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State/Territory Name: Nebraska

State Plan Amendment (SPA) #: 20-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



Financial Management Group

October 15, 2020

Jeremy Brunssen, DHA, Interim 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 20-0009

Dear Mr. Brunssen:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0009. This amendment rebases Intermediate Care Facility for Individuals with Intellectual Disabilities payment rates. Provider reported base costs are adjusted so that state fiscal year 2021 ICF-IID payment rates will result in aggregate expenditures remaining within legislative appropriation increases.

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, 2020. We are enclosing the CMS-179 and the amended approved plan page.

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

Sincerely,

[Redacted Signature]

For

Rory Howe
Acting Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: NE 20-0009	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, 2020	

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

NEW STATE PLAN
 AMENDMENT TO BE CONSIDERED AS NEW PLAN
 AMENDMENT

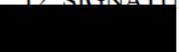
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2020 \$201,709 b. FFY 2021 \$617,690
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-D, Page 67	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Att. 4.19-D, Page 67

10. SUBJECT OF AMENDMENT:
Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Rates for SFY21

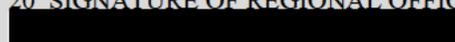
11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 OTHER, AS SPECIFIED: Governor has waived review
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Jeremy Brunssen	
14. TITLE: Interim Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: August 13, 2020	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 08/13/2020	18. DATE APPROVED: 10/15/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020	20. SIGNATURE OF REGIONAL OFFICIAL:  For
21. TYPED NAME: Rory Howe	22. TITLE: Acting Director

23. REMARKS:

31-008.06C4b ICF/IIDs 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/IID provider's most recent cost report period.

31-008.06C5 ICF/IID 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/IID 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/IID Inflation Factor: The Inflation Factor is determined from spending projections computed using:

1. Audited cost and census data following the initial desk audits;
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).

For the Rate Period of July 1, 2020 through June 30, 2021, the inflation factor is positive 25.03%.

31-008.06C8 ICF/IID Revenue Tax Cost Component:

31-008.06C8a ICF/IIDs with 16 or more beds:

Under the ICF/DD Reimbursement Protection Act, the ICF/IID revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentage(s) divided by the prior report period facility resident days. 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/IIDs with 4-15 beds:

Under the ICF/DD Reimbursement Protection Act, the ICF/IID revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentage(s) divided by the prior report period facility resident days. The Tax Cost Component shall be prorated when the revenue tax is based on less than a full year's data.

31-008.06C9 ICF/IID 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 increases(s).

TN #. NE 20-0009

Supersedes

Approval Date 10/15/20

Effective Date 07/01/2020

TN #. NE 19-0008