NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

October 11, 2023
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 45 of the Nebraska Administrative Code (NAC) – *Rates for Nursing Facility Services.* These regulations govern services provided under the Medical Assistance Act, Neb. Rev. Stat. §§ 68-901 et seq. The proposed changes update definitions; clarify reimbursement bed hold days and therapeutic leave days for in-state nursing facilities; incorporate the new Patient Driven Payment Model (PDPM) system and remove the Resource Utilization Groups III (RUGs) system language; update resident level of care weights and requirements; add resident assessment information; and clarify language throughout the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-908.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax, or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Jeremy Brunssen
Chapter: 45	Date prepared: July 17, 2023
Subject: Rates for Nursing Facilty Services	Telephone: 402-540-0380

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

These changes incorporate necessary language changes to transition to a new nursing casemix system (transition from Resource Utilization Groups (RUGS) to Patient Driven Payment Model (PDPM)) and has been modeled for budget neutrality in the Medicaid payment system. The migration from RUGs to PDPM acuity-level based reimbursement is budget-neutral.

State Agency: None

Political Subdivision: None

Regulated Public: None

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 45 RATES FOR NURSING FACILITY SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq. (the Medical Assistance Act).

002. DEFINITIONS. The following definitions apply:

002.01 ALLOWABLE COST. 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 Nebraska Administrative Code (NAC) 45-006.

002.02 ASSISTED LIVING RATES. 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.

002.03 DEPARTMENT. As defined in Neb. Rev. Stat. § 68-907.

002.04 DIVISION. The Division of Medicaid and Long-Term Care.

002.05 FAIR MARKET VALUE. The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

002.06 INDIAN HEALTH SERVICES NURSING FACILITY PROVIDER. An Indian Health Services nursing facility or a tribal nursing facility designated as an Indian Health Services provider and funded by the Title I or ill of the Indian Self-Determination and Education Assistance Act, Public Law 93-638.

002.07 LEVEL OF CARE. The classification of each resident based on his or her acuity level.

002.08 MEDIAN. 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.

002.09 NURSING FACILITY. 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.

002.10 RATE DETERMINATION. Per Diem rates calculated under provisions of this chapter. These rates may differ from rates actually paid for nursing facility services for Levels of Care ~~101, 102, 103 and 104~~ 201 and 202.

002.11 RATE PAYMENT. Per Diem rates paid under provisions of 471 NAC 45. The payment rate for Levels of Care ~~101, 102, 103, and 104~~ 201 and 202 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 adjusted to include the Nursing Facility Quality Assessment Component and the Quality Measures Component.

002.12 REVISIT FEES. Fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under Centers for Medicare & Medicaid Services for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys.

002.13 STRAIGHT-LINE METHOD. A depreciation method in which the cost or other basis of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

002.14 URBAN. Douglas, Lancaster, Sarpy, and Washington Counties. Rural means all other Nebraska counties.

002.15 WAIVERED FACILITY. Facilities for which the State Certification Agency has waived professional nurse staffing requirements of omnibus budget reconciliation act of 1987 are classified as waivered if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

002.16 WEIGHTED RESIDENT DAYS. A facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

003. 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 the beginning of each applicable cost report period 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 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 Indian Health Services nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year report period will not file a cost report.

004. ALLOWABLE COSTS. The following items are allowable costs under Medicaid:

004.01 COST OF MEETING LICENSURE AND CERTIFICATION STANDARDS. Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

(A) Meet the definition and requirements for a nursing facility of Title XIX of the Social Security Act, Section 1919;

(B) Comply with the standards prescribed by the Secretary of the Federal Health and Human Services for nursing facilities in 42 Code of Federal Regulations (CFR) 442;
(C) Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health standards, under 42 CFR 431.610; and
(D) Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

004.02 ROUTINE SERVICES. Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen and oxygen equipment; the use of equipment and facilities; and other routine services.

004.03 ANCILLARY SERVICES. Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as routine services. The facility must contract for ancillary services not readily available in the facility. If ancillary services are provided by a licensed provider or another licensed facility, the ancillary service provider must submit a separate claim for each client served. Allowable costs paid to physical, occupational, and speech therapists are limited to reasonable amounts paid for general consulting services plus reasonable transportation costs not covered through direct billing. General consulting services are not client specific, but instead, are staff related. These services include staff education, in-services, and seminars. Respiratory therapy is an allowable cost. Department-required independent qualified mental retardation professional assessments are considered ancillary services.

004.04 PAYMENTS TO OTHER PROVIDERS. Items for which payment may be authorized to non-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 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. Items for which payment may be authorized are:

(A) Legend drugs, over the counter drugs, and compounded prescriptions, including intravenous solutions and dilutants. Bulk supply over the counter drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility’s cost report;
(B) Personal appliances and devices, if recommended in writing by a physician;
(C) Orthoses, lower and upper limb, foot and spinal;
(D) Prostheses, breast, eye, lower and upper limb;
(E) Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care;
    (i) To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, Medicaid will not make payment for ambulance service; or
    (ii) Non-emergency ambulance transports to a physician or practitioner’s office, clinic, or therapy enter are covered when the client is bed confined before, during

and after transport and when the services cannot or cannot reasonably be expected to be provided at the client's residence, including the nursing facility.

004.05 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. 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 October 1, 2017, and is effective for services provided on or after that date. Items for which payment may be made are:

(A) 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;
(B) Air fluidized bed units and low air loss bed units; and
(C) Negative pressure wound therapy.

005. UNALLOWABLE COSTS. The following costs are specifically unallowable:

(A) Provisions for income tax;
(B) Fees paid board of directors;
(C) Non-working officers' salaries;
(D) 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;
(E) Travel and entertainment, other than for professional meetings and direct operations of facility;
(F) Donations;
(G) Expenses of non-nursing home facilities and operations included in expenses;
(H) Insurance or annuity premiums on the life of the officer or owner;
(I) Bad debts, charity, and courtesy allowances;
(J) 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;
(K) 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;
(L) Return on equity;
(M) Carry-over of costs lost due to any limitation in this system;
(N) Expenses for equipment, facilities, and programs provided to clients 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 service; and
(O) Revisit fees.

006. LIMITATIONS FOR RATE DETERMINATION. The Department applies the following limitations for rate determination.

006.01 EXPIRATION OR TERMINATION OF LICENSE OR CERTIFICATION. The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under Medicaid. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under Medicaid.

006.02 TOTAL INPATIENT DAYS. In computing the provider's allowable per diem rates, total inpatient days are used. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bed holding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year. Both bed hold days and therapeutic leave days for in-state nursing facilities are reimbursed equal to the resident's applicable level of care classification. Medicaid inpatient days are days for which claims or electronic Standard Health Care Claim: Institutional transaction, ASC X12N 837, from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a spenddown category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under this chapter for these days. An inpatient day is:

(A) A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
(B) A day on which the bed is held for hospital leave or therapeutic home visits.

006.03 START-UP COSTS. All new providers entering Medicaid 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.

006.04 COMMON OWNERSHIP OR CONTROL. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

(A) The supplying organization is a bona fide separate organization;
(B) A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
(C) The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions. Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply; and

(D) The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

006.05 LEASED FACILITIES. Allowable costs leased facilities including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of this chapter will apply. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

(A) Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and

(B) Make records available for audit upon request of the Department, the federal Department of Health and Human Services, or their designated representatives.

006.06 HOME OFFICE COSTS - CHAIN OPERATIONS. A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to healthcare. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, are limited to direct patient care services provided at the facility and must be included in the applicable cost category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, are included in the administration cost category. The Medicaid does not distinguish between capital related and non-capital related interest expense and interest income.

006.07 INTEREST EXPENSE. Interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for nursing facility care. This limitation does not apply to government owned facilities.

006.08 RECOGNITION OF FIXED COST BASIS. The fixed cost basis of real property, and personal property for facilities purchased on or after July 1, 2020, as an ongoing operation or for newly constructed facilities or facility additions is the lesser of, the acquisition cost of the asset to the purchaser; or for facilities purchased as an ongoing operation on or after July 1, 2020, the seller’s Medicaid net book value at the time of purchase. Costs, including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of any capital asset, by acquisition or merger, for which any payment has previously been made are not allowable.

006.09 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. Beginning with the following calendar year base numbers for 12/31/2010, the Administrator Compensation Maximum Amounts can be calculated based on the following methodology.

006.09(A) 2010 BASE NUMBERS. The base numbers for 2010 to be used in the below calculation are: HIM%: 1.5%; Beds 0-74: 81,490; Beds 75-79: 82,954; Beds 100-149: 98,569; Beds 150-200: 99,544; Beds 200 or greater: 146,388.

006.09(B) CALCULATION. To determine the maximum amount for state fiscal year 2011, for each bed category, add 1 to the Calendar Year 2010 HIM % and multiply this amount by 50% of the Calendar Year 2010 bed total. To this amount add 50% of the Calendar Year 2010 bed total. For future years update the calendar year information above (A) by replacing the HIM % with the updated HIM % from HIM 15 Section 905.6.

006.09(C) COMPENSATION TO BE INCLUDED. 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 comparison to salaries paid for comparable position or positions within the specific facility, if applicable, or, if not applicable, then comparison to salaries for comparable position or positions as published by the Department of Administrative Services, Division of State Personnel in the State of Nebraska Salary Survey.

006.10 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.

006.11 DIRECT NURSING COSTS. Direct nursing costs include cost report lines 94 through 103.

006.12 PLANT RELATED COSTS. Plant related costs include cost report lines 129 through 163.

006.13 EQUIPMENT LEASE AND MAINTENANCE AGREEMENTS. Costs of equipment lease or maintenance agreements that include or are tied to usage or supplies must be reported in the operating cost category that most closely relates to the equipment.

006.14 OTHER LIMITATIONS. Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

006.15 NURSING FACILITY QUALITY ASSESSMENT. The nursing facility quality assessment is an allowable cost addressed through the nursing facility quality assessment component.

007. RATE DETERMINATION. The Department determines rates for facilities under the following cost-based prospective methodology.

007.01 RATE PERIODS. The Rate Periods are defined as July 1 through December 31, and January 1 through June 30. Rates paid during the rate periods are determined from base year cost reports. For purposes of this section, base year cost reports means full and part-year cost reports filed with a base year report period ending date of June 30.

007.02 REPORT PERIOD. Each facility must file a cost report each year for the reporting period of July 1 through June 30 or part-year cost reports, when applicable.

007.03 CARE CLASSIFICATIONS. A portion of each individual facility's rate may be based on the urban or rural location of the facility.

007.04 PROSPECTIVE RATES. Subject to the allowable, unallowable, and limitation provisions of this chapter, 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 base year report period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the component maximums and minimums. Component maximums and minimums 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 computations. Cost reports from providers entering or leaving Medicaid during the immediately preceding report period are not used in the computations. Each facility's prospective rates are the sum of the following components; the direct nursing component adjusted by the inflation factor and weighted for level of care; the support services component adjusted by the inflation factor; the fixed cost component; the nursing facility quality assessment component; and the quality measures component. The direct nursing component and the support services component are subject to maximum and minimum per diem payments based on Median or Maximum computations. For each care classification, the median for the direct nursing component is computed using nursing facilities within that care classification with an average occupancy of 40 or more residents, excluding waivered, or facilities with partial or initial or final full year cost reports. For each care classification, the median for the support services component is computed using nursing facilities within that care classification with an average occupancy of 40 or more residents, excluding hospital based, waivered, or facilities with partial or initial or final full year cost reports. The Department will reduce the direct nursing component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs. The maximum per diem is computed as 105% of the median direct nursing component, and 100% of the median support services component. The Department will reduce the direct nursing component maximum by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered

nursing care costs. The minimum per diem is computed as 77% of the median direct nursing component, and 72% of the median support services component. The fixed cost component is subject to a maximum Per Diem of $27.00, excluding personal property and real estate taxes.

007.04(A) DIRECT NURSING COMPONENT. This component of the prospective rate is computed by dividing the base year allowable direct nursing costs, lines 94 through 103 of Form FA-66, Long Term Care Cost Report, by the base year weighted resident days for each facility. The resulting quotient is the facility's computed base year per diem. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

007.04(B) SUPPORT SERVICES COMPONENT. This component of the prospective rate is computed by dividing the base year allowable costs for support services, lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66; Resident Transportation - Medical from the Ancillary Cost Center, line~~s~~ 219 ~~211 through 218~~ from the FA-66; and respiratory therapy from the Ancillary Cost Center, line~~s~~ ~~203 through~~ 210 from the FA-66, by the total base year inpatient days for each facility. The computed base year per diem is subject to the component maximum per diem and minimum per diem for rate determination purposes.

007.04(C) FIXED COST COMPONENT. This component of the prospective rate is computed by dividing the facility's base year allowable interest, depreciation, amortization, long-term rent or lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total base year inpatient days. Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, plus any prior approved increase under 471 NAC 45-007.05, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

007.04(D) 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 state-operated veterans' homes; nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and continuing care retirement communities. the quality assessment component rate will be determined by calculating the anticipated tax payment' during the rate year and then dividing the total anticipated tax payments by total anticipated nursing facility or skilled nursing facility patient days, including bed hold days and Medicare patient days. for each rate year, July 1 through the following June 30, 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 or skilled nursing facility patient days. For 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. for 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. For 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).

007.04(E) BASE YEAR REPORT PERIOD AND INFLATION FACTOR. For the Rate Periods July 1 through December 31~~,~~ ~~2020,~~ and January 1 through June 30~~,~~ ~~2021~~, the base year is updated no less frequently than every 5 years. The inflation factor is updated annually. ~~is the report period ending June 30, 2018; and the inflation factor is positive 1.51%.~~

007.04(F) QUALITY MEASURES COMPONENT. This component of the prospective rate is based on the quality measures component of the Centers for Medicare & Medicaid nursing facility star rating system. The published rating as of May 1 is used to determine the rate component for the following July 1 through December 31 rate period. The published rating as of November 1 is used to determine the rate component for the following January 1 through June 30 rate period. Per Diem amounts corresponding to the quality measures rating are: 5 star rating = $10.00 a day; 4 star rating = $6.75 a day; 3 star rating = $3.50 a day; 1 star, 2 star, or NR (no rating) = $0.00 (zero dollars). This component applies to all nursing facility care levels (101-180).

007.05 EXCEPTION PROCESS. An individual facility may request, on an exception basis, the Medicaid Director or designee, to consider specific facility circumstance or circumstances, which warrant an exception to the facility's rate computed for its fixed cost component. For existing facilities, an exception may only be requested if the facility's total annualized fixed costs, total costs, not per diem rate, as compared to the annualized base year costs, have increased by twenty percent or more. Facilities without a base year cost report, and with 1,000 or more annualized Medicaid days, may only request an exception if the facility's fixed costs per day, computed using an 85% minimum occupancy, exceeds the care classification average fixed cost component by 20% or more. In addition, the facility's request must include: Specific identification of the increased cost or costs that have caused the facility's total fixed costs to increase by 20% or more, with justification for the reasonableness and necessity of the increase; Whether the cost increase or increases are an ongoing or a one-time occurrence in the cost of operating the facility; and If applicable, preventive management action that was implemented to control past and future cause or causes of identified cost increase or increases. Approved increases from July 1 through December 31, will be effective the following January 1. Approved increases from January 1 through June 30, will be effective the following July 1.

007.06 RATE PAYMENT FOR ASSISTED LIVING LEVELS OF CARE ~~101, 102, 103, AND 104~~. The payment rate for Levels of Care ~~101, 102, 103, and 104~~ 201 and 202 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 adjusted to include the nursing facility quality assessment component and quality measures component.

007.07 OUT-OF-STATE FACILITIES. The Department pays out-of-state facilities participating in Medicaid at ~~a~~ the rates established by that state's Medicaid program for nursing facility days, bed hold days and therapeutic leave days at the time of ~~the~~ establishment of the Medicaid provider agreement. The rates are periodically updated to align with the current and applicable rates assigned by the out-of-state facility's State Medicaid program. ~~The payment is not subject to any type of adjustment~~.

007.08 RATES FOR PROVIDERS WITHOUT A BASE YEAR COST REPORT. A provider without a base year cost report is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility, meaning the business operation, not the physical property, due to a change in ownership, or to operate a nursing facility not previously enrolled in Medicaid, after the base year cost report end date; or a provider with 1,000 or fewer Medicaid inpatient days in the base year. Prospective Medicaid rates for providers without a base year cost report are the sum of the following components:

(A) The applicable urban or rural average direct nursing base rate component of all other providers in the same care classification, adjusted by the inflation factor; and weighted for level of care;
(B) The applicable urban or rural average support services base rate component of all other providers in the same care classification, adjusted by the inflation factor;
(C) The applicable urban or rural average fixed cost base rate component of all other providers in the same care classification;
(D) The Nursing Facility Quality Assessment component; and
(E) The quality measures component.

007.09 PROVIDERS LEAVING THE MEDICAID. Providers leaving Medicaid as a result of change of ownership or exit from the program shall comply with provisions of this chapter.

007.10 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.

007.10(A) CITY OR COUNTY OWNED FACILITIES. 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 Medicaid federal financial participation percentage by the facility's allowable costs above the respective maximum for the direct nursing, support services, and fixed cost components. Verification of the eligibility of the expenditures for federal financial participation is accomplished during the audit process.

007.11 SPECIAL FUNDING PROVISIONS FOR INDIAN HEALTH SERVICES NURSING FACILITY PROVIDERS. Indian Health Services 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.

007.11(A) INDIAN HEALTH SERVICES. Indian Health Services providers may receive quarterly, interim Special Funding payments by filing quarterly cost reports, FA-66, for periods ending September 30, December 31, 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 (ii) 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.

(i) 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.

(ii) The special funding amount is computed after desk audit and determination of allowable costs for the report period. The amount is calculated by adding the following two figures:

(1) The allowable federal medical assistance percentage for Indian Health Services-eligible Medicaid residents multiplied by the difference between the allowable costs for all Indian Health Services-eligible Medicaid residents and the total amount paid for all Indian Health Services-eligible Medicaid residents, if greater than zero; and

(2) The allowable federal medical assistance percentage for non-Indian Health Services-eligible Medicaid residents multiplied by the difference between the allowable costs for all non-Indian Health Services-eligible Medicaid residents and the total amount paid for all non-Indian Health Services-eligible Medicaid residents, if greater than zero.

008. DEPRECIATION. This subsection replaces Medicare regulations on depreciation in their entirety, except those 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. At the time of an asset acquisition, the nursing facility must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life.

008.01 CAPITALIZATION GUIDELINES. Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

008.01(A) CAPITALIZATION THRESHOLD. The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for their facility, but the threshold amount must be at least $100 and no greater than $5,000.

008.01(B) ACQUISITIONS. If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and an allowable cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has an allowable cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

008.01(C) ACQUISITIONS UNDER $100. Acquisitions after July 1, 2005, with a per unit cost of less than $100 cannot be depreciated. Costs of these items are included in the applicable operating cost category on the cost report in the current period.

008.01(D) INTEGRATED SYSTEM PURCHASES. When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold.

008.01(E) MULTIPLE ITEMS WITH PER UNIT COST GREATER THAN OR EQUAL TO $100. Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy must describe how the provider elects to treat these items.

008.01(F) NON-CAPITAL PURCHASES. Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

008.01(G) BETTERMENTS AND IMPROVEMENTS. Betterments and improvements extend the life, increase the productivity, or significantly improve the safety of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

008.02 BUILDINGS AND EQUIPMENT. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

(A) Identifiable and recorded in the provider's accounting records;

(B) Based on book value of the asset or assets in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;

(C) Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation;

(D) Based on the fair market value at the time of donation for donated assets without a prior Medicaid basis; or based on the donor's Medicaid net book value at the time of the donation for donated assets with a prior Medicaid basis. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and

(E) Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

008.03 OTHER GAINS AND LOSSES ON DISPOSITION OF ASSETS. Losses on the sale of real property are not recognized under Medicaid. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains or losses on personal property will be reduced from or included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

008.04 SALE OR TRANSFER OF CORPORATE STOCK. Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

009. REPORTING REQUIREMENTS AND RECORD RETENTION. Providers with greater than 1,000 Medicaid inpatient days for a full Report Period must submit cost and statistical data on Form FA-66, Report of Long Term Care Facilities for Reimbursement. Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation will prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes. Each facility must complete the required schedules and submit the original, signed report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in Medicaid. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due. When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment. If the provider takes no action to comply with the obligation, the Department may refer the case for legal action. If a required cost report has not been filed, the sum of the following is due: all prospective rate payments made during the rate period to which the cost report applies; all prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and costs incurred by the department in attempting to secure reports and payments. If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing. Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department will retain all cost reports for at

least five years after receipt from the provider. 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 rep ort 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.

009.01 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 Division. 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, based on current Department policy, must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

010. AUDITS. The Department will perform at least one initial desk audit and may perform subsequent desk audits 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 or periods and subject or subjects 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 or periods 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.

011. SETTLEMENT AND RATE ADJUSTMENTS. When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on a remittance advice. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment

period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion. The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is fully recovered. The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

012. 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.

013. 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 Division Director. 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. After the Division Director 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.

014. 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 Division Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Division Director is the sole authority in deciding whether to reopen. The action may be taken on the initiative of the Department within the three-year period; in response to a written request from a provider or other entity within the three-year period. Whether the Division Director 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 anytime fraud or abuse is suspected. A provider does not have the right to appeal a finding by the Division Director that a reopening or correction of a determination or decision is not warranted.

015. CHANGE OF HOLDER OF PROVIDER AGREEMENT. A holder of a provider agreement receiving payments under 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 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 this chapter 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.

016. CLASSIFICATION OF RESIDENTS AND CORRESPONDING WEIGHTS.

016.01 RESIDENT LEVEL OF CARE. ~~The Department will use a federally-approved resource utilization group grouper to assign each resident to a level of care based on information contained on his or her minimum data set assessment.~~ The Department will use a federally approved patient driven payment-model grouper to assign a level of care using the information from the minimum data set. Each level of care will be assigned the federally recommended weight. When no minimum data set assessment is available, the resident will be assigned to a default level of care, Level 280~~180~~.

016.02 WEIGHTING OF RESIDENT DAYS USING RESIDENT LEVEL OF CARE AND WEIGHTS. Each facility resident is assigned to a level of care. Each resident's level of care is appropriately updated from each assessment to the next 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 is retroactive to the effective date of the assessment which is audited. For purposes of the 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 & Medicaid Services minimum data set data base, but the Department will not replace the existing record in the 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 resident days, per the minimum data set system, at each care level are multiplied by the corresponding weight. The resulting products are summed to determine the total weighted resident days per the minimum data set system. This total is then divided by the minimum data set total resident days per the minimum data set system. This total is then divided by the minimum data set total resident days and multiplied by total resident days per the facility's Medicaid cost report to determine the total number of weighted resident days for the facility, which is the divisor for the direct nursing component.

~~016.03 RESIDENT LEVEL OF CARE WEIGHTS. The following weighting factors must be assigned to each resident level of care, based on the Centers for Medicare and Medicaid Services Resource Utilization Groups III 5.20 version:~~

~~(A) Level of care: 163; Casemix Index Vaue: RAD; Casemix Index Description: Rehabilitation/ADL = 17-18; Casemix Index Value: 1.66;~~

~~(B) Level of care: 162; Casemix Index Vaue: RAC; Casemix Index Description: Rehabilitation/ADL = 14-16; Casemix Index Value: 1.31;~~

~~(C) Level of care: 161; Casemix Index Vaue: RAB; Casemix Index Description: Rehabilitation/ADL = 4-8; Casemix Index Value: 1.24;~~

~~(D) Level of care: 160; Casemix Index Vaue: RAA; Casemix Index Description: Rehabilitation/ADL = 17-18; Casemix Index Value: 1.07;~~

~~(E) Level of care: 172; Casemix Index Vaue: SE3; Casemix Index Description: Extensive Services 3/ADL >6; Casemix Index Value: 2.10;~~

~~(F) Level of care: 171; Casemix Index Vaue: SE2; Casemix Index Description: Extensive Services 2/ADL >6; Casemix Index Value: 1.79;~~

~~(G) Level of care: 170; Casemix Index Vaue: SE1; Casemix Index Description: Extensive Services 1/ADL >6; Casemix Index Value: 1.54;~~

~~(H) Level of care: 152; Casemix Index Vaue: SSC; Casemix Index Description: Special Care/ADL = 17-18; Casemix Index Value: 1.44;~~

~~(I) Level of care: 151; Casemix Index Vaue: SSB; Casemix Index Description: Special Care/ADL = 15-16; Casemix Index Value: 1.33;~~

~~(J) Level of care: 150; Casemix Index Vaue: SSA; Casemix Index Description: Special Care/ADL = 4-14; Casemix Index Value: 1.28;~~

~~(K) Level of care: 145; Casemix Index Vaue: CC2; Casemix Index Description: Clinically Complex w/Depression/ADL = 17-18; Casemix Index Value: 1.42;~~

~~(L) Level of care: 144; Casemix Index Vaue: CC1; Casemix Index Description: Clinically Complex/ADL = 17-18; Casemix Index Value: 1.25;~~

~~(M) Level of care: 143; Casemix Index Vaue: CB2; Casemix Index Description: Clinically Complex w/ Depression/ADL = 12-16; Casemix Index Value: 1.15;~~

~~(N) Level of care: 142; Casemix Index Vaue: CB1; Casemix Index Description: Clinically Complex/ADL = 12-16; Casemix Index Value: 1.07;~~

~~(O) Level of care: 141; Casemix Index Vaue: CA2; Casemix Index Description: Clinically Complex w/Depression/ADL = 4-11; Casemix Index Value: 1.06;~~

~~(P) Level of care: 140; Casemix Index Vaue: CA1; Casemix Index Description: Clinically Complex/ADL = 4-11; Casemix Index Value: 0.95;~~

~~(Q) Level of care: 133; Casemix Index Vaue: IB2; Casemix Index Description: Cognitive Impairment with Nursing Rehab/ADL= 6-10; Casemix Index Value: 0.88;~~

~~(R) Level of care: 132; Casemix Index Vaue: IB1; Casemix Index Description: Cognitive Impairment/ADL = 6-10; Casemix Index Value: 0.85;~~

~~(S) Level of care: 131; Casemix Index Vaue: IA2; Casemix Index Description: Cognitive Impairment with Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.72;~~

~~(T) Level of care: 130; Casemix Index Vaue: IA1; Casemix Index Description: Cognitive Impairment/ADL = 4-5; Casemix Index Value: 0.67;~~

~~(U) Level of care: 123; Casemix Index Vaue: BB2; Casemix Index Description: Behavior Prob w/Nursing Rehab/ADL = 6-10; Casemix Index Value: 0.86;~~

~~(V) Level of care: 122; Casemix Index Vaue: BB1; Casemix Index Description: Behavior Prob/ADL = 6-10; Casemix Index Value: 0.82;~~

~~(W) Level of care: 121; Casemix Index Vaue: BA2; Casemix Index Description: Behavior Prob w/Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.71;~~

~~(X) Level of care: 120; Casemix Index Vaue: BA1; Casemix Index Description: Behavior Prob/ADL = 4-5; Casemix Index Value: 0.60;~~

~~(Y) Level of care: 115; Casemix Index Vaue: PE2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 16-18; Casemix Index Value: 1.00;~~

~~(Z) Level of care: 114; Casemix Index Vaue: PE1; Casemix Index Description: Physical Function/ADL = 16-18; Casemix Index Value: 0.97;~~

~~(AA) Level of care: 113; Casemix Index Vaue: PD2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 11-15; Casemix Index Value: 0.91;~~

~~(BB) Level of care: 112; Casemix Index Vaue: PD1; Casemix Index Description: Physical Function/ADL = 11-15; Casemix Index Value: 0.89;~~

~~(CC) Level of care: 111; Casemix Index Vaue: PC2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 9-10; Casemix Index Value: 0.83;~~

~~(DD) Level of care: 110; Casemix Index Vaue: PC1; Casemix Index Description: Physical Function/ADL = 9-10; Casemix Index Value: 0.81;~~

~~(EE) Level of care: 104; Casemix Index Vaue: PB2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 6-8; Casemix Index Value: 0.65;~~

~~(FF) Level of care: 103; Casemix Index Vaue: PB1; Casemix Index Description: Physical Function/ADL = 6-8; Casemix Index Value: 0.63;~~

~~(GG) Level of care: 102; Casemix Index Vaue: PA2; Casemix Index Description: Physical Function w/Nursing Rehab/ADL = 4-5; Casemix Index Value: 0.62;~~

~~(HH) Level of care: 101; Casemix Index Vaue: PA1; Casemix Index Description: Physical Function/ADL = 4-5; Casemix Index Value: 0.59; or~~

~~(II) Level of care: 180; Casemix Index Vaue: STS; Casemix Index Description: Short-Term Stay; Casemix Index Value: 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 minimum data set admission assessment of the client. This is effective for admissions on or after July 1, 2010.~~

016.03 RESIDENT LEVEL OF CARE WEIGHTS. The following weighting factors must be assigned to each resident level of care, based on the Centers for Medicare and Medicaid Services Patient Driven Payment Model Nursing classifications:

(A) Level of care: 272; Case Mix Group: ES3; Description: Extensive Services 3, Tracheostomy and Ventilator; Case Mix Index Value: 4.06;

(B) Level of care: 271; Case Mix Group: ES2; Description: Extensive Services 2, Tracheostomy or Ventilator; Case Mix Index Value: 3.07;

(C) Level of care: 270; Case Mix Group: ES1; Description: Extensive Services 1, Infection Isolation; Case Mix Index Value: 2.93;

(D) Level of care: 263; Case Mix Group: HDE2; Description: Special Care High, Depressed, Function Score 0-5; Case Mix Index Value: 2.40;

(E) Level of care: 262; Case Mix Group: HDE1; Description: Special Care High, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.99;

(F) Level of care: 261; Case Mix Group: HBC2; Description: Special Care High, Depressed, Function Score 6-14; Case Mix Index Value: 2.24;

(G) Level of care: 260; Case Mix Group: HBC1; Description: Special Care High, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.86;

(H) Level of care: 253; Case Mix Group: LDE2; Description: Special Care Low, Depressed, Function Score 0-5; Case Mix Index Value: 2.08;

(I) Level of care: 252; Case Mix Group: LDE1; Description: Special Care Low, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.73;

(J) Level of care: 251; Case Mix Group: LBC2; Description: Special Care Low, Depressed, Function Score 6-14; Case Mix Index Value: 1.72;

(K) Level of care: 250; Case Mix Group: LBC1; Description: Special Care Low, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.43;

(L) Level of care: 245; Case Mix Group: CDE2; Description: Clinically Complex, Depressed, Function Score 0-5; Case Mix Index Value: 1.87;

(M) Level of care: 244; Case Mix Group: CDE1; Description: Clinically Complex, Not Depressed, Function Score 0-5; Case Mix Index Value: 1.62;

(N) Level of care: 243; Case Mix Group: CBC2; Description: Clinically Complex, Depressed, Function Score 6-14; Case Mix Index Value: 1.55;

(O) Level of care: 241; Case Mix Group: CA2; Description: Clinically Complex, Depressed, Function Score 15-16; Case Mix Index Value: 1.09;

(P) Level of care: 242; Case Mix Group: CBC1; Description: Clinically Complex, Not Depressed, Function Score 6-14; Case Mix Index Value: 1.34;

(Q) Level of care: 240; Case Mix Group: CA1; Description: Clinically Complex, Not Depressed, Function Score 15-16; Case Mix Index Value: 0.94;

(R) Level of care: 221; Case Mix Group: BAB2; Description: Behavior SX Cognition, Restorative Nursing ≥ 2; Case Mix Index Value: 1.04;

(S) Level of care: 220; Case Mix Group: BAB1; Description: Behavior SX Cognition, Restorative Nursing = 1 or 2; Case Mix Index Value: 0.99;

(T) Level of care: 206; Case Mix Group: PDE2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 0-5; Case Mix Index Value: 1.57;

(U) Level of care: 205; Case Mix Group: PDE1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 0-5; Case Mix Index Value: 1.47;

(V) Level of care: 204; Case Mix Group: PBC2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 6-14; Case Mix Index Value: 1.22;

(W) Level of care: 202; Case Mix Group: PA2; Description: Reduced Physical Function, Restorative Nursing ≥ 2, Function Score 15-16; Case Mix Index Value: 0.71;

(X) Level of care: 203; Case Mix Group: PBC1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 6-14; Case Mix Index Value: 1.13;

(Y) Level of care: 201; Case Mix Group: PA1; Description: Reduced Physical Function, Restorative Nursing = 1 or 2, Function Score 15-16; Case Mix Index Value: 0.66; or

(Z) Level of care: 280; Casemix Index Vaue: STS; Casemix Index Description: Short-Term Stay; Casemix Index Value: 0.59; Level of Care 280, 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 minimum data set admission assessment of the client. This is effective for admissions on or after July 1, 2023.

016.04 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.

017. SPECIALIZED ADD-ON SERVICES PAYMENTS. Specialized add-on services are paid to the provider or providers of specialized add-on services. Payments to providers for medically necessary services, including specialized add-on services in excess of limitations for covered services identified elsewhere in the state plan, or not listed as specialized add-on services according to the state plan, require pre-authorization.

017.01 SPECIALIZED ADD-ON SERVICES. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of specialized add-on services provided in the nursing facility. The Medicaid agency's rates were set as of June

30, 2018, and are effective for dates of services provided on and after that date.

017.02 HABILITATIVE SERVICES. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of habilitative services, provided to individuals residing in a nursing facility. The rates for these specialized add-on services were established using existing developmental disabilities waiver fee schedules. The rates were set as of June 30, 2018, and are effective for dates of service provided on and after that date, and updated as specified by the Department.

017.03 SUPERVISORY ACTIVITIES. Payment excludes the supervisory activities rendered as a normal part of the employment support.

018. PAYMENT FOR SERVICES FOR LONG TERM CARE CLIENTS WITH SPECIAL NEEDS. Payment for services to all special needs clients must be prior authorized by Department staff in the Central Office.

018.01 NEBRASKA FACILITIES. To establish a Nebraska facility's payment rate for care of special needs clients:

(A) The facility must submit Form FA-66, Long Term Care Cost Report, to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with this chapter, Completion of Form FA-66, Long Term Care Cost Report, Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM15). If the facility provides both nursing facility services and special needs services, direct accounting, or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department;

(B) The Department shall compute the allowable cost per day from the most recent State fiscal year Form FA-66 or the most recent Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated. Payment for fixed costs is limited to the lower of the individual facility's fixed cost per diem or a maximum per diem of $54.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation or deflation expectations for the rate period and significant increases or decreases in the cost of providing services that are not reflected in the applicable cost report;

(C) If the facility has no prior cost experience in providing special needs services, the facility must submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience;

(D) An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;

(E) After a rate is agreed upon, the provider must sign a provider agreement addendum. The addendum originated by the Department, must include:

(i) The rate and its applicable dates;

(ii) A description of the criteria for care; and

(iii) A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and

(F) 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.

018.02 OUT-OF-STATE FACILITIES. The Department pays out-of-state facilities participating in Medicaid at ~~a~~ the rates established by that state's Medicaid program for nursing facility days, bed hold days and therapeutic leave days at the time of ~~the~~ establishment of the Medicaid provider agreement. The rates are periodically updated to align with the current and applicable rates assigned by the out-of-state facility's State Medicaid program. ~~The payment is not subject to any type of adjustment.~~

~~018.03 PAYMENT FOR BED HOLD. 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. The rate will be no lower than the Level 105 rate, as defined in this chapter, and will not exceed the per diem inpatient unit rate.~~