12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective for services provided beginning July 1, 2009.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Assisted Living Rates means standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

IHS Nursing Facility Provider means an Indian Health Services Nursing Facility or a Tribal Nursing Facility designated as an IHS provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Level of Care means the classification (see 471 NAC 12-013.01) of each resident based on his/her acuity level.

Median means a value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility means an institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 35 and 36.

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 35 and 36 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Revisit Fees means fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under 'Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management' for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys.

Urban means Douglas, Lancaster, Sarpy, and Washington Counties.

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of 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 (see 471 NAC 12-013.03 and 12-013.04).

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Division of Public Health's regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2007 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be the average base rate components, effective July 1, 2009, of all other providers in the same care classification, computed using audited data as of March 15, 2009.

12-011.04 Allowable Costs: The following items are allowable costs under NMAP.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

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

12-011.08H Rates for New Providers Entering NMAP after July 1, 2007:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A new provider is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility due to a change in ownership, or to operate a nursing facility not previously enrolled in NMAP. For purposes of this definition, "nursing facility" means the business operation, not the physical property.

A. For the July 1, 2009 through June 30, 2010 Rate Period, the Department will pay new providers, except for IHS nursing facility providers, interim rates determined as follows:

1. For new providers entering NMAP from July 2, 2007 through June 30, 2008, the interim rates for the rate period July 1, 2009 through June 30, 2010 are the rates computed from the provider's initial, part-year cost report for the period ending June 30, 2008, subject to the rate period's maximums and limitations. Interim rates for the July 1, 2009 through June 30, 2010 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2010, subject to maximums and limitations applicable to the 2009-2010 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period.

2. For new providers entering NMAP as a result of a change of ownership from July 1, 2008 through June 30, 2009, the interim rates for the rate period July 1, 2009 through June 30, 2010 are the rates computed from the seller's cost report for the period ending June 30, 2008, subject to maximums and limitations applicable to the 2009-2010 rate period.

   For other new providers entering NMAP from July 1, 2008 through June 30, 2009, the initial interim rates for the rate period July 1, 2009 through June 30, 2010 are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data. The initial interim rates will be revised based on the provider's audited June 30, 2009 cost report, subject to maximums and limitations applicable to the 2009-2010 rate period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report.

   Interim rates and revised interim rates for the July 1, 2009 through June 30, 2010 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2010, subject to maximums and limitations applicable to the 2009-2010 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period.

3. For new providers entering NMAP as a result of a change of ownership from July 1, 2009 through June 30, 2010, the interim rates for the rate period beginning with the sale date through June 30, 2010 are the rates of the seller in effect on the sale date.

   For other new providers entering NMAP from July 1, 2009 through June 30, 2010, the interim rates for the rate period beginning with the sale date through June 30, 2010, are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data.

B. For the July 1, 2010 through June 30, 2011 Rate Period, the Department will pay new IHS nursing facility providers, rates determined as follows:

   For new IHS nursing facility providers entering NMAP as a result of a change of ownership from July 1, 2010 through June 30, 2011, the rates for the rate period beginning with the sale date through June 30, 2011 are the rates of the seller in effect on the sale date.

   For other new IHS nursing facility providers entering NMAP from July 1, 2010 through June 30, 2011, the rates for the rate period beginning with the certification date through June 30, 2011, are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data.

12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transactions to increase reimbursement. Both transactions are subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonable be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

1. City or county-owned facilities with a 40% or more Medicaid mix of inpatient days are eligible to receive the Federal Financial Participation share of allowable costs exceeding the applicable maximums for the Direct Nursing and the Support Services Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current NMAP Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing and the Support Services Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.
2. City or county-owned facilities may also participate in the proportionate share pool. The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology adjusts for pharmacy, laboratory, radiology, retroactive payment adjustments (including adjustments made under 471 NAC 12-011.08K, item 1), and any other factors necessary to equate Medicaid to Medicare payment methodologies.

The Department annually submits to CMS workpapers demonstrating the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.

The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.

The initial proportionate share pool is created beginning January 1, 1998. Because this is the midpoint of the July 1, 1997 through June 30, 1998, Reporting Period, the pool is prorated to one half. The date for the estimated distribution for this initial prorated period will be on or about April 1, 1998.

Participation in this pool requires each facility to return their proportionate share of the pool, less a participation fee, to the State the same day as received. Each facility retains a participation fee of $2,500 for facility use. In cases where a facility's proportionate share of the pool is less than $2,500, the facility receives $2,500.

Payments are made annually during a transition period from a pool of funds based on the aggregate difference between estimated Medicaid payments and the upper payment limit for nursing facilities for state fiscal year 2000, as determined under the state plan in effect in that year. The pool amount for each transition year shall be the percentage specified below of the aggregate difference for private facilities for state fiscal year 2000 (SFY 2000 excess $75,004,569), plus 100% of the aggregate difference for public facilities through June 30, 2005:

State fiscal year 2004 -	85%
State fiscal year 2005 -	70%
State fiscal year 2006 -	55%
State fiscal year 2007 -	40%
State fiscal year 2008 -	25%
Portion of SFY 2009 -	10%

No proportionate share pools will be created under this section after September 30, 2008.

12-011.08L Special Funding Provisions for IHS Nursing Facility Providers: IHS nursing facility providers are eligible to receive one hundred percent (100%) Federal Financial Participation share of allowable costs exceeding the rates paid for the Direct Nursing, Support Services and Fixed Cost Components for all Medicaid residents who are IHS eligible. This amount is computed after desk audit and determination of allowable costs for a Report Period. The amount is calculated as the difference between allowable costs for all Medicaid IHS eligible residents and the total amount paid for all Medicaid IHS eligible residents, if greater than zero.

12-011.08M (Reserved)

12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

OS Notification

State/Title/Plan Number: Neb 10-006

Type of Action: SPA Approval

Required Date for State Notification: 03/01/2010

Fiscal Impact: FFY 10 $4,385,000 FFY 11 $5,475,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: Yes **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:

Effective for services on or after March 1, 2010, this amendment proposes to revise the payment methodology for IHS nursing facilities. This amendment also proposes to establish a rate for new IHS nursing facility providers for the rate period July 1, 2010 through June 30, 2011. In addition, this amendment proposes to establish a special funding provision for IHS nursing facility providers allowing them to receive 100% of cost based on desk audits.

The State provided adequate documentation that Tribal consultation was completed in association with this amendment.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

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