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State/Territory Name: Nebraska

State Plan Amendment (SPA) #: 21-0008

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

December 22, 2021

Kevin Bagley, DHA, Director
Division of Medicaid and Long Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: Nebraska SPA 21-0008

Dear Mr. Bagley:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0008. This amendment updates Nursing Facility rates for SFY 2022.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2021. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: NE 21-0008

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2021 $1,733,288
b. FFY 2022 $5,322,333

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-D, pg 15 & 15a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-D, pg 15 & 15a

10. SUBJECT OF AMENDMENT:
Nursing Facility Rates for SFY22

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Kevin Bagley

14. TITLE:
Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
September 29, 2021

16. RETURN TO:

Dawn Kastens
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/29/2021

18. DATE APPROVED:
December 22, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2021

20. [redacted]ONAL OFFICIAL:

21. TYPED NAME: Rory Howe

22. TITLE: Director

23. REMARKS:

FORM HCFA-179 (07-92)

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's base year allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total base year inpatient days (see 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, plus any prior approved increase under 12-011.08E, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

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

For purposes of this section, facilities exempt from the Quality Assurance Assessment are:
1. State-operated veterans homes;
2. Nursing facilities and skilled nursing facilities with twenty-six or fewer licensed beds; and
3. Continuing care retirement communities.

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

For each rate year, July 1 through the following June 30th, total facility patient days, including bed hold days, less Medicare days, for the four most recent calendar quarters available at the time rates are determined will be used to calculate the 'anticipated tax payments.' Total facility patient days, including bed hold days and Medicare days, for the same four calendar quarters will be used to calculate the 'anticipated nursing facility/skilled nursing facility patient days.'

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

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

Existing providers changing from non-exempt to exempt status:
For Rate Periods beginning with the first day of the first full month the provider is exempt from the Quality Assurance Assessment, the quality assessment rate component will be $0.00 (zero dollars).

12-011.08D5 Base Year Report Period and Inflation Factor: For the Rate Periods July 1 through December 31, 2021, and January 1 through June 30, 2022, the base year is the report period ending June 30, 2018; and the inflation factor is positive 15.99%.

12-011.08D6 Quality Measures Component: This component of the prospective rate is based on the Quality Measures component of the CMS Nursing Facility Star Rating system, published at https://www.medicare.gov/nursinghomecompare/search.html. The published rating as of May 1 is used to determine the rate component for the following July 1 through December 31 rate period. The published rating as of November 1 is used to determine the rate component for the following January 1 through June 30 rate period.

Per diem amounts corresponding to the Quality Measures rating are:
5 star rating = $10.00/day
4 star rating = $6.75/day
3 star rating = $3.50/day
1 star, 2 star, or NR (no rating) = $0.00 (zero)

This component applies to all nursing facility care levels (101-180).

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Medicaid Director or designee, to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. For existing facilities, an exception may only be requested if the facility's total annualized fixed costs (total costs, not per diem rate), as compared to the annualized base year costs, have increased by twenty percent or more. Facilities without a base year cost report, and with 1,000 or more annualized Medicaid days, may only request an exception if the facility's fixed costs per day, computed using an 85% minimum occupancy, exceeds the Care Classification average Fixed Cost Component by twenty 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 20 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).

Approved increases from July 1 through December 31, will be effective the following January 1. Approved increases from January 1 through June 30, will be effective the following July 1.

12-011.08F Rate Payment for Levels of Care 101, 102, 103, and 104: 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 adjusted to include the Nursing Facility Quality Assessment Component and Quality Measures Component (see 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.