NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY KINSLEY • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

SIGNATURE REQUEST MEMORANDUM

TO: Dave Richard DR

FROM: Cecilia Williams, SPA Coordinator

RE: State Plan Amendment

Title XIX, Social Security Act
Transmittal #2022-0035

Purpose
Attached for your review and signature is a Medicaid State Plan amendment, summarized below, and submitted on December 15, 2022, with a due date of December 15, 2022.

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Cecilia Williams, Betty J. Staton, Emma Sandoe, Melanie Bush, Lotta Crabtree and Adam Levinson

Background and Summary of Request
It is recommended that you sign the State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-D Pages 4, 5, and 6 of the North Carolina Medicaid State Plan. This amendment will modify the structure of the existing provider assessment on nursing facility services. Additionally, the modification will allow state authority to reinvest the additional provider tax collections and associated federal matching dollars into an increase in Medicaid rates for nursing facilities.

Your approval of this State Plan Amendment is requested. If you have any questions or concerns, please contact me or Cecilia Williams at (919) 270-2530.

(ii) The facility's per diem neutralized case-mix adjusted cost times the Medicaid resident-day weighted average case-mix index, plus the facility's per diem non case -mix adjusted cost.

The incentive allowance is equal to 100% times the difference (if greater than zero) of (i) minus (ii) as calculated above.

(H) The Division of Health Benefits may negotiate direct rates that exceed the facility's specific direct care ceiling for ventilator dependent and head injury patients. Payment of such special direct care rates shall be made only after specific prior approval of the Division of Health Benefits.

(I) The statewide direct care ceiling will be adjusted annually using the index factor set forth in Section .0102(e). The facility's base year per diem neutralized case-mix adjusted cost plus the facility's base year per diem non-case-mix adjusted cost will be adjusted annually using the index factor set forth in Section .0102(e).

(J) Effective for Medicaid rates beginning November 1, 2022, a direct care facility stabilization per diem is added to the nursing facility payment rate and is intended to reimbursement providers for the additional direct care costs incurred beyond the standard inflationary rate adjustment. The add-on for each facility shall be $31.90 per Medicaid resident day.

(3) The indirect rate is intended to cover the following costs of an efficiently and economically operated facility:
(A) Administrative and General,
(B) Laundry and Linen,
(C) Housekeeping,
(D) Operation of Plant and Maintenance/Non-Capital,
(E) Capital/Lease,
(F) Medicaid cost of Indirect Ancillary Services.

(4) Effective for dates of service beginning October 1, 2003, the indirect rate will be standard for all nursing facilities. Each facility's per diem indirect cost is the sum of 1) the facility's indirect base year cost, excluding the Medicaid cost of indirect ancillary services, divided by the facility's total base year inpatient days plus 2) the facility's Medicaid cost of indirect ancillary services base year cost divided by the facility's total base year Medicaid resident days. The base year per diem indirect cost, excluding property ownership and use and mortgage interest shall be trended forward using the index factor set forth in Section .0102(e) of this section. Each facility's base year per diem indirect cost is arrayed from low to high and the Medicaid-day-weighted median cost is determined. The indirect rate is established at 100 percent of the Medicaid-day-weighted median cost. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(c) Nursing facility assessments. An adjustment to the nursing facility payment rate calculated in accordance with Section .0102(b) is established, effective October 1, 2003, to reimburse Medicaid participating nursing facilities for the provider's assessment costs that are incurred for the care of North Carolina Medicaid residents. No adjustment will be made for the provider's assessment costs that are incurred for the care of privately paying residents or others who are not Medicaid eligible.

(d) Fair Rental Value Payment for Capital. Effective for dates of service on or after January 1, 2007, the nursing facility capital related costs shall be reimbursed under a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost. This payment is considered to cover costs related to land, land improvements, renovations, repairs, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator.

(1) New facilities are those entities whose beds have not previously been certified to participate or otherwise participated in the Medicaid program immediately prior to the operation of the new owner. A new facility's rate will be determined as follows and will continue to be reimbursed under this section until the incentive allowance percentage referenced in the applicable Section .0102(b)(2)(F) or .0102(b)(2)(G) is equal to 100%:

(A) The direct care rate for new facilities will be equal to the statewide Medicaid day weighted average direct care rate that is calculated effective on the 1st day of each calendar quarter. After the second full calendar quarter of operation, the statewide Medicaid day-weighted average direct care rate in effect for the facility shall be adjusted to reflect the facility's Medicaid acuity and the facility's direct care rate is calculated as the sum of the following:

(i) Prior to rates effective April 1, 2022,

a.) 65 percent of the statewide Medicaid day-weighted average direct care rate multiplied by the ratio of the facility's Medicaid average case-mix index (numerator) to the statewide Medicaid day-weighted average Medicaid case-mix index (denominator).

b.) For rates effective April 1, 2022 and after, 65 percent of the statewide Medicaid day-weighted average direct care rate multiplied by the ratio of the facility's Medicaid resident-day-weighted average case-mix index (numerator) to the statewide Medicaid resident day-weighted average case-mix index (denominator).

(ii) The statewide Medicaid day-weighted average direct care rate times 35%.

(B) The indirect rate for a new facility will be equal to the standard indirect rate in effect at the time the facility is enrolled in the Medicaid Program. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(C) A new facility's rate will include the direct care facility stabilization per diem determined in accordance with Section .0102(b)(2)(J) and the nursing assessment adjustment calculated in accordance with Section .0102(c).

(2) Transfer of ownership of existing facilities. Transfer of ownership means, for reimbursement purposes, a change in the majority ownership that does not involve related parties or related entities including, but not limited to, corporations, partnerships and limited liability companies. Majority ownership is defined as an individual or entity that owns more than 50 percent of the entity, which is the subject of the transaction. The following applies to the transfer of ownership of a nursing facility:

(A) For any facility that transfers ownership, the new owner shall receive a per diem rate equal to the previous owner's per diem rate less any return on equity adjustment received by the previous owner, rate adjusted quarterly to account for changes in its Medicaid average case-mix index. The old provider's base year cost report shall become the new facility's base year cost report until the new owner has a cost report included in a base year rate setting.

(B) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control of ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid program, regardless of when the services were rendered.

(g) Each out-of-state provider is reimbursed at the lower of the appropriate North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate or the provider's payment rate as established by the state in which the provider is located. For patients with special needs who must be placed in specialized out of-state facilities, a payment rate that exceeds the North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate may be negotiated. A facilities' negotiated rate for specialized services is based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review.

(h) Specialized Service Rates:

(1) Head Injury Intensive Rehabilitation Services –

(A) A single all-inclusive prospective rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive rehabilitation services for head injured patients as specified by criteria in Appendix 3 to Attachment 3.1-A of the State Plan. The rate may exceed the maximum rate applicable to other Nursing Facility services. A facility must specialize to the extent of staffing at least fifty percent (50%) of its nursing facility licensed beds for intensive head injury rehabilitation services. The facility must also be accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF).

(B) A facility's initial rate is negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review upon the completion of an audited full year cost report. The negotiated rate shall not be less than the North Carolina statewide Medicaid day-weighted average direct care plus the indirect rate. A complete description of the facility's medical program must also be provided. Rates in subsequent years are determined by applying the index factor as set forth in Section .0102(e) to the rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice. Effective for dates of service provided on or after December 1, 2016 the rates are frozen at the rates in effect as of June 30, 2015. All rates are published on the website at https://medicaid.ncdhhs.gov/feeschedule-index.

(C) Cost reports for this service shall be filed in accordance with Section .0104 but there shall not be cost settlements for any difference between cost and payments. The negotiated rate is considered to provide payment for all financial considerations and shall not include the fair rental value adjustment as defined in Section .0102 but shall include the nursing assessment adjustment as defined in Section .0102. The negotiated rate will be paid to the facility for services provided to head injured patients only. The per diem payment rate for non-head injured patients shall be the rate calculated in accordance with Section .0102 (b)–(e).