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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 12-001

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

CMS
CENTERS for MEDICARE & MEDKAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

DEC 13, 2012

Mr. Albert A Delia
Acting Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

RE: SPA NC 12-001

Dear Secretary Delia:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-001. Effective April 1, 2012 this amendment proposes to revise the payment methodology for nursing facility services. Specifically, the amendment proposes to implement a 3.129% increase in provider rates effective April1, 2012, unfreeze the case mix index quarterly rate adjustment, and implement a prospective cost based reimbursement method to establish annual rates for nursing facilities owned and operated by an Indian Tribe, Tribal organization for Urban Indian Organization. In addition, effective July 1, 2012 the state will implement a 2.17% decrease in rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CPR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of April1, 2012 and July 1, 2012. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

//s//

Cindy Mann
Director, CMCS

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: **12-001**	2. STATE **NC**
	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 **April 1, 2012**	

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: 42 CFR 413.310	7. FEDERAL BUDGET IMPACT: a. **FFY 2012 $4,814,302** b. **FFY 2013 $1,313,049**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Page 2, Attachment 4.19-D, Page 2a, Attachment 4.19-D, Page 3, Attachment 4.19-D, Page 4b, Attachment 4.19-D, Page 4c, Attachment 4.19-D, Page 11, Attachment 4.19-D, Page 24, and Attachment 4.19-D, Supplement 1, Page 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Page 2, Attachment 4.19-D, Page 3, Attachment 4.19-D, Page 4b, Attachment 4.19-D, Page 4c, Attachment 4.19-D, Page 11, Attachment 4.19-D, Page 24, and Attachment 4.19-D, Supplement 1, Page 3

10. SUBJECT OF AMENDMENT:

Nursing Facilities

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: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001
13. TYPED NAME: Albert A. Delia	
14. TITLE: Secretary	
15. DATE SUBMITTED: 05-03-12	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 05/03/14	18. DATE APPROVED: 12/13/12
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/12 and 07/01/12	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director, CMS

23. REMARKS: Approved with following changes as authorized by state agency:

Block #4 Changed to read: April 1, 2012 and July 1, 2012.

Block # 7a changed to read: FFY 2012 $2,651,095 and FFY 2013 16,206,763.

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.0102 RATE SETTING METHODS

(a) A rate for nursing facility care is determined quarterly for each facility to be effective for dates of service for a three-month period beginning the first day of each calendar quarter. Rates are derived from audited cost reports for a base year period to be selected by the state. Audited cost reports for a base year is defined as desk audits performed on all Medicaid nursing facility cost reports filed for the base year plus a minimum of fifty (50) field audits on Medicaid nursing facility cost reports filed for the base year. The selection of field audits includes, but is not limited to, a risk based selection of providers with a direct cost per patient day above or below the Medicaid day weighted median direct cost per patient day. The selection of field audits also includes, but is not limited to, a risk based selection of providers with an indirect cost per patient day above or below the Medicaid day weighted median indirect cost per patient day. For rates effective January 1, 2008, the FY05 cost reports shall be used as the base year period. Cost reports are filed and audited under provisions set forth in Section .0104.

(b) Each prospective rate consists of two components – a direct care rate and an indirect rate – computed and applied as follows:

(1) The direct care rate is that portion of the Medicaid daily rate that is attributable to:

(A) Case-mix adjusted costs defined as
- (i) registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
- (ii) a direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and
- (iii) the direct allowable cost of contracted services for RN, LPN and nurse aide staff from outside staffing companies.

(B) Non-case-mix adjusted costs defined as
- (i) Nursing supplies;
- (ii) Dietary or Food Service;
- (iii) Patient Activities;
- (iv) Social Services
- (v) A direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and
- (vi) Medicaid cost of Direct Ancillary services.

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(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. The facility cost report period case-mix index is the resident-weighted average of quarterly facility-wide average case-mix indices, carried to four decimal places. 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).

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(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 102.6 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.

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(B) The fixed capital replacement value is calculated by multiplying the new value construction cost per square foot of $127.00 by the historical cost index factor by the location factor by the standard square footage. 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 and the Medicaid utilization percentage.

(D) Effective January 1, 2007, to calculate the Medicaid FRV per diem rate the nursing facility's Medicaid annual fair rental value shall be divided by the greater of the facility's annualized Total Patient Days as reported on the 2005 Medicaid cost report or 90 percent of the annualized licensed capacity of the facility to determine the FRV per diem (capital component of the rate). Subsequently effective April 1, 2008, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized Total Patient Days as reported on the 2006 Medicaid cost report or 90 percent of the annualized licensed capacity of the facility to determine the FRV per diem. Each April 1st, the FRV calculation will utilize the most recent year of audited cost report patient days.

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(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. The index factor shall not exceed that approved by the North Carolina General Assembly. 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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.0104 COST REPORTING: AUDITING

(a) Each facility that receives payment from the North Carolina Medicaid Program must prepare and submit an annual report of its costs, including costs to meet the requirements of OBRA 87 (section 1919 of the Social Security Act) and other financial information to include, the facility's original working trial balance, year-end adjusting journal entries, and the facility's daily midnight census records for the cost reporting period. Pursuant to 42 CFR § 413, the report must include costs from the provider's fiscal period and must be submitted to the state; nursing facilities must submit cost reports within five (5) months after the provider's fiscal year end; hospital based nursing facility providers must submit cost reports pursuant to this plan, Attachment 4.19-A, Page 26, Paragraph (b). Facilities that fail to file their cost reports by the due date are subject to payment suspension as provided for under Section .0107(d)(4) until the reports are filed. The Division of Medical Assistance may extend the deadline 30 days for filing the report if, in its view, good cause exists for the delay. A good cause is an action that is uncontrollable by the provider. Cost report due date extensions must be requested by the facility and approved by the Division prior to the original filing deadline.

(b) Cost report format. For cost reports filed with the Division on or after January 1, 2012, for fiscal periods ending after September 30, 2011, nursing facilities shall use the CMS 2540 and hospital based nursing facility providers shall use the CMS 2552. These cost reports shall be completed in accordance with Medicare Reimbursement Principles and shall include supplemental schedules which are furnished by the Division to comply with the provisions of this plan. (c) Cost finding and allocation. Costs must be reported in the cost report and supplemental schedules in accordance with the following rules and in the order of priority stated.

(1) Costs must be reported in accordance with the specific provisions of this plan as set forth in this Section.

(2) Costs must be reported in conformance with the Medicare Provider Reimbursement Manual, CMS Publication 15.

(3) Costs must be reported in conformance with Generally Accepted Accounting Principles.

(1) Upon determination of any sum due the Medicaid Program or upon instruction from a legally authorized agent of State or Federal Government, the state may withhold sums to meet the obligations identified.
(2) The state may arrange repayment schedules within the limits set forth in federal regulations in lieu of withholding funds.
(3) The state may charge reasonable interest on over-payments from the date that the overpayment occurred.
(4) The State may withhold up to twenty (20) percent per month of a provider's payment for failure to file a timely cost report and associated accounting records. The funds will be released to the provider after a cost report is acceptably filed. The provider will experience delayed payment while the check is routed to the State and split for the amount withheld.

.0108 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

(a) A certified State-operated nursing facility is reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its patients and to comply with federal and state laws and regulations. The costs are determined in accordance with Sections .0103 and .0104 except that annual cost reports are required for the fiscal year beginning on July 1 and ending on the following June 30 and must be submitted to the Division of Medical Assistance within 150 days after their fiscal year end. Payments will be suspended if reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report, if in its view; good cause exists for the delay. The Medicare principles for the reimbursement of skilled nursing facilities will be utilized for the cost principles that are not specifically addressed in the State Plan.
(b) A per diem rate based on the provider's estimated annual cost divided by patient days will be used to make interim payments. A desk audit will be performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.

.0109 REIMBURSEMENT METHODS FOR TRIBAL OPERATED FACILITIES

(a) A nursing facility owned and operated by an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in section 1139(c) of the Social Security Act shall be reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its patients and to comply with federal and state laws and regulations. The costs are determined in accordance with sections .0103 and .0104 except that annual cost reports are required for the fiscal year beginning on October 1 and ending on the fallowing September 30 and must be submitted to the Division of Medical Assistance within 90 days after their fiscal year end. Payments will be suspended if reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report, if in its view; good cause exists for the delay. The Medicare principles for the reimbursement of skilled nursing facilities will be utilized for the cost principles that are not specifically addressed in the State Plan.

(b) A facility per diem rate shall be calculated annually by dividing the allowed Medicaid cost by the Medicaid days. The provider's last audited cost report shall be the basis for the calculation. The rate shall be effective each October 1, and shall not be subject to cost settlement.

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Payment for Nursing Facility Beds:

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

FY 2007 – An appropriated 1.482% recurring inflationary increase for the Nursing Home program will be effective January 1, 2007.

FY 2009-2010 – The rates for SFY2010 are frozen as of the rates in effect July 1, 2009. Effective October 1, 2009 an overall rate reduction adjustment of 1.30% rate reduction (annualized over 8 months) for Nursing Care facilities.

FY 2010-2011 – Effective January 1, 2011, rates will be adjusted for an increase of 2.15% for Nursing Care facilities.

FY 2011-2012 – Effective July 1, 2011, rates will be adjusted for a decrease of 3.06% for Nursing Care facilities.

FY 2012 – Effective April 1, 2012, the direct and indirect components of reimbursement rates will be adjusted for an increase of 3.129% for Nursing Care facilities.

FY 2012-2013 – As of July 1, 2012, rates will be adjusted to reflect a flat, 2.17% reduction on the direct and indirect components of the Nursing Facility rates in effect on June 30, 2011. Rates will be reviewed annually prior to each September 1st of the succeeding calendar year.

Reference: Attachment 4.19-D, Page 1 thru 5