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, 2010.~~

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.

IHS Nursing Facility Provider means an Indian Health Services Nursing Facility or a Tribal Nursing Facility designated as an IHS provider and funded by the Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

Level of Care means the classification 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 101, 102, 103 and 104.

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

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

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

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

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility.

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

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2009~~2008~~ are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (Medicaid) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

Except for IHS nursing facility providers, a provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be based on the average base rate components, effective July 1 of the rate period, ~~2010,~~ of all other providers in the same care classification, following the initial desk audits.

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

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

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.

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). See Appendix 471-000-111 for Administrator compensation maximums. ~~for the cost report period ending June 30, 2009 are:~~

~~Bed Size~~	~~Maximum~~
~~1 – 74~~	~~$80,128~~
~~75 – 99~~	~~$81,567~~
~~100 – 149~~	~~$96,921~~
~~150 – 200~~	~~$97,880~~
~~201 +~~	~~$143,942~~

For future cost report periods, administrator compensation maximums will be adjusted annually based on inflation factors published in HIM 15, Section 905.6 and will not be specified in the regulations. Once calculated, these maximums will be available for review from the Department and published in Appendix 471-000-111.

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, 2010.~~ 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~~, 2010~~ through June 30~~, 2011~~. Rates paid during the ~~this~~ Rate Period are determined (see 471 NAC 12-011.08D) from cost reports submitted for the Report Period ending June 30, two years prior to the end of the Rate Period. For example, cost reports submitted for the Report Period ending June 30, 2009 determine rates for the Rate Period July 1, 2010 through June 30, 2011 ~~2009 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, 2008 through June 30, 2009~~ 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 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 computation. Cost reports from providers entering or leaving the Medicaid 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 adjusted by the inflation factor;
2. The Support Services Component adjusted 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 waivered, 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, waivered, and/or facilities with partial or initial/final full year cost reports.

12-011.08H Rates for New Providers ~~Entering Medicaid after July 1, 2008~~:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A new provider is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility due to a change in ownership, or to operate a nursing facility not previously enrolled in Medicaid. For purposes of this definition, "nursing facility" means the business operation, not the physical property. A "new provider" retains that status until the start of the prospective Rate Period corresponding to the provider's first, full twelve-month Report Period.
Example A: A new provider enters the Medicaid program on May 7, 2007. Their first full, twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from May 7, 2007 through June 30, 2009.
Example B: A new provider enters the Medicaid program on July 1, 2007. Their first full, twelve-month Report Period is for the period ending June 30, 2008, which corresponds to the prospective Rate Period beginning July 1, 2009. They are a "new provider" from July 1, 2007 through June 30, 2009.

Definition: The "Report Period" for a fiscal year determines rates, or interim rates, for a "prospective Rate Period" two years after the Report Period. For example, Report Period 2006-2007 determines prospective rates, or interim rates, for the 2008-2009 Rate Period.

A. ~~For the July 1, 2010 through June 30, 2011 Rate Period, the Department will pay~~ Medicaid rates for new providers, except for HIS nursing facility providers~~, interim rates~~ are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:
   For the Rate Period beginning on the date ownership is transferred through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive interim Medicaid rates equal to the rates of the seller in effect on the date ownership is transferred, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the date ownership is transferred through the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

   For the following July 1 through June 30 Rate Period, new providers receive interim rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

If applicable, for the next July 1 through June 30 Rate Period, new providers receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the date ownership is transferred and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

2. 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, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive interim Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending on the following June 30, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a Report Period do not file a cost report and are not subject to a retro-settlement of their rates.

For the following July 1 through June 30 Rate Period, new providers receive initial interim rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits. The initial interim rates are revised based on the provider's audited Medicaid cost report for their first Report Period, subject to maximums and limitations applicable to the Rate Period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report. The revised interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive interim Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period. The interim rates are retroactively settled based on the facility's audited Medicaid cost report for the same July 1 through June 30 Report Period, subject to maximums and limitations applicable to the Rate Period. Providers with 1,000 or fewer annualized Medicaid days during a report period do not file a cost report and are not subject to a retro-settlement of their rates.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

~~For new providers entering Medicaid from July 2, 2008 through June 30, 2009, the interim rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the provider's initial, part-year cost report for the period ending June 30, 2009, subject to the rate period's maximums and limitations. Interim rates for the July 1, 2010 through June 30, 2011 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2011, subject to maximums and limitations applicable to the 2010-2011 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period~~.

~~2. For new providers entering Medicaid as a result of a change of ownership from July 1, 2009 through June 30, 2010, the interim rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the seller's cost report for the period ending June 30, 2009, subject to maximums and limitations applicable to the 2010-2011 rate period.~~

~~For other new providers entering Medicaid from July 1, 2009 through June 30, 2010, the initial interim rates for the rate period July 1, 2010 through June 30, 2011 are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using audited data following the initial desk audits. The initial interim rates will be revised based on the provider's audited June 30, 2010 cost report, subject to maximums and limitations applicable to the 2010-2011 rate period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report.~~

~~3. For new providers entering Medicaid as a result of a change of ownership from July 1, 2010 through June 30, 2011, the interim rates for the rate period beginning with the sale date through June 30, 2011 are the rates of the seller in effect on the sale date.~~

~~For other new providers entering Medicaid from July 1, 2010 through June 30, 2011, the interim rates for the rate period beginning with the sale date through June 30, 2011, are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using audited data following the initial desk audits.~~

~~Interim rates and revised interim rates for the July 1, 2010 through June 30, 2011 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2011, subject to maximums and limitations applicable to the 2010-2011 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period.~~

B. ~~For the July 1, 2010 through June 30, 2011 Rate Period, the Department will pay~~Medicaid rates for new IHS nursing facility providers~~, rates~~ are determined as follows:

1. New providers entering the Medicaid program as a result of a change of ownership:
   For the Rate Period beginning on the date ownership was transferred through the following June 30, new providers entering the Medicaid program as a result of a change of ownership receive Medicaid rates equal to the rates of the seller in effect on the date ownership was transferred, subject to maximums and limitations applicable to the Rate Period.

   For the following July 1 through June 30 Rate Period, new providers receive rates computed from the seller's audited cost report for the corresponding Report Period, subject to maximums and limitations applicable to the Rate Period.

   If applicable, for the next July 1 through June 30 Rate Period, new providers receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the date ownership was transferred and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

   When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

   ~~For new IHS nursing facility providers entering Medicaid from July 2, 2008 through June 30, 2009, the rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the provider's initial, part-year cost report for the period ending June 30, 2009, subject to the rate period's maximums and limitations.~~

2. 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, new providers entering the Medicaid program to operate a nursing facility not previously enrolled in Medicaid receive Medicaid rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification.

For the following July 1 through June 30 Rate Period, new providers receive rates based on the average base rate components effective at the beginning of the Rate Period of all other providers in the same Care Classification, computed using audited data following the initial desk audits.

If applicable, for the next July 1 through June 30 Rate Period, new providers will receive Medicaid rates computed from their initial part-year, audited Medicaid cost report for the Report Period beginning on the Medicaid certification date and ending the following June 30, subject to maximums and limitations applicable to the Rate Period.

When "new provider" status no longer applies, rates are computed under 471 NAC 12-011.08D Prospective Rates.

~~For new IHS nursing facility providers entering Medicaid as a result of a change of ownership from July 1, 2009 through June 30, 2010, the rates for the rate period July 1, 2010 through June 30, 2011 are the rates computed from the seller's cost report for the period ending June 30, 2009, subject to maximums and limitations applicable to the 2010-2011 rate period.~~

~~For other new IHS nursing facility providers entering Medicaid from July 1, 2009 through June 30, 2010, the rates for the rate period July 1, 2010 through June 30, 2011 are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data following the initial desk audits.~~

~~3. For new IHS nursing facility providers entering Medicaid as a result of a change of ownership from July 1, 2010 through June 30, 2011, the rates for the rate period beginning with the sale date through June 30, 2011 are the rates of the seller in effect on the sale date.~~

~~For other new IHS nursing facility providers entering Medicaid from July 1, 2010 through June 30, 2011, the rates for the rate period beginning with the certification date through June 30, 2011, are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable audited data.~~

12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transaction~~s~~ to increase reimbursement. The~~Both~~ transaction~~s~~ is~~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~~.

~~The Department annually submits to CMS workpapers demonstrating the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.~~

~~The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.~~

~~The initial proportionate share pool is created beginning January 1, 1998. Because this is the midpoint of the July 1, 1997 through June 30, 1998, Reporting Period, the pool is prorated to one half. The date for the estimated distribution for this initial prorated period will be on or about April 1, 1998.~~

~~Participation in this pool requires each facility to return their proportionate share of the pool, less a participation fee, to the State the same day as received. Each facility retains a participation fee of $2,500 for facility use. In cases where a facility's proportionate share of the pool is less than $2,500, the facility receives $2,500.~~

~~Payments are made annually during a transition period from a pool of funds based on the aggregate difference between estimated Medicaid payments and the upper payment limit for nursing facilities for state fiscal year 2000, as determined under the state plan in effect in that year. The pool amount for each transition year shall be the percentage specified below of the~~

~~aggregate difference for private facilities for state fiscal year 2000 (SFY 2000 excess $75,004,569), plus 100% of the aggregate difference for public facilities through June 30, 2005:~~

~~State fiscal year 2004 -~~	~~85%~~
~~State fiscal year 2005 -~~	~~70%~~
~~State fiscal year 2006 -~~	~~55%~~
~~State fiscal year 2007 -~~	~~40%~~
~~State fiscal year 2008 -~~	~~25%~~
~~Portion of SFY 2009 -~~	~~10%~~

~~No proportionate share pools will be created under this section after September 30, 2008.~~

12-011.08L Special Funding Provisions for IHS Nursing Facility Providers: IHS nursing facility providers are eligible to receive one hundred percent (100%) 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 who are IHS eligible. This amount is computed after desk audit and determination of allowable costs for a Report Period. The amount is calculated as the difference between allowable costs for all Medicaid IHS eligible residents and the total amount paid for all Medicaid IHS eligible residents, if greater than zero.

12-011.08M (Reserved)

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 report 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.

12-011.10A 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 Department of Health and Human Services, Division of Medicaid and Long-Term Care~~Financial Services~~, Audit. 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 (http://www2.dhhs.ne.gov/policies/PublicRecords.pdf), must be paid in advance. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department will perform at least one initial desk audit and may perform subsequent desk audits and/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(s) and subject(s) 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(s) 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.

~~12-011.14A MDS 2.0 Reconsideration Process (effective only through September 30, 2010): In place of or in advance of requesting an administrative appeal, a facility may request a rate payment reconsideration with the Department or its designee for a specific Level of Care 101, 102, 103 or 104 resident. The facility must submit information on the client's need for professional medical care, supervision or other needs that justify a rate payment at Level 191, 192, 193 or 194. Note: The reconsideration process neither limits nor promotes the facility's responsibility to make MDS changes on a quarterly basis or whenever a significant change has occurred, as federally defined.~~

~~To request reconsideration, the facility must submit information on the resident's needs, with supportive documentation, to the Department or its designee. The supportive documentation must include the degree of instability involved and the frequency of intervention in one or more of the following areas of the MDS 2.0:~~

1. ~~Section B.5. Indicators of delirium, periodic disordered thinking awareness, for residents with the diagnosis of mental illness, mental retardation or a related condition (developmental disability), dementia, or a brain injury. The behavior must be present and not of recent onset (Code 1).~~
2. ~~Section E.1. Indicators of depression, anxiety, and/or sad mood. The behavior must be exhibited (Code 1 or 2) PLUS an indicator in Section I of a disease of psychiatric/mood.~~
3. ~~Section J. Health Conditions (present in the last 7 days unless other time frame is indicated) that affect the stability of condition and/or require professional nurse monitoring.~~
4. ~~Section O. Medications that require professional nurse administration and/or monitoring.~~
5. ~~Section P. Special Treatments and Procedures #2 for Section E indicators and Section I disease of psych/mood.~~

~~Other documentation supporting the need for nursing judgement or intervention may also be submitted.~~

~~The following conditions do not constitute valid reasons for reconsideration:~~

1. ~~Lack of informal support;~~
2. ~~Amount of time the person has resided at the nursing facility, with payment either through Medicaid or through another source;~~
3. ~~Presence of a specific diagnosis without supporting documentation of the need for nursing judgement or intervention; and~~
4. ~~Advanced age.~~

~~12-011.14A1 Effective Date of Reconsideration: A facility may request a rate reconsideration review for MDS 2.0 assessments by December 31, 2010. If granted, the adjusted rate will be effective the first day of the month for which the resident's need for medical supervision or intervention is documented, retroactive for a period not to exceed three calendar months before the first day of the month in which the reconsideration request and supporting documentation is received by the Department or its designee.~~

12-013 Classification of Residents and Corresponding Weights

12-013.01 Resident Level of Care: The Department will use a federally-approved Resource Utilization Groups (RUG) grouper to assign each resident to a level of care based on information contained on his/her Minimum Data Set (MDS) assessment. Each level of care will be assigned the federally-recommended weight (see 471 NAC 12-013.04). When no MDS assessment is available, the resident will be assigned to a default level of care (Level 180).

12-013.02 Weighting of Resident Days Using Resident Level of Care and Weights: Each facility resident is assigned to a level of care per 471 NAC 12-013.01. Each resident's level of care is appropriately updated from each assessment to the next – the 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 (see 471 NAC 12-013.05) is retroactive to the effective date of the assessment which is audited.

For purposes of the Nebraska 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 and Medicaid Services (CMS) MDS data base, but the Department will not replace the existing record in the Nebraska 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 MDS system) at each care level are multiplied by the corresponding weight (see 471 NAC 12-013.0~~4~~3). The resulting products are summed to determine the total weighted resident days per the MDS system. This total is then divided by the MDS total resident days and multiplied by total resident days per the facility's Nebraska Medicaid Cost Report to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.

~~For each reporting period, the total number of residents in each level of care is multiplied by the total number of corresponding days for each resident at that level. This product is then multiplied (weighted) by the corresponding weight (see 471 NAC 12-013.04). Each resulting product is the Weighted Resident Days for that level. The Weighted Resident Days for all levels are then summed to determine the total number of Weighted Resident Days for the facility, which is the divisor for the Direct Nursing Component.~~

*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 MDS admission assessment of the client. This is effective for admissions on or after July 1, 2010.

~~**Levels of Care 191, 192, 193 and 194 are used for clients at Levels of Care 101, 102, 103 and 104, respectively, who are approved under 471 NAC 12-011.14A.~~

12-013.04 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.

2. 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. ~~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 $54.00~~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.