State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

(C) The base year per diem neutralized case-mix adjusted cost and the base year per diem non-case-mix adjusted cost are summed for each nursing facility. Each facility's base year per diem result is arrayed from low to high and the Medicaid day weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

(D) The statewide direct care ceiling is established at 105 percent of the base year neutralized case-mix adjusted and non-case mix adjusted Medicaid day-weighted median cost.

(E) For each nursing facility, the statewide direct care ceiling shall be apportioned between the per diem case-mix adjusted component and the per diem non-case-mix adjusted component using the facility-specific percentages determined in .0102(b)(2)(C).

(F) On a quarterly basis, each facility's direct care rate shall be adjusted to account for changes in its Medicaid average case-mix index. The facility's direct care rate is determined as the lesser of (i) or (ii) as calculated below plus an incentive allowance.

(i) The facility's specific case-mix adjusted component of the statewide ceiling times the facility's Medicaid average case-mix index, plus each facility's specific non-case mix adjusted component of the statewide ceiling.

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

Effective January 1, 2008, the incentive allowance is equal to 100% times the difference (if greater than zero) of (i) minus (ii) as calculated above. The Division of Medical Assistance 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 Medical Assistance.

(G) For rates effective April 1, 2012, a Medicaid average case-mix index calculated for the snap shot dates September 30, 2011 and December 31, 2011, less any MDS review adjustments, shall be used to adjust the case-mix adjusted component of the statewide direct care ceiling. Effective July 1, 2012, the average case mix adjustment will return to a quarterly adjustment based on the prior quarter.

(3) The initial age of each nursing facility used in the FRV calculation was determined from the 2004-2005 Capital Data Survey, using each facility's year of construction. This may be reduced for replacements, renovations and/or additions which are recorded on the Capital Data Survey to be filed annually with the Medicaid cost report. The age of the facility will be further adjusted each April 1 to make the facility one year older, up to the maximum age of 32 ½ years, and to reduce the age for those facilities that have completed and placed into service major renovation or bed additions. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. If a facility performed a major renovation/replacement project (defined as a project with capitalized cost equal or greater than $500 per licensed bed), the cost of the renovation project completed as of September 30th will be used to determine the weighted average age of all beds for this facility. To compute the weighted average of the beds, do a weighted average using the number of beds in the age group (value) as the weight. First, multiply each value by its weight. Second, add up the products of age multiplied by weight to get the total value. Third, add the weights together to get the total weight. Fourth, divide the total value by the total weights. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation/replacement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation project.

(e) Index factor. The index factor shall be based on the Skilled Nursing Facility Market Basket without Capital Index published by Global Insight using the most current quarterly publication available annually as of August 1. If necessary, the Division of Medical Assistance shall adjust the annual index factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations.

(f) New Facilities and Transfer of Ownership of Existing Facilities

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Payment for Nursing Facility Beds – Continued:

SFY 2016 – Effective July 1, 2015, rates will be frozen at the rates in effect on June 30, 2015. There will be no further adjustments this state fiscal year.

SFY 2017 – Effective October 1, 2016, the overall rate reduction adjustment of 1.30% implemented in FY 2009 – 2010 and the flat 2.17 % reduction on the direct and indirect components of the Nursing Facility rates implemented in FY 2012 – 2013 will be removed from rate calculations and rates will be adjusted accordingly. Effective October 1, 2016, the case mix for direct care services will be unfrozen. Rates will be thereafter adjusted pursuant to the reimbursement methodology in Attachment 4.19-D.

Reference: Attachment 4.19-D, Page 1 thru 5