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, 2010.

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

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

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

Department means the Nebraska Department of Health and Human Services.

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

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

Level of Care means the classification of each resident based on his/her acuity level.

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

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

Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 101, 102, 103 and 104.

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 101, 102, 103 and 104 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

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

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

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

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

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2008 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

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

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be the average base rate components, effective July 1, 2010, of all other providers in the same care classification, following the initial desk audits.

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

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

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

12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). Administrator compensation maximums for the cost report period ending June 30, 2009 are:

Bed Size	Maximum
1-74	$80,128
75-99	$81,567
100-149	$96,921
150-200	$97,880
201 +	$143,942

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing and Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing and Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing and Support Services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.07 (Reserved)

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning July 1, 2010. The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Period: The Rate Period is defined as July 1, 2010 through June 30, 2011. Rates paid during this Rate Period are determined (see 471 NAC 12-011.08D) from cost reports submitted for the June 30, 2009 Report Period (see 471 NAC 12-011.08B).

12-011.08B Report Period: Each facility must file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the urban or non-urban location of the facility.

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the July 1, 2008 through June 30, 2009 Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed using audited data following the initial desk audits, and are not revised based on subsequent changes to the data. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving Medicaid during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of three components:

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

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

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

12-011.08D4 Inflation Factor: For the Rate Period of July 1, 2010 through June 30, 2011, the inflation factor negative 1.54%.

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08F Rate Payment for Levels of Care 101, 102, 103 and 104: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. The payment rate for Levels of Care 101, 102, 103 and 104 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08H Rates for New Providers Entering Medicaid after July 1, 2008:

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

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

1. For new providers entering Medicaid from July 2, 2008 through June 30, 2009, the interim rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the provider's initial, part-year cost report for the period ending June 30, 2009, subject to the rate period's maximums and limitations. Interim rates for the July 1, 2010 through June 30, 2011 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2011, subject to maximums and limitations applicable to the 2010-2011 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 Medicaid as a result of a change of ownership from July 1, 2009 through June 30, 2010, the interim rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the seller's cost report for the period ending June 30, 2009, subject to maximums and limitations applicable to the 2010-2011 rate period.

   For other new providers entering Medicaid from July 1, 2009 through June 30, 2010, the initial interim rates for the rate period July 1, 2010 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 audited data following the initial desk audits. The initial interim rates will be revised based on the provider's audited June 30, 2010 cost report, subject to maximums and limitations applicable to the 2010-2011 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.

3. For new providers entering Medicaid as a result of a change of ownership from July 1, 2010 through June 30, 2011, the interim 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 providers entering Medicaid from July 1, 2010 through June 30, 2011, the interim rates for the rate period beginning with the sale 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 audited data following the initial desk audits.

Interim rates and revised interim rates for July 1, 2010 through June 30, 2011 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 20, 2011,subject to maximums and limitations applicable to the 2010-2011 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.

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 Medicaid 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 Medicaid 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 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 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 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 NMAP Federal Financial Participation percentage times 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.

Facilities which provide any services other than certified nursing facility services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. A Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.10A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services, Financial Services, 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 must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department will perform at least one initial desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Care classification maximums and average base rate components are computed using audited data following the end of the Cost Report Period. Subsequent desk and field audits will not result in a revision of care classification maximums or average base rate components.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

12-011.13 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

12-011.14 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Division of Medicaid and Long-Term Care within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis or explanation of each item, or both. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director of the Division of Medicaid and Long-Term Care issues a determination in regard to *the* administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

12-011.14A MDS 2.0 Reconsideration Process (effective only through September 30, 2010): In place of or in advance of requesting an administrative appeal, a facility may request a rate payment reconsideration with the Department or its designee for a specific Level of Care 101, 102, 103 or 104 resident. The facility must submit information on the client's need for professional medical care, supervision or other needs that justify a rate payment at Level 191, 192, 193 or 194. Note: The reconsideration process neither limits nor promotes the facility's responsibility to make MDS changes on a quarterly basis or whenever a significant change has occurred, as federally defined.

To request reconsideration, the facility must submit information on the resident's needs, with supportive documentation, to the Department or its designee. The supportive documentation must include the degree of instability involved and the frequency of intervention in one or more of the following areas of the MDS 2.0:

1. Section B.5. Indicators of delirium, periodic disordered thinking awareness, for residents with the diagnosis of mental illness, mental retardation or a related condition (developmental disability), dementia, or a brain injury. The behavior must be present and not of recent onset (Code 1).
2. Section E.1. Indicators of depression, anxiety, and/or sad mood. The behavior must be exhibited (Code 1 or 2) PLUS an indicator in Section I of a disease of psychiatric/mood.

3. Section J. Health Conditions (present in the last 7 days unless other time frame is indicated) that affect the stability of condition and/or require professional nurse monitoring.
4. Section O. Medications that require professional nurse administration and/or monitoring.
5. Section P. Special Treatments and Procedures #2 for Section E indicators and Section I disease of psych/mood.

Other documentation supporting the need for nursing judgment or intervention may also be submitted.

The following conditions do not constitute valid reasons for reconsideration:

1. Lack of informal support;
2. Amount of time the person has resided at the nursing facility, with payment either through Medicaid or through another source;
3. Presence of a specific diagnosis without supporting documentation of the need for nursing judgment or intervention; and
4. Advanced age.

12-011.14A1 Effective Date of Reconsideration: A facility may request a rate reconsideration review for MDS 2.0 assessments by December 31, 2010. If granted, the adjusted rate will be effective the first day of the month for which the resident's need for medical supervision or intervention is documented, retroactive for a period not to exceed three calendar months before the first day of the month in which the reconsideration request and supporting documentation is received by the Department or its designee.

12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director of the Division of Medicaid and Long-Term Care to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken:

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director of the Division of Medicaid and Long-Term Care will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director of the Division of Medicaid and Long-Term Care that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under 471 NAC 12-011 must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under 471 NAC 12-011 has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved RUG grouper to assign each resident to a level of care based on information contained on his/her MDS assessment. Each level of care will be assigned the federally-recommended weight (see 471 NAC 12-013.04). When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care per 471 NAC 12-013.01. Each resident's 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 (see 471 NAC 12-013.05) is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska Medicaid Case Mix System, the Department does not change an assessment record. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment.

For each reporting period, the total number of residents in each level of care is multiplied by the total number corresponding days for each resident at that level. This product is then multiplied (weighted) by the corresponding weight (see 471 NAC 12-013.04). Each resulting product is the Weighted Resident Days for that level. The Weighted Resident Days for all levels are then summed to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.

12-013.03 Resident Level of Care Weights: The following weighting factors shall be assigned to each resident level of care, based on the CMS RUG III 5.20 version:

Level of Care	Casemix Index Value	Casemix Index Description	Casemix Index Value
163	RAD	Rehabilitation/ADL = 17-18	1.66
162	RAC	Rehabilitation/ADL = 14-16	1.31
161	RAB	Rehabilitation/ADL = 9-13	1.24
160	RAA	Rehabilitation/ADL = 4-8	1.07
172	SE3	Extensive Services 3/ADL >6	2.10
171	SE2	Extensive Services 2/ADL >6	1.79
170	SE1	Extensive Services 1/ADL >6	1.54
152	SSC	Special Care/ADL = 17-18	1.44
151	SSB	Special Care/ADL = 15-16	1.33
150	SSZ	Special Care/ADL = 4-14	1.28
145	CC2	Clinically Complex w/Depression/ADL = 17-18	1.42
144	CC1	Clinically Complex/ADL = 17-18	1.25
143	CB2	Clinically Complex w/ Depression/ADL = 12-16	1.15
142	CB1	Clinically Complex/ADL = 12-16	1.07
141	CA2	Clinically Complex w/Depression/ADL = 4-11	1.06
140	CA1	Clinically Complex/ADL = 4-11	0.95
133	IB2	Cognitive Impairment with Nursing Rehab/ADL = 6-10	0.88
132	IB1	Cognitive Impairment/ADL = 6-10	0.85
131	IA2	Cognitive Impairment with Nursing Rehab/ADL = 4-5	0.72
130	IA1	Cognitive Impairment/ADL = 4-5	0.67
123	BB2	Behavior Prob w/Nursing Rehab/ADL = 6-10	0.86
122	BB1	Behavior Prob/ADL = 6-10	0.82
121	BA2	Behavior Prob w/Nursing Rehab/ADL = 4-5	0.71
120	BA1	Behavior Prob/ADL = 4-5	0.60
115	PE2	Physical Function w/Nursing Rehab/ADL = 16-18	1.00
114	PE1	Physical Function/ADL = 16-18	0.97
113	PD2	Physical Function w/Nursing Rehab/ADL = 11-15	0.91
112	PD1	Physical Function/ADL = 11-15	0.89
111	PC2	Physical Function w/Nursing Rehab/ADL = 9-10	0.83
110	PC1	Physical Function/ADL = 9-10	0.81
Medicaid Waiver Assisted Living Levels of Care			
104	PB2	Physical Function w/Nursing Rehab/ADL = 6-8	0.65
103	PB1	Physical Function/ADL = 6-8	0.63
102	PA2	Physical Function w/Nursing Rehab/ADL = 4-5	0.62
101	PA1	Physical Function/ADL = 4-5	0.59
Default Rate – Used When No Assessment is Available			
180*	STS	Short Term Stay	0.59

*Level of Care 180 (Short-term stay) is used for stays of less than 14 days when a client is discharged and the facility does not complete a full MDS admission assessment of the client. This is effective for admissions on or after July 1, 2010.

Additionally, Levels of Care 191,192,193 and 194 are used for clients at Levels of Care 101,102,103 and 104 who are approved under the reconsideration process described in 471 NAC 12-011.14A. Levels of Care 191,192,193 and 194 are weighted at the Casemix Index Values listed for Levels of Care 101,102,103 and 104, respectively.

12-013.04 Verification: Resident assessment information is audited as a procedure in the Department of Health and Human Services Division of Public Health, Survey and Certification process.

12-014 Services for Long Term Care Clients with Special Needs

12-014.01 The term "Long term care clients with special needs" means those whose medical/nursing needs are complex or intensive and are above the usual level of capabilities of staff and exceed services ordinarily provided in a nursing facility as defined in 471 NAC 12-003.

12-014.01A Ventilator-Dependent Clients: These clients are dependent on mechanical ventilation to continue life and require intensive or complex medical services on an on-going basis. The facility shall provide 24-hour R.N. nursing coverage.

12-014.01A1 Criteria for Care: The client must-

1. Require intermittent (but not less than 10 hours in a 24-hour period) or continuous ventilator support. S/he is dependent on mechanical ventilation to sustain life, or is in the process of being weaned from mechanical ventilation. (This does not include individuals using continuous positive airway pressure (C-PAP) or Bi-level positive airway pressure (Bi-PAP) nasally; patients requiring use of Bi-PAP via a tracheostomy will be considered on a case-by-case basis);
2. Be medically stable and not require intensive acute care services;
3. Have care needs which require multi-disciplinary care (physician, nursing, respiratory therapist, psychology, occupational therapy, physical therapy, pharmacy, speech therapy, spiritual care, or specialty disciplines);

Reserved for Future Use

Reserved for Future Use

31-008 Payment for ICF/MR Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/MR 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.

The rate determination described herein is effective beginning July 1, 2010.

31-008.02 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as July 1, 2008) are used in determining the cost for Nebraska ICF/MRs with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

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

31-008.03 Allowable Costs: The following items are allowable costs under Medicaid.

31-008.03A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

31-008.05B2 For ICF/MRs with 4-15 beds: In computing the provider's allowable cost per day for determination of the rate, total inpatient days for fixed costs are the greater of actual inpatient days or 85% of licensed beds. For computing the non-fixed costs per day the actual patient days are utilized.

31-008.05C New Construction, Reopening, and Certification Changes: For new construction (entire facility or bed additions), facility reopening, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering Medicaid after July 31, 1982, must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months. Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding).

Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05E1 ICF/MRs with 16 beds or more:
An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, adjusted by the Inflation Factor (see 471 NAC 31-008.06C7) for the most recent report period.

31-008.05E2 ICF/MRs with 4-15 beds:
An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's average customary charge to the general public for the same retroactively settled payment period, for the same level of care services, except for public facilities providing services at a nominal charge.

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department, for the purposes of rate setting, is the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

ICF/MRs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). Administrator compensation maximums for the cost report period ending June 30, 2009 are:

Bed size	Maximum
1 - 74	$80,128
75 - 99	$81,567
100 - 149	$96,921
150 - 200	$97,880
201 +	$143,942

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

31-008.05M Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise Personnel Operating and Non-Personnel Operating Cost Components for the facility.

This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

31-008.05N Facility Bed Size Exception: For the rate period July 1, 2010 through June 30, 2011, rates for any privately-owned ICF/MR with less than 16 beds that was receiving Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/MRs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period is defined for non-State- operated ICF/MR providers for services provided from July 1, 2010 through June 30, 2011. The Rate Period for State-Operated ICF/MR providers is defined as a calendar year.

31-008.06B Reporting Period: Each facility must file a cost report each year for the reporting period ending June 30.

31-008.06C Rates for Intermediate Care Facility for the Mentally Retarded (ICF/MR) Excluding State-Operated ICF/MR Providers:

31-008.06C1 ICF/MRs with 16 beds or more:
Effective July 1, 2010, subject to the allowable, unallowable, and limitation provisions of this system, the Department pays each facility a prospectively determined amount based on the facility's allowable, reasonable and adequate costs incurred and documented during the July 1, 2008 through June 30, 2009 Report Period. The per diem rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

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

31-008.06C4b ICF/MRs 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/MR provider's most recent cost report period.

31-008.06C5 ICF/MR Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C6 ICF/MR Ancillary Cost Component: The ancillary cost component of the rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C7 ICF/MR Inflation Factor: For the Rate Period of July 1, 2010 through June 30, 2011, the inflation factor is 1.97%.

31-008.06C8 ICF/MR Revenue Tax Cost Component:

31-008.06C8a ICF/MRs with 16 or more beds:
Under the ICF/MR Reimbursement Protection Act, for the Rate Period July 1, 2010 through June 30, 2011, the ICF/MR revenue tax per diem is computed as the ICF/MR revenue tax based on State Fiscal Year 2009-10 net revenue divided by State Fiscal Year 2009-10 facility resident days. (See 405 NAC 1-003.)

31-008.06C8b ICF/MRs with 4-15 beds:
Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.)

31-008.06C9 ICF/MR Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increases(s).

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs. The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D6 ICF/MR Revenue Tax Cost Component: This component includes the allowable ICF/MR revenue tax, computed on a per diem basis as the ICF/MR revenue tax based on State Fiscal Year 2009-10 net revenue divided by State Fiscal Year 2009-10 facility resident days. (See 405 NAC 1-003.)

31-008.06E Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.06F Initial Rates for New Providers:

31-008.06F1 Initial Rates for New Providers of ICF/MRs with 16 beds or more: Providers entering Medicaid as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering Medicaid as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

Facilities that provide any services other than certified ICF/MR services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

31-008.08A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the ICF/MR name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Lincoln State Office Building address; pick up copies from the Department; or mail copies). The total fee must be paid in advance. The ICF/MR will receive a copy of a request to inspect its cost report.

31-008.08B Descriptions of Form FA-66, "Long Term Care Cost Report": All providers participating in Medicaid must complete Form FA-66, consisting of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2) and "Certification by Officer, Owner, or Administrator." (See 471-000-41 and 471-000-42 for an example of all schedules.) For FA-66 must be completed in accordance with regulations found at 471 NAC 12-012. Form FA-66 contains the following schedules, as described:

1. General Data: This schedule provides general information concerning the provider and its financial records.
2. Schedule A, Occupancy Data: This schedule summarizes the licensed capacity and inpatient days for all levels of care.
   Part 1 identifies the certified days available, and Part 2 identifies the inpatient census data of the facility. This data is used in determining the divisor in computing the facility's per diem rate.
3. Schedule B, Revenue and Costs: This schedule reports the revenues and costs incurred by the provider. The schedule begins with the facility's trial balance, and identifies revenue offsets, adjustments, and/or allocations necessary to arrive at the Medicaid reimbursable costs.
   Part 1 identifies all revenues from patient services and any necessary offsets to costs from these revenues. Part 2 identifies other revenues realized by the facility and any necessary offsets to costs from these revenues. Part 3 identifies the facility's costs, summarizes the revenue offsets, summarizes the cost adjustments, and reports any necessary allocation of reimbursable costs. Part 4 summarizes the revenue and costs reported in parts 1, 2, and 3, and reports net income and identifies provision for income tax.

31-008.09 Audits: The Department will perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Payment rates are determined after the initial desk audit is completed.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

OS Notification

State/Title/Plan Number: NE 10-019

Type of Action: SPA Approval

Required Date for State Notification: 05/02/2011

Fiscal Impact: FY 2010 $ 267,295
FY 2011 $1,031,752

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective for services on or after July 1, 2010, this State Plan amendment (SPA) revises the payment methodology for nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) services. For NF services, this SPA provides for several updates to the prospective rate methodology. Specifically, it updates the rate period and base period, updates various cost containment provisions, clarifies base period cost report requirements, specifies the inflation methodology, and institutes a case mix reimbursement system based on the CMS RUG III 5.20 version. For ICF/MR services, this SPA updates the rate period and the base period, updates various cost containment provisions, specifies the inflation methodology, and adds provisions for completing the Long Term Care Cost Report.

Other Considerations: For payments proposed under this SPA, CMS is satisfied that the State has met all the Federal requirements. However, during the review of this SPA, it was determined that the State was covering durable medical equipment (DME) services under the home health benefit for residents of NFs and ICFs/MR and paying DME providers directly for these services on a fee-for-service basis. Under current policy, DME is reimburseable for Medicaid beneficiaries under the home health services benefit at 42 CFR 440.70, but 42 CFR 440.70(c) specifies that home health services cannot be provided in a nursing facility or ICF/MR. In order for medical equipment to be coverable for long-term care

residents, the equipment must be part of the LTC service and must be a component of the LTC payment rates. Therefore, we are also sending a companion letter with this approval to resolve these issues and give the State the opportunity to accommodate DME reimbursement within the nursing facility and ICF/MR payment rates.

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

Prior to submitting this SPA, the Nebraska Division of Medicaid Long-Term Care sought consultation from federally recognized Native American Tribes with the State to discuss the impact that the proposed SPA might have, if any, on the Tribes.

We do not recommend the Secretary contact the governor.

CMS Contact: Tim Weidler, NIRT 816-426-6429