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.

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.

Nursing Facility Quality Assurance Fund means the fund created in Neb. Rev. Stat. § 68-1926 as the repository for provider tax payments remitted by nursing facilities and skilled nursing facilities.

Quality Assurance Assessment means the assessment imposed under the Nursing Facility Quality Assurance Assessment Act in Neb. Rev. Stat. § 68-1917.

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, adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 101, 102, 103, 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5) adjusted to include the Nursing Facility Quality Assurance Assessment component (see 471 NAC 12-011.08D.

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~~ 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 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, 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.

12-011.08D4 Nursing Facility Quality Assessment Component: The Nursing Facility Quality Assessment component shall not be subject to any cost limitation or revenue offset.

The quality assessment component rate will be determined by calculating the "anticipated tax payments" during the rate period and then dividing the total anticipated tax payments by "total anticipated nursing facility/skilled nursing facility patient days", including bed-hold days and Medicare patient days.

For the first rate period, during which this section becomes operative, the "anticipated tax payments" will be determined by annualizing total facility patient days, including bed-hold days, less Medicare days from the time period beginning the January 1 and ending the June 30 preceding the beginning of the rate period. "Total anticipated nursing facility/skilled nursing facility patient days" will be determined by annualizing total facility patient days, including bed-hold days and Medicare days, from the time period beginning the January 1 and ending the June 30 preceding the beginning of the rate period. Nursing facilities will not be assessed a tax on any patient days prior to July 1, 2011.

For each subsequent rate period, total facility patient days, including bed-hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the "anticipated tax payments". Total facility patient days, including bed-hold days and Medicare days, for the same four calendar quarters will be used to calculate the "anticipated nursing facility/skilled nursing facility patient days".

12-011.08D5 Inflation Factor: ~~For the Rate Period of July 1, 2010 through June 30, 2011, the inflation factor is negative 1.54 percent. For future rate periods,~~ The inflation factor ~~will be calculated using the following formula~~ is determined from spending projections using: ~~and will not be specified in the regulations. Once calculated, rates are available for review from the Department.~~

1. Audited cost and census data following the initial desk audits; ~~and~~
2. Budget directives from the Nebraska Legislature; and
3. Funding generated by the Nursing Facility Quality Assurance Assessment.

Once calculated, rates are available for review from the Department.

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

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.90/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.08/day.
4. For rate periods after June 30, 2016, prospective rates will not be increased by a DME rate add-on.

The DME rate add-on does not apply to Levels of Care 101-105.

Retroactive rate settlements computed according to 471 NAC 12-011.08H1 will not include a DME rate add-on as actual DME costs will be included in the reported Support Services – Other Nursing costs. To account for these increased Support Services costs on retroactive rate settlements only:

1. For the rate period August 1, 2013 through June 30, 2014, the Support Services Maximum will be increased by $.90/day.
2. For the rate period July 1, 2014 through June 30, 2015, the Support Services Maximum will be increased by $.90/day.
3. For the rate period July 1, 2015 through June 30, 2016, the Support Services Maximum will be increased by $.08/day.

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

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

12-011.08F Rate Payment for Levels of Care 101, 102, 103, 104 and 105: Rates as determined for Levels of Care 101, 102, 103 and 104 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. Level of Care 105 is used for payment of qualifying bed-hold days. The payment rate for Levels of Care 101, 102, 103, 104 and 105 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5), adjusted to include the Nursing Facility Quality Assessment Component (see 471 NAC 12-011.08D).

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

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

City or county-owned facilities with a 40 percent 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~~ Medicaid 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.

12-011.08L Special Funding Provisions for IHS Nursing Facility Providers: IHS nursing facility providers are eligible to receive ~~100 percent~~ 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 ~~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.~~

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

2. Quarterly, Interim Special Funding payments shall be made within 30 days of receipt of the quarterly cost report or requested supporting documentation. Quarterly, interim Special Funding payments subsequent to the payment for the "final" quarterly cost report shall be made on or about 90-day intervals following the previous payment.

3. 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:

a. The allowable Federal Medical Assistance Percentage for IHS-eligible Medicaid residents multiplied by the difference between the allowable costs for all IHS-eligible Medicaid residents and the total amount paid for all IHS-eligible Medicaid residents, if greater than zero: and

b. The allowable Federal Medical Assistance Percentage for non-IHS eligible Medicaid residents multiplied by the difference between the allowable costs for all non-IHS-eligible Medicaid residents and the total amount paid for all non-IHS-eligible Medicaid residents, if greater than zero.

12-011.08M (Reserved)

~~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.~~

31-008 Payment for ICF/~~MR~~DD Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/~~MR~~DD services;
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.

31-008.02 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 ~~July 1, 2009~~ of the beginning of each applicable cost report period) are used in determining the cost for Nebraska ICF/~~MR~~DDs 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.

31-008.03 Allowable Costs: The following items are allowable costs under Medicaid.

31-008.03A 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 in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the 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 skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, 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, is 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.

ICF/~~MRs~~DDs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L 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 471-000-11~~4~~ for administrator compensation maximums.

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 471-000-11.

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".

31-008.05M 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 Personnel Operating and Non-Personnel Operating Cost Components for the facility.

This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost 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.

31-008.05N Facility Bed Size Exception: Rates for any privately-owned ICF/~~MR~~DD with less than 16 beds that received Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/~~MRs~~ DDs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period for non-State-operated ICF/~~MR~~DD providers is defined as July 1 through June 30. Rates paid during the Rate Period are determined from cost reports submitted for the Report Period ending June 30 two years prior to the end of the Rate Period (see 471 NAC 31-008.06C1). 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.

The Rate Period for State-Operated ICF/~~MR~~DD providers is defined as July 1 through June 30.

31-008.06B Report Period: Each facility must file a cost report each year for the reporting period ending June 30.

31-008.06C Rates for Intermediate Care Facility for ~~the Mentally Retarded~~ Persons with Developmental Disabilities (ICF/~~MR~~DD) Excluding State-Operated ICF/~~MR~~DD Providers:

31-008.06C1 ICF/~~MRs~~DDs with 16 beds or more: Subject to the allowable, unallowable, and limitation provisions of this system, the Department determines facility-specific prospective per diem rates based on the facility's allowable, reasonable and adequate costs incurred and documented during the Report Period. The rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

1. The ICF/~~MR~~DD Personnel Operating Cost Component adjusted by the inflation factor;
2. The ICF/~~MR~~DD Non-Personnel Operating Cost Component adjusted by the inflation factor;
3. The ICF/~~MR~~DD Fixed Cost Component;
4. The ICF/~~MR~~DD Ancillary Cost Component adjusted by the inflation factor; and
5. The ICF/~~MR~~DD Revenue Tax Cost Component.

An ICF/~~MR~~DD facility's prospective rate is the sum of the five components.

31-008.06C1a Durable Medical Equipment (DME) Rate Add-on: Effective August 1, 2013, facilities are responsible for costs of certain durable medical equipment. To account for these increased costs:

1. For the rate period August 1, 2013 through June 30, 2014, prospective rates will be increased by $.28/day.
2. For the rate period July 1, 2014 through June 30, 2015, prospective rates will be increased by $.28/day.
3. For the rate period July 1, 2015 through June 30, 2016, prospective rates will be increased by $.02/day.
4. For the rate periods after June 30, 2016, prospective rates will not be increased by a DME rate add-on.

31-008.06C2 ICF/~~MR~~sDDs with 4-15 beds:

31-008.06C2a Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06C2b Final Rate: The Department pays each ICF/~~MR~~DD with 4-15 beds a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/~~MR~~ DD Revenue Tax Cost Component. This component is not retroactively settled (see 31-008.06C8b).

The final rate is the sum of the above five components.

31-008.06C3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry and housekeeping, property and plant, and administrative services.

3. 30 percent of the weighted mean for all ICF/~~MR~~ DD facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under 471 NAC 31-008.06C7. The mean will be weighted by the Nebraska Medicaid ICF/~~MR~~DD days.

31-008.06C4b ICF/~~MR~~sDDs with 4-15 beds: The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/~~MR~~ DD provider's most recent cost report period.

31-008.06C5 ICF/~~MR~~DD Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C6 ICF/~~MR~~DD Ancillary Cost Component: The ancillary cost component of the rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C7 ICF/~~MR~~DD Inflation Factor: The Inflation Factor is determined from spending projections computed using:

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

31-008.06C8 ICF/~~MR~~DD Revenue Tax Cost Component:

31-008.06C8a ICF/~~MR~~sDDs with 16 or more beds: Under the ICF/~~MR~~ DD Reimbursement Protection Act, the ICF/~~MR~~ DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003). The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06C8b ICF/~~MR~~sDDs with 4-15 beds: Under the ICF/~~MR~~DD Reimbursement Protection Act, the ICF/~~MR~~DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/~~MR~~DD provider's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs. The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/~~MR~~DD provider's most recent cost report period.

31-008.06D6 ICF/~~MR~~DD Revenue Tax Cost Component: Under the ICF/~~MR~~DD Reimbursement Protection Act, the ICF/~~MR~~DD revenue tax per diem is computed as the prior report period net revenue multiplied by the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.) The Tax Cost Component shall be prorated when the revenue tax is based on less than a full fiscal year's data.

31-008.06E Out-of-State Facilities: The Department pays out-of-state facilities participating in Medicaid at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.16 Additional Payment to Non-State-Operated Intermediate Care Facility for ~~the Mentally Retarded~~ Persons with Developmental Disabilities (ICF/~~MR~~ DD) Providers: In accordance with Neb. Rev. Stat. § 68-1804~~(4)~~(3)(d), non-state-operated ICF/~~MR~~DD providers are eligible to participate in an additional distribution. ~~Beginning in~~ For FY2011-12 ~~and each fiscal year thereafter~~, FY2012-13, and FY2013-14, on the second Wednesday of May, the Department will determine the amount available in the ICF/~~MR~~DD Reimbursement Protection Fund. Following the distributions of the payments identified in Neb. Rev. Stat. § 68-1804~~(4)~~(3)(a-c), the amount remaining in the Fund, not to exceed a total of $600,000, will be distributed to non-state-operated ICF/~~MR~~DD providers by the end of May of each year based on the following methodology:

1. On the second Wednesday of May each year, the number of Medicaid resident days paid for the period from the preceding July through March will be determined for each provider; and
2. Each provider's percentage of the total will then be determined and multiplied by the amount remaining in the Fund, not to exceed a total of $600,000, in order to determine the payment for each provider.