STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

BEDHOLDING

The Nebraska Medical Assistance Program makes payments to reserve a bed in a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF/MR) during a client's absence due to hospitalization for an acute condition and for therapeutically-indicated home visits. Therapeutically-indicated home visits are overnight visits with relatives and friends or visits to participate in therapeutic or rehabilitative, programs. Payment for bedholding is subject to the following conditions:

1. A held bed must be vacant and counted in the census. The census must not exceed licensed capacity;
2. For ICF/MR residents, hospital bedholding is limited to full per diem reimbursement for 15 days per hospitalization (hospital bedholding does not apply to hospital NF-swing-beds or to hospitalization following a Medicare-covered (SNF) stay);
3. For NF residents, except for the months of April and May of 2012 in which payment is at full per diem reimbursement, hospital bedholding is limited to reimbursement at the applicable rate in effect for assisted living services under the Home and Community-Based Waiver for Aged Persons and Adults or Children with Disabilities for 15 days per hospitalization (hospital bedholding does not apply to hospital NF-swing-beds or to hospitalization following a Medicare-covered (SNF) stay);
4. For ICF/MR residents, therapeutic bedholding is limited to full per diem reimbursement for 36 days per calendar year.
5. For NF residents, except for the months of April and May of 2012 in which payment is at full per diem reimbursement, therapeutic leave bedholding is limited to the applicable rate in effect for assisted living services under the Home and Community-Based Waiver for Aged Persons and Adults or Children with Disabilities for 18 days per calendar year. Bedholding days are prorated when a client is admitted after January 1;
6. A transfer from one facility to another does not begin a new 18-day or 36-day period;
7. The client's comprehensive care plan must provide for therapeutic leave; and
8. Facility staff shall work with the client, the client's family and/or guardian to plan the use of the allowed 18 days of therapeutic leave for the calendar year.

When the limitation for therapeutic leave interferes with an approved therapeutic or rehabilitation program, the facility may submit a request for special limits of up to an additional six days per calendar year to the Medical Services Division.

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). Except the payment for level of care 105 (bed-hold) for the months of April and May 2012 is the applicable payment rate as determined under 471 NAC 12-011.08.

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). Except the payment for level of care 105 (bed-hold) for the months of April and May 2012 is the applicable payment rate as determined under 471 NAC 12-011.08.

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 12-011**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**09/20/2012**
Fiscal Impact:	**FY 2012 $156,114** **FY 2013 $ -0-**

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 for services in April and May 2012, this amendment increases the nursing facility (NF) reimbursement rate for hospital and therapeutic leave days (bedhold), from the rate that is in effect for assisted living services under the HCBS Aged & Disabled waiver to the full NF per diem rate.

In a prior amendment (SPA 12-02) the State had reduced the bedhold rate from the NF per diem to the assisted living rate effective January 15, 2012. Subsequent to approval of SPA 12-02, the State decided they didn't want to fully implement the rate reduction until June 1, 2012. They therefore submitted this amendment to permit a rate increase for the months of April and May 2012. Effective June 1, 2012, the bedhold rate will return to the assisted living rate.

Public notice and tribal consultation requirements were met for this SPA. The bedhold payments are funded by appropriations. The funding questions were answered acceptably.

Other Considerations:	**There has been no expressed interest from the Governor's Office, Congressional staff, or other outside parties.**
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