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State/Territory Name: NE

State Plan Amendment (SPA) #: 16-0012

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Financial Management Group

MAR 30 2017

Calder Lynch, Director
Division of Medicaid & Long Term Care
Nebraska Department of Health & Human Service
301 Centennial Mall South
Lincoln, NE 68509

RE: Nebraska State Plan Amendment TN: 16-012

Dear Mr. Lynch:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-012. This amendment increases payment rates by 2.25% for nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID) services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 16-012 is approved effective July 1, 2016. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 16-0012	2. STATE Nebraska
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2016	

5. TYPE OF PLAN MATERIAL (Check One):

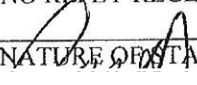
- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

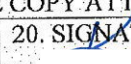
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$944,468.00 b. FFY 2017 \$2,833,403.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 5, 15, 18, 55, 67	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, Pages 5, 15, 18, 55, 67

10. SUBJECT OF AMENDMENT:
Nursing Facility and ICF/DD Medicaid Rate Increase SFY17

11. GOVERNOR'S REVIEW (Check One):
- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Governor has waived review
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE/AGENCY OFFICIAL: 	16. RETURN TO: Nancy Keller Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Calder Lynch	
14. TITLE: Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: August 11, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAR 30 2017
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG
23. REMARKS:	

12-011.04E Payments to Nursing Facility Provider SEPARATE from Per Diem Rates: Items for which payment may be made to Nursing Facility providers and are not considered part of the facility's Medicaid per diem are listed below.

To be covered, the client's condition must meet the criteria for coverage for the item outlined in the appropriate Medicaid provider chapter.

1. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use (see 471 NAC 7-000);
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000); and
3. Negative Pressure Wound Therapy, See 471 NAC 7-000).

Reimbursement to Nursing Facility providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of nursing facility services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at

http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians, therapists or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;

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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.

For purposes of this section, facilities exempt from the Quality Assurance Assessment are:

1. State-operated veterans homes;
2. Nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and
3. Continuing care retirement communities.

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 each 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.'

New providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid: For the Rate Period beginning on the Medicaid certification date through the following June 30, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from exempt to non-exempt status:

For the Rate Period beginning on the first day of the first full month the provider is subject to the Quality Assurance Assessment through the following June 30, the quality assessment rate component is computed as the Quality Assurance Assessment Amount Due from the provider's first Quality Assurance Assessment Form covering a full calendar quarter, divided by Total Resident Days in Licensed Beds from the same Quality Assurance Assessment Form.

Existing providers changing from non-exempt to exempt status:

For Rate Periods beginning with the first day of the first full month the provider is exempt from the Quality Assurance Assessment, the quality assessment rate component will be \$0.00 (zero dollars).

12-011.08D5 Inflation Factor: For the Rate Period of July 1, 2016 through June 30, 2017, the inflation factor is positive .47%.

12-011.08D6 Durable Medical Equipment (DME) Rate Add-on: Effective August 1, 2013, nursing facilities are responsible for costs of certain durable medical equipment. To account for these increased costs on prospective rates only:

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by \$.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by \$.90/day.

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12-011.08K Special Funding Provisions for Governmental Facilities: City and county-owned and operated nursing facilities 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. The reimbursement is subject to the payment limits of 42 CFR 447.272.

- A. 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, Support Services, and Fixed Cost 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, Support Services, and the Fixed Cost Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.

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.

- A. IHS providers may receive quarterly, interim Special Funding payments by filing quarterly cost reports (FA-66) for periods ending September 30, December 31 and/or March 31. Quarterly, interim Special Funding payments are retroactively adjusted and settled based on the provider's corresponding annual cost report for the period ending June 30. Quarterly, interim payments and the retroactive settlement amount are calculated in accordance with Section C below. If the average daily census from a quarterly cost report meets or exceeds 85% of licensed beds, this shall be the "final" quarterly cost report filed by the provider. Subsequent quarterly, interim Special Funding payments shall be based on the "final" quarterly cost report. Quarterly, interim Special Funding payments may also be revised based on data from the annual cost reports.
- B. Quarterly, interim Special Funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim Special Funding payments subsequent to the payment for the "final" quarterly cost report shall be made on or about 90-day intervals following the previous payment.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility must provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.03C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/IDD and are not properly classified as "routine services." The ICF/IDD must contract for ancillary services not readily available in the ICF/IDD.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider must submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for ICF/IDDs.

Department-required Independent QMRP assessments are considered ancillary services.

31-008.03D Payment to ICF/IDD Provider SEPARATE from Per Diem Rates: Items for which payment may be made to ICF/IDD Facility providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item outlined in 471 NAC 7-000.

1. Non-standard wheelchairs and components;
2. Air fluidized bed units and low air loss bed units; and
3. Negative Pressure Wound Therapy.

Reimbursement to ICF/IDD providers separate from per diem rates is based on a Medicaid fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ICF/IDD services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

31-008.03E Payments to Other Providers: Items for which payment may be authorized to non-ICF/IDD providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Orthoses (e.g. lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
4. Prostheses (e.g. breast, eye, lower and upper limb) as defined in 471 NAC 7-000;

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31-008.06C4b ICF/IIDs 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/IID_provider's most recent cost report period.

31-008.06C5 ICF/IID 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/IID 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/IID Inflation Factor: The Inflation Factor is determined from spending projections computed using:

1. Audited cost and census data following the initial desk audits;
2. Budget directives from the Nebraska Legislature; and
3. Effective for the rate period beginning July 1, 2015 and for subsequent rate periods, proceeds from the ICF/DD Reimbursement Protection Fund as specified in Nebraska Revised Statute 68-1804(4)(e).

For the Rate Period of July 1, 2016 through June 30, 2017, the inflation factor is positive 18.42%.

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

31-008.06C8a ICF/IIDs with 16 or more beds:

Under the ICF/DD Reimbursement Protection Act, the ICF/IID 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.). The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06C8b ICF/IIDs with 4-15 beds:

Under the ICF/DD Reimbursement Protection Act, the ICF/IID 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.). The Tax Cost Component shall be prorated when the revenue tax is based on less than a full year's data.

31-008.06C9 ICF/IID 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).

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