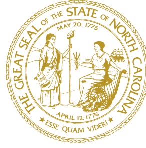

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

December 9, 2021

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2021-0024

Dear Mr. Scott:

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 2a, 3, 4, 4a, 4b, 4c, 5, 20, and 21.

This state plan amendment will allow Medicaid to revise the Skilled Nursing Facility reimbursement section in Attachment 4.19-B of the Medicaid State Plan. This amendment will include (a) revision of the methodology used to calculate fair rental value (FRV) rate components and (b) to initiate the transition from the Point -in-Time Case Mix Index (CMI) reporting method to the Time Weighted CMI reporting methodology.

This amendment is effective October 1, 2021.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at 919-538-3215.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

Enclosures

(2) Each facility's direct care rate shall be determined as follows:

(A) The per diem case-mix adjusted cost is determined by dividing the facility's case-mix adjusted base year cost by the facility's total base year inpatient days. This case-mix adjusted base year cost per diem shall be trended forward using the index factor set forth in Section .0102(e). A per diem neutralized case-mix adjusted cost is then calculated by dividing each facility's case-mix adjusted per diem cost by the facility cost report period case-mix index. Prior to rates effective April 1, 2022, the facility cost report period case-mix index is the resident-weighted average (Point-In-Time) of quarterly facility-wide average case-mix indices, carried to four decimal places. For rates effective April 1, 2022 and after, the facility cost report period case-mix index is the resident-day-weighted average case-mix (Time-Weighted) indices, carried to four decimal places updated for every Medicaid participating nursing facility each calendar quarter. The quarters used in this average will be the quarters that most closely coincide with the facility's base year cost reporting period. Example: An October 1, 2000 – September 2001 cost report period would use the facility-wide average case-mix indices for quarters ending December 31, 2000, March 31, 2001, June 30, 2001, and September 30, 2001.

(B) The per diem non-case-mix adjusted cost is determined by dividing the facility's non-case-mix adjusted base year cost, excluding the Medicaid cost of direct ancillary services, by the facility's total base year inpatient days plus the facility's Medicaid cost of direct ancillary services base year cost divided by the facility's total base year Medicaid resident days. This non-case-mix adjusted base year cost per Diem shall be trended forward using the index factor set forth in Section .0102(e).

(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) Prior to rates effective April 1, 2022, on a quarterly basis, each facility's direct care rate shall be adjusted on the second quarter following the updated Medicaid average case-mix index to account for changes in its Medicaid average case-mix index. Example – Rates effective for the quarter beginning April 1, 2022 will be based on the quarter ending December 31, 2021 time weighted case mix. 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.

(G) For rates effective April 1, 2022 and after, on a quarterly basis, each facility's direct care rate shall be adjusted on the second quarter following the updated Medicaid resident-day-weighted average case-mix index to account for changes in its Medicaid resident-day-weighted 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 resident-day-weighted 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 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).

(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) FRV Rate Year. Each provider shall receive a new capital per diem rate each year effective April 1st. The FRV payment rate shall be a facility specific per diem rate determined each year, using the data available from the Capital Data Surveys as of the previous September 30th. Capital Data Surveys will be submitted annually on or before December 31 covering the prior 12 month period ending September 30. For determining the new capital per diem rate effective April 1, 2022, the Capital Data Survey may cover a 24 month period ending September 30, 2021. The per diem shall be determined prospectively and shall apply for an entire FRV rate year. FRV data elements that are not provider specific, including those published by Gordian in its Square Foot Costs with RSMeans data publication (or its successor publication) and the rental rate as determined by the Rolling 3-Year Average of the 10 Year US Treasury Bond interest rate, shall be determined annually on or about July 1st and shall apply to provider rates effective on the subsequent April 1st.

(2) Calculation of FRV Per Diem Rate for Capital. Effective October 1, 2021, the new value construction cost per square foot shall be $222.96. For FRV Per Diem rates effective April 1, 2022 and annually on April 1 of each year thereafter, the new value construction cost of $222.96 per square foot shall be updated based on the historical cost index factor each July 1st as published annually in the Square Foot Costs with RSMeans data publication. The standard square feet per nursing bed used in the rate calculation shall be the current actual square feet per nursing bed of the facility, subject to a maximum of 700 square feet per nursing bed and a minimum square footage per nursing bed. The minimum square footage per nursing bed shall be based on facility FRV age as follows: 0 up to 10 years, 425 square feet per nursing bed; greater than 10 up to 20 years, 400 square feet per nursing bed; greater than 20 up to 25 years, 375 square feet per nursing bed; greater than 25 up to 30 years, 350 square feet per nursing bed; greater than 30 years, 325 square feet per nursing bed. A nursing facility's fair rental per diem is calculated as follows.

(A) The fixed capital replacement value is calculated by multiplying the number of licensed beds by the standard square feet per nursing bed as determined above; multiply this product by the October 1, 2021 new value construction cost per square foot of $222.96 (this value will be updated for rates effective April 1, 2022 and annually thereafter each April 1st)**;** multiply this product by the appropriate location factor in the RSMeans data publication for rates effective April 1, 2021, and updated annually thereafter). Location factors are determined by the state and the first three digits of the facility location zip code.

To the fixed capital replacement value add the product of the total licensed beds times $9,000 for equipment. This result shall be depreciated at 2.00 percent per year according to the weighted average age of the facility. Bed additions, replacements and renovations may lower the weighted age of the facility. The maximum calculated age of a nursing facility shall be 32.5 years in 2021; 33.5 years in 2022; 34.5 years in 2023; 35.5 years in 2024; 36.5 years in 2025; and 37.5 years in 2026 and thereafter. Therefore, nursing facilities shall not be depreciated to an amount less than 35 percent or (100 percent minus (2.00 percent * 32.5)) in 2021; 33 percent or (100 percent minus (2.00 percent * 33.5)) in 2022; 31 percent or (100 percent minus (2.00 percent * 34.5)) in 2023; 29 percent or (100 percent minus (2.00 percent * 35.5)) in 2024; 27 percent or (100 percent minus (2.00 percent * 36.5)) in 2025; 25 percent or (100 percent minus (2.00 percent * 37.5)) in 2026 and thereafter of the new bed value. There shall be no recapture of depreciation. This result is the total depreciable capital assets.

(B) The land value is calculated by multiplying the fixed capital replacement value by 15 percent. The total replacement value is the sum of the land value plus the total depreciable capital assets.

(C) A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's total replacement value by a rental factor. The rental factor shall be determined by a rolling 3-Year average of the yield on the 10 Year US Treasury Bond (monthly frequency) as of July of the previous year plus a risk factor of 3.0 percent with an imposed floor of 7.5 percent and a ceiling of 9.5 percent. The risk factor of 3.0 percent with an imposed floor of 7.5 percent and a ceiling of 9.5 percent was negotiated with the nursing home industry. The Medicaid bed annual FRV is calculated by multiplying the annual fair rental value by the Medicaid utilization percentage.

(D) Effective October 1, 2021, to calculate the Medicaid FRV per diem rate the nursing facility's Medicaid bed annual FRV shall be divided by the greater of (i) the facility's annualized Total Medicaid Days as reported on the 2019 Medicaid cost report; or (ii) 85 percent of the annualized licensed capacity of the facility multiplied by the Medicaid utilization percentage, to determine the FRV per diem (capital component of the rate). Each April 1st thereafter, the FRV calculation will utilize the most recent year of audited cost report patient days.

(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 by December 31st. 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 32.5 years in 2021; 33.5 years in 2022; 34.5 years in 2023; 35.5 years in 2024; 36.5 years in 2025; and 37.5 years in 2026 and thereafter, 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.

(4) Facilities exceeding the maximum age shall not receive greater than a $1.00 per diem annual increase in the Medicaid FRV per diem rate.

(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.

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

(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 also 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.

.0105 CASE-MIX INDEX CALCULATION

(a) The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility to the Division of Facility Services. The following case-mix indices shall be the basis for calculating facility average case-mix indices and the resident-day-weighted average case-mix indices to be used in determining the facility's direct care rate.

RUG Code	Case-Mix Index	RUG Code	Case-Mix Index	RUG Code	Case-Mix Index
SE3	2.08	CB2	1.13	PE2	0.97
SE2	1.70	CB1	1.01	PE1	0.96
SE1	1.45	CA2	1.02	PD2	0.91
RAD	1.68	CA1	0.92	PD1	0.83
RAC	1.41	IB2	0.89	PC2	0.82
RAB	1.28	IB1	0.82	PC1	0.80
RAA	1.06	IA2	0.74	PB2	0.66
SSC	1.40	IA1	0.64	PB1	0.61
SSB	1.29	BB2	0.86	PA2	0.60
SSA	1.25	BB1	0.80	PA1	0.57
CC2	1.39	BA2	0.72		
CC1	1.23	BA1	0.61		

(b) Prior to October 1, 2021, each resident in the facility on the last day of each quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available with an assessment reference date on or prior to the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a". If the most current assessment available with an assessment reference date on or prior to the last day of the calendar quarter is a delinquent MDS then the RUG-III code assigned shall be a BC1-delinquent and the lowest case-mix index in paragraph "a" will be applied. A delinquent MDS is defined as 121 days from the A2300 date of the MDS assessment reference date. From the individual resident case-mix index, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

(c) Effective for assessments active as of October 1, 2021, each completed and submitted assessment that has been transmitted and accepted by CMS shall be assigned a RUG-III 34 group. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph “a”. If the assessment is a delinquent MDS then the RUG-III code assigned shall be a BC1-delinquent and the lowest case-mix index in paragraph “a” will be applied. A delinquent MDS is defined as 121 days from the A2300 date of the MDS assessment (assessment reference date). Two case-mix indices for each Medicaid participating nursing facility shall be determined each calendar quarter. The facility resident-day-weighted average case-mix index shall be based on the resident assessments that are active for all residents in the facility during the calendar quarter calculated on a facility-average day-weighted basis. The Medicaid resident-day-weighted average case-mix index shall be based on the Medicaid resident assessments that are active for all Medicaid residents in the facility during the calendar quarter calculated on a facility-average day-weighted basis.

(d) Prior to October 1, 2021, the facility-wide average case-mix index is the simple-average, carried to four decimal places, of all resident case-mix indices. The Medicaid case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid or Medicaid pending is known to be the per diem payor source on the last day of the calendar quarter ending September 30, 2021 or prior.

(e) Effective for assessments active as of October 1, 2021, the facility resident-day-weighted average case-mix index is the average, carried to four decimal places, of all resident assessment case-mix indices. The Medicaid resident-day-weighted average case-mix index is the average, carried to four decimal places, of all indices for residents where Medicaid or Medicaid pending is known to be the per diem payor source.

.0106 RECONSIDERATION REVIEWS

(a) Providers may either accept agency reimbursement determinations or request a reconsideration review in accordance with the procedures set forth in 10A NCAC 22I and 22J.

(b) Indirect rates shall not be adjusted on reconsideration review.

(c) Direct rates may be adjusted for the following reasons:

(1) to accommodate any changes in the minimum standards or minimum levels of resources required in the provision of patient care that are mandated by state or federal laws or regulations.

(2) to correct any adjustments or revisions to ensure that the payment rate is calculated in accordance with Section .0102.