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

12-011.06Q Nursing Facility Quality Assessment: The nursing facility quality assessment is an allowable cost addressed through the Nursing Facility Quality Assessment Component.

12-011.07 (Reserved)

12-011.08 Rate Determination: The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Period: The Rate Period is defined as July 1 through June 30. Rates paid during the Rate Period are determined (see 471 NAC 12011.08D) from cost reports submitted for the Report Period ending June 30 two years prior to the end of the Rate Period. For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011.

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

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

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011,06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

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

Each facility's prospective rates consist of four components:
1. The Direct Nursing Component adjusted by the inflation factor;
2. The Support Services Component adjusted by the inflation factor;
3. The Fixed Cost Component; and
4. The Nursing Facility Quality Assessment Component.

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

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

12-011.08D4 Nursing Facility Quality Assessment Component: The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset.

The quality assessment component rate will be determined by calculating the 'anticipated tax payments' during the rate year and then dividing the total anticipated tax payments by 'total anticipated nursing facility/skilled nursing facility patient days,' including bed hold days and Medicare patient days.

For the rate year beginning July 1, 2011, the 'anticipated tax payments' will be determined by annualizing total facility patient days, including bed hold days, less Medicare days from the time period beginning January 1, 2011 and ending June 30, 2011. 'Total anticipated nursing facility/skilled nursing facility patient days' will be determined by annualizing total facility patient days, including bed hold days and Medicare days, from the time period beginning January 1, 2011 and ending June 30, 2011. Nursing Facilities will not be assessed a tax on any patient days prior to July 1, 2011.

For each subsequent rate year, total facility patient days, including bed hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the 'anticipated tax payments.' Total facility patient days, including bed hold days and Medicare days, for the same four calendar quarters will be used to calculate the 'anticipated nursing facility/skilled nursing facility patient days.'

12-011.08D5 Inflation Factor: For the Rate Period of July 1, 2011 through June 30, 2012, the inflation factor is positive 3.03%.

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.

OS Notification

State/Title/Plan Number:	**NE 11-029**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**04/30/2012**
Fiscal Impact:	**FY 2011 $ 4,810,480** **FY 2012 $19,241,917**

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 July 1, 2011, this SPA proposes a 3.03% across the board increase in NF payment rates. The increase will be funded by the new Nursing Facility Quality Assessment, the State's new NF provider tax. On April 3, 2012, CMS approved the State's request for a waiver of uniformity requirements and the new provider tax is effective July 1, 2011. Approval of SPA 11-029 negates the effects of a 2.5% reduction in NF rates proposed under SPA 11-024 which would have gone into effect on July 1, 2011 had SPA 11-029 and the new provider tax not been approved.

Other Considerations:	**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. No comments were received.** **We do not recommend the Secretary contact the governor.**
CMS Contact:	**Tim Weidler, NIRT 816-426-6429**