CDE1; Description: Clinically Complex, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.62;
(N) Level of care: 243; Case Mix Group: CBC2; Description: Clinically Complex, Depressed, Function Score 6-14; Case Mix Index Value: 1.55;
(O) Level of care: 241; Case Mix Group: CA2; Description: Clinically Complex, Depressed, Function Score 15-16; Case Mix Index Value: 1.09;
(P) Level of care: 242; Case Mix Group: CBC1; Description: Clinically Complex, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.34;
(Q) Level of care: 240; Case Mix Group: CA1; Description: Clinically Complex, Not Depressed, Function Score 15-16; Case Mix Index Value: 0.94;
(R) Level of care: 221; Case Mix Group: BAB2; Description: Behavior SX Cognition, Restorative Nursing ≥ 2; Case Mix Index Value: 1.04;

(S) Level of care: 220; Case Mix Group: BAB1; Description: Behavior SX Cognition, Restorative Nursing = 1 or 2; Case Mix Index Value: 0.99;
(T) Level of care: 206; Case Mix Group: PDE2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 0-5; Case Mix Index Value: 1.57;
(U) Level of care: 205; Case Mix Group: PDE1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 0-5; Case Mix Index Value: 1.47;
(V) Level of care: 204; Case Mix Group: PBC2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 6-14; Case Mix Index Value: 1.22;
(W) Level of care: 202; Case Mix Group: PA2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 15-16; Case Mix Index Value: 0.71;
(X) Level of care: 203; Case Mix Group: PBC1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 6-14; Case Mix Index Value: 1.13;
(Y) Level of care: 201; Case Mix Group: PA1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 15-16; Case Mix Index Value: 0.66; or
(Z) Level of care: 280; Casemix Index Vaue: STS; Casemix Index Description: Short-Term Stay; Casemix Index

Value: 0.59; Level of Care 280, 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 minimum data set admission assessment of the client. This is effective for admissions on or after July 1, 2023.

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.

Section XIX. Specialized Add-on Services Payments

Specialized add-on services are paid to the provider(s) of specialized add-on services. Payments to providers for medically necessary services, including specialized add-on services in excess of limitations for covered services identified elsewhere in the state plan, or not listed as specialized add-on services according to the state plan, require pre-authorization.

1) Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of specialized add-on services provided in the nursing facility. The Medicaid agency's rates were set as of June 30, 2018, and are effective for dates of services provided on and after that date. The fee schedule can be found on the agency's website http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

2) Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of habilitative services (i.e. those specialized add-on services not covered under the fee schedule described in section 1 above), provided to individuals residing in a nursing facility. The rates for these specialized add-on services were established using existing DD waiver fee schedules. The rates were set as of June 30, 2018 and are effective for dates of service provided on and after that date. The fee schedule can be found on the Department's website http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

3) Payment excludes the supervisory activities rendered as a normal part of the employment support.

Services for Long Term Care Clients with Special Needs

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~~.

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.

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).

Clients with Brain Injury:

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; 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 Nebraska Medicaid.

Criteria for Care: The client must:

1. Require services that exceed Physician Services and Physician Tasks as described in Definitions;
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.

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.

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:

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.)

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).

The revised admission criteria does not apply to clients admitted before the effective date of these regulations.

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.

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 Medicaid (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.

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 Services for Long-Term Care Clients with Special Needs;
8. Have written policies specific to the special needs unit regarding:
    1. Emergency resuscitation;
    2. Fire and natural disaster procedures;
    3. Emergency electrical back-up systems;
    4. Equipment failure (e.g.: ventilator malfunction);
    5. Routine and emergency laboratory and/or radiology services; and
    6. 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 Services for Long-Term Care Clients with Special Needs. The initial assessment and the team's review and decisions for care must be retained in the client's permanent record;
    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;
10. Maintain financial records; 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).

Approval Process: Nebraska Medicaid pays for a special need nursing facility service as defined in Prior to Admission when prior authorized by the designated program specialist in the Central Office. Each admission shall be individually prior authorized.

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. 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 and Level II Evaluation, when applicable, 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.

Facilities serving the needs of individuals who are ventilator-dependent and other special needs clients 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).

Facilities serving the needs of clients with brain injuries 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).

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.

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:

1. Complete an admission Form MC-9-NF (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.

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:

1. Complete an admission Form MC-9-NF (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.

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 Services for Long-Term Care Clients with Special Needs. 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 Services for Long-Term Care Clients with Special needs that pertains to his/her specific program needs (for example, ventilator use, complex care needs are resolved, pediatric client turns 22).

Comprehensive Plan of Care: The facility must submit copies of the initial comprehensive plan of care and subsequent interdisciplinary team meetings that document the client's progress/lack of progress toward the client's established program outcomes/goals to the Medicaid Central Office quarterly.

Nebraska Medicaid will require monthly reviews for extended brain injury rehabilitation stays beyond two years.

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.

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. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM15). 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.

Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at the rates established by that state's Medicaid program for nursing facility days, bed hold days and therapeutic leave days at the time of establishment of the Medicaid provider agreement. The rates are periodically updated to align with the current and applicable rates assigned by the out-of-state facility's State Medicaid program.

INTERMEDIATE SPECIALIZED SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Introduction: Nebraska Medicaid–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". These individuals need more support than nursing facilities would normally provide, but not at a "specialized services" level.

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.

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.

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-10-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.

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 I evaluation and the ISS evaluation process; and
2. The Resident Assessment.

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.

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.

Returning from Receiving Specialized Services for Mental Illness: For ISS clients, this process must follow the following procedures below in addition to Criteria for ISS. If an individual is returning to a nursing facility (NF) from receiving intensive treatment services for serious mental illness, a new Level I screen is required to determine further screening requirements. If the Level I screen indicates that the individual meets serious mental illness criteria as indicated in this chapter, a Level II summary of findings report must be issued. The summary may be based upon a document-based review of the psychiatric facility's medical records, if an on-site Level II assessment was performed within the 90-day period and current documentation supports that the individual is sufficiently stable. An on-site evaluation is required if an on-site Level II has not been performed within the prior 90-day period or if the documentation does not sufficiently indicate adequate psychiatric stabilization.

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, 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.

Transfers: For ISS clients, transfers between nursing facilities will not require a Level I or Level II PASARRP evaluation. A Tracking Form must be completed and faxed to the PASP contractor for clients with a PASP determination.

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 Medicaid participation requirements. 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.

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.

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.

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.

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.

Client Rights: The facility must ensure that clients rights are ensured in accordance with 42 CFR 483.10.

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.

Payment: The Department pays for ISS services as noted within the state plan.

Payment for ICF/IID Services

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.

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 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.

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

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.

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

1. Routine Services: Routine ICF/DD 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);
   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 Routine Services;
   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.

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 assessments are considered ancillary services.

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.

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 October 1, 2017, 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.

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. *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);
4. Prostheses (e.g. breast, eye, lower and upper limb);

5. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care.
   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, Nebraska Medicaid 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/DD).

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/DD's will be allowed.

Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/DDs that are not State-operated.

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 Nebraska Medicaid. 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 Nebraska Medicaid.

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/DD client.

Medicaid inpatient days are days for which claims 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/DD 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.

For ICF/DDs 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.

For ICF/DDs 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.

New Construction Reopening and Certification Changes: For new construction (entire facility or bed additions), facility reopening, or a certification change from Nursing Facility to ICF/DD 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.

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.

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 will not be subject to the customary charge limitation.

ICF/DDs with 16 beds or more:
An ICF/DD's payment for ICF/DD services must not exceed the ICF/DD'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 for the most recent report period.

ICF/DDs with 4-15 beds:
An ICF/DD's payment for ICF/DD services must not exceed the ICF/DD'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.

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.

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~~ to Recognition of Fixed Cost Basis 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.

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~~DD care. This limitation does not apply to government owned facilities.

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.

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.

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.

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 Salaries of Administrators, Owners, and Directly Related Parties 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".

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.

Facility Bed Size Exception: Rates for any privately-owned ICF/DD with less than 16 beds that received Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in Rates for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Excluding State-Operated ICF/DD Providers.

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

Rate Determination: The Department determines rates under the following guidelines:

Rate Period: The Rate Period for non-State-operated ICF/DD 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 ICF/DDs with 16 beds or more). 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/DD providers is defined as July 1 through June 30.

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

Rates for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Excluding State-Operated ICF/DD Providers:

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

An ICF/IID facility's prospective rate is the sum of the five components.

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.

ICF/IIDs with 4-15 Beds:

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.

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 ICF/IID Revenue Tax Cost Component – ICF/IIDs with 4-15 beds).

The final rate is the sum of the above five components.

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.

ICF/DDs 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 ICF/IID Inflation Factor, or
2. The facility's Personnel Operating Cost Model, adjusted by the Inflation Factor computed under provisions of ICF/IID Inflation Factor.

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.

Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in Standard Wage Rates, 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. QIDPs, 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.

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.

ICF/DDs 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/DD provider's most recent cost report period.

ICF/DD 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.

ICF/DDs with 16 beds or more:
The non-personnel 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 ICF/IID Inflation Factor;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/DD facilities, adjusted by a percentage equal to the Inflation Factor computed under ICF/IID Inflation Factor; or
3. 30 percent of the weighted mean for all ICF/DD facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under ICF/IID Inflation Factor. The mean will be weighted by the Nebraska Medicaid ICF/DD days.

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.

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.

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.

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, 2024 through June 30, 2025, the inflation factor is positive 19.05%.

ICF/IID Revenue Tax Cost Component:

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. The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

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. The Tax Cost Component shall be prorated when the revenue tax is based on less than a full year's data.

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).

Rates for State-Operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DD): The Department pays State-operated ICF/DD 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/DD 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/DD 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.

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.

Final Rate: The Department pays each ICF/DD a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

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/DD provider's most recent cost report period.

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/DD provider's most recent cost report period.

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/DD provider's most recent cost report period.

ICF/MR Revenue Tax Cost Component: Under the ICF/DD Reimbursement Protection Act, the ICF/DD 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. The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at the rates established by that state's Medicaid program for nursing facility days, bed hold days and therapeutic leave days at the time of establishment of the Medicaid provider agreement. The rates are periodically updated to align with the current and applicable rates assigned by the out-of-state facility's State Medicaid program.

Initial Rates for New Providers:

~~31-008.06F1~~ Initial Rates for New Providers of ICF/DDs 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/DD 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.

Initial Interim Rates for New Providers of ICF/DDs with 4-15 Beds: All new providers entering Nebraska Medicaid 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 ICF/IIDs with 4-15 Beds – Final Rate.

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/DD 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/DD 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.

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.

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.

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.

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.

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

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.

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.

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.

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 Capitalization Guidelines 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.

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

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. See Recognition of Fixed Cost Basis;

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 Recognition of Fixed Cost Basis);
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.

Recapture of Depreciation: Depreciation referenced in this section refers to real property only. An ICF/DD which is sold for a profit and has received Nebraska Medicaid 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.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \text{ X (Sales Price – Book Value)}$$

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.

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 Nebraska Medicaid.

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 Nebraska Medicaidfor Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under Nebraska Medicaid. 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.

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.

Reporting Requirements and Record Retention: Providers must submit cost and statistical data on Form FA-66, “Report of Long Term Care Facilities for Reimbursement”. 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 Nebraska Medicaid. 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/DD 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.

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/DD 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 must be paid in advance. The ICF/DD will receive a copy of a request to inspect its cost report.

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." 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.

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 Medicaid. 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 or when grounds exist to suspect that fraud or abuse has occurred.

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.

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.

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.

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.

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.

Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments, except that the Department is not required to give 30 days notice.

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.