Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 101, 102, 103 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

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, 2009 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 12-011.088) will not file a cost report. The rate paid will be based on the average base rate components, effective July 1 of the rate period of all other providers in the same care classification, following the initial desk audits.

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

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

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

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

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

12-011.08F Rate Payment for Levels of Care 101, 102, 103, 104 and 105: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. Level of Care 105 is used for payment of qualifying bedhold days. The payment rate for Levels of Care 101, 102, 103,104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

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.

d. Other applicable requirements that are necessary to be included in all Department contracts.

6. In lieu of the rate establishment procedure described in this section and under mutual agreement of both the provider and the Department, a multiyear contractual arrangement may be entered into by the parties. Reimbursement must reflect the facility's actual reasonable cost of providing services to special needs clients and must be updated annually using an appropriate inflation adjustment.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the establishment of the Nebraska Medicaid provider agreement. The payment is not subject to any type of adjustment.

12-014.05C Payment for Bedhold: The Medicaid payment rate for hospital and therapeutic leave days will be negotiated between the service provider and the Department based on the costs of operating a special needs unit (e.g. required medical equipment, staffing levels). The rate will be no lower than the Level 105 rate, as defined in 471 NAC 12-011.08F, and will not exceed the per diem inpatient unit rate.

12-014.06: The requirements of 471 NAC 12 apply to services provided under 471 NAC 12-014 unless otherwise specified in 471 NAC 12-014.

OS Notification

State/Title/Plan Number:	**NE 12-002**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**05/01/2012**
Fiscal Impact:	**FY 2011 ($702,512)** **FY 2012 ($936,683)**

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: No

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

Detail:

Effective January 15, 2012, this amendment reduces the nursing facility (NF) reimbursement rate for hospital and therapeutic leave days (bedhold), to be consistent with the rate that is in effect for assisted living services under the HCBS Aged & Disabled waiver. The State submitted a concurrent SPA (SPA 12-001) that makes corresponding changes to Attachment 4.19-C of the NE Medicaid State Plan. That SPA has been reviewed and cleared by Dan Timmel, and the OSN has been submitted for approval by the RO.

As part of our review we requested that the State provide information that supported their assertion that access to services would not be affected by reducing rates for leave days. The State engaged providers, provider organizations and client representatives in 2011, and had several meetings with the Medical Assistance Advisory Committee, to communicate the Department's fiscal limitations and legislative mandate to reduce expenditures. Providers expressed their disappointment about reductions, but understood the current state budgetary circumstances and remained committed to serving the Medicaid population.

In recent years, the State has been able to increase nursing facility and ICF/MR provider rates on an annual basis. From State Fiscal Year 2006 to 2011 provider rates were increased by an average of 2.92% per year. For SFY 2012, nursing facility payment rates are being increased by an additional 3.03%. The rate reduction for leave days is more than off-set by these recent increases. For the

period of January 1 through September 30, 2011, the overall average occupancy rate of Nebraska long term care facilities was 79%, with an excess of 3,500 beds available. The State has not seen a decrease in providers willing to care for Medicaid clients or an increase in client complaints about access to care. The State will ensure continued access to care through an active monitoring plan utilizing several measures such as provider participation, Medicaid enrollment and Inquiry lines calls, and service utilization for the fee-for-service population.

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**