

12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective for services provided beginning July 1, ~~2007~~ 2008.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means 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 NAC 12-011.06.

Assisted Living Rates means 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 (see 480 NAC 5).

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

Level of Care means the classification (see 471 NAC 12-013.01) of each resident based on his/her acuity level.

Median means 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.

Nursing Facility means 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.

Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 35 and 36.

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 35 and 36 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Revisit Fees means fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under 'Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management' for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys.

Urban means Douglas, Lancaster, Sarpy, and Washington Counties.

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waived days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility (see 471 NAC 12-013.03 and 12-013.04).

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Division of Public Health's regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, ~~2005~~ 2006 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) 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.

A provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be the average base rate components, effective July 1, ~~2007~~ 2008, of all other providers in the same care classification, computed using audited data as of March 15, ~~2007~~ 2008.

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

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

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;
2. Comply with the standards prescribed by the Secretary of the federal Health and Human Services (HHS) for nursing facilities in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services Division of Public Health, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility services, as applicable.

13. Carry-over of costs "lost" due to any limitation in this system; ~~and~~
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) 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. Examples include, but are not limited to, swimming pools, tennis courts, handball courts; and
15. Revisit fees.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A 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 NMAP. 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 NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are used. An inpatient day is:

1. 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
2. A day on which the bed is held for hospital leave or therapeutic home visits.

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. Bedholding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year.

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 471 NAC 12-011 for these days.

12-011.06C Start-Up Costs: All new providers entering NMAP 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.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

12-011.06J Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 12-011, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department for the purposes of rate setting are the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

12-011.06K 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 (see HIM-15, Section 905.6). Administrator compensation maximums for the cost report period ending June 30, 2007 are:-

<u>Bed Size</u>	<u>Maximum</u>
<u>1 – 74</u>	<u>\$75,166</u>
<u>75 – 99</u>	<u>\$76,516</u>
<u>100 – 149</u>	<u>\$90,919</u>
<u>150 – 200</u>	<u>\$91,820</u>
<u>201 +</u>	<u>\$135,029</u>

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: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

12-011.06L 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.

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning July 1, ~~2007~~ 2008. The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Period: The Rate Period is defined as July 1, ~~2007~~ 2008 through June 30, ~~2008~~ 2009. Rates paid during this Rate Period are determined (see 471 NAC 12-011.08D) from cost reports submitted for the June 30, ~~2006~~ 2007 Report Period (see 471 NAC 12-011.08B).

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

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

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the July 1, ~~2005~~ 2006 through June 30, ~~2006~~ 2007 Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed using audited data as of the March 15<sup>th</sup> following the end of the Cost Report Period, and are not revised based on subsequent desk audits or field audits. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the NMAP during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of three components:

1. The Direct Nursing Component increased by the inflation factor;
2. The Support Services Component increased by the inflation factor; and
3. The Fixed Cost Component.

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

Median: 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 waived, and/or facilities with partial or initial/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, waived, and/or facilities with partial or initial/final full year cost reports.

The Department will reduce the Direct Nursing Component median by 2% for facilities that are waived from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 125% of the median Direct Nursing Component, and 115% of the median Support Services Component. The Department will reduce the Direct Nursing Component maximum by 2% for facilities that are waived from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

The Fixed Cost Component is subject to a maximum per diem of ~~\$25.00~~ \$26.00, excluding personal property and real estate taxes.

Each facility's base prospective rate is computed as the sum of the facility-specific Direct Nursing and Support Services components adjusted by the inflation factor and the Fixed Cost Component, subject to the rate limitations and component maximums of this system. The Direct Nursing, Support Services, and Fixed Cost components are expressed in per diem amounts.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the 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 (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (lines 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Rate determination for the Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

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 ~~\$25.00~~ \$26.00 excluding personal property and real estate taxes.

12-011.08D4 Inflation Factor: For the Rate Period of July 1, ~~2007~~ 2008 through June 30, ~~2008~~ 2009, the inflation factor is ~~4.9%~~ 4%.

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

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

12-011.08F Rate Payment for Levels of Care 35 and 36: Rates as determined for Levels of Care 35 and 36 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. The payment rate for Levels of Care 35 and 36 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08H Rates for New Providers Entering NMAP After July 1, 2005 and Before July 1, 2008: For the July 1, 2007 through June 30, 2008 and July 1, 2008 through June 30, 2009 Rate Periods, the Department will pay new providers interim rates determined as follows:

1. For new providers entering NMAP as a result of a change of ownership occurring on or after July 1, 2007 ~~and before July 1, 2008~~, the interim rates are the rates of the seller in effect on the sale date.
2. For all other new providers entering NMAP after July 1, 2005 ~~and before July 1, 2008~~, the interim rates are the average base rate components effective at the beginning of each applicable rate period, July 1, 2007 of all other providers in the same Care Classification, computed using the applicable March 15<sup>th</sup> audited data as of March 15, 2007.

~~The interim rates for the July 1, 2007 through June 30, 2008 rate period will be retroactively settled based on the new provider's audited cost report for the period ending June 30, 2008, subject to maximums and limitations applicable to the 2007-2008 rate period. Interim rates for the July 1, 2008 through June 30, 2009 rate period will be retroactively settled based on the new provider's audited cost report for the period ending June 30, 2009, subject to maximums and limitations applicable to the 2008-2009 rate period. New providers with 1,000 or fewer annualized Medicaid days during the report period will not file a June 30, 2008 cost report and will not be subject to a retro-settlement of their rates for that period.~~

~~A new provider may request an increase or decrease to its interim rate components to better approximate its projected final rates. Requests for interim rate adjustments must include cost, revenue and census data sufficient to support the requested amounts. The Director of the Division of Medicaid and Long-Term Care determines whether an interim rate adjustment is warranted. A new provider does not have the right to appeal the determination of the Director of the Division of Medicaid and Long-Term Care.~~

12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transactions to increase reimbursement. Both transactions are subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonable be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.—

1. 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 and the Support Services 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 and the Support Services Components. The participating facility certifies the non-federal share of cost. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.
2. City or county-owned facilities may also participate in the proportionate share pool. The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology adjusts for pharmacy, laboratory, radiology, retroactive payment adjustments (including adjustments made under 471 NAC 12-011.08K, item 1), and any other factors necessary to equate Medicaid to Medicare payment methodologies.

12-011.10 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" (see 471-000-41). 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 NMAP. Under extenuating circumstances, an extension not to exceed ~~15~~ 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:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. 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.

2. The Department shall compute the allowable cost per day from Form FA-66 or the Medicare cost report, as applicable, which will be the basis from which a prospective rate is negotiated, ~~effective for the following calendar year rate period.~~ Cost reports submitted for the June 30, 2007 report period will be used as the basis for rates for the 18-month rate period from January 1, 2008 through June 30, 2009. Payment for fixed costs is limited to the lower of the individual facility's fixed cost per diem or a maximum per diem of ~~\$50.00~~ \$52.00 excluding personal property and real estate taxes. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to:

- a. Room and board;
- b. Preadmission and admission assessments;
- c. All direct and indirect nursing services;
- d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
- e. All routine equipment, to include suction machine, IV poles, etc.;
- f. Oxygen and related supplies;
- g. Psychosocial services;
- h. Therapeutic recreational services;
- j. Administrative costs;
- k. Plant operations;
- l. Laundry and linen supplies;
- m. Dietary services, to include tube feeding supplies and pumps;
- n. Housekeeping; and
- o. Medical records.

Services not commonly included in the per diem (unless specifically provided via the facility's contract) include, but are not limited to:

- a. Speech therapy;
- b. Occupational therapy;
- c. Physical therapy;
- d. Pharmacy;
- e. Audiological services;
- f. Laboratory services;
- g. X-ray services;
- h. Physician services; and
- j. Dental services;

These services are reimbursed under the Department's established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. 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.