Table of Contents

State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 23-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

May 18, 2023

Krista Fremming
Interim Director
Medical Services Division
Department of Human Services
600 East Boulevard Avenue
Department 325
Bismarck, ND 58505-0250

Re: North Dakota 23-0001

Dear Ms. Fremming:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0001. Effective for dates of service on or after January 1, 2023, this amendment provides for an inflationary increase of 3.75 percent for nursing facility (NF) services and implements a new payment methodology for property costs.

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 are pleased to inform you that Medicaid State plan amendment TN 23-0001 is approved effective January 1, 2023. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044 or chistine.storey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0001

2. STATE: ND

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447, Subpart C, 42 CFR 447.252

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 4,992,511
b. FFY 2024 $ 6,949,808

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Subsection 1, Pages i, 3, 4a, 4b-4c, 11, 37, 45, 46, 48a, 52, 53-54, 54a, 71-80

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attach 4.19-D, Sub 1, Pgs i, 4b-4c, 11, 37, 46, 52, 53-54, 71-80; Attach 4.19-D, Sub 1, Pg 4a; Attach 4.19-D, Sub 1, Pgs 48a, A-1 thru A-4 , B-3 thru B-4; Attach 4.19-D, Sub 1, Pgs C-1 thru C-2; Attach 4.19-D, Sub 1, Pgs B-5 thru B-6; Attach 4.19-D, Sub 1, Pg 54a; Attach 4.19-D, Sub 1, Pg 3; Attach 4.19-D, Sub 1, Pgs 45, B-1 thru B-2

9. SUBJECT OF AMENDMENT

Amends the State Plan to implement a new payment methodology for property costs and an inflationary increase for NF Services.

10. 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:
Krista Fremming, Interim Director
Medical Services Division

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Krista Fremming

13. TITLE
Interim Medical Services Director

14. DATE SUBMITTED
February 21, 2023

15. RETURN TO
Krista Fremming, Interim Director
Medical Services Division
ND Department of Health and Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250

FOR CMS USE ONLY

16. DATE RECEIVED
February 21, 2023

17. DATE APPROVED
May 18, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2023

ROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Table of Contents

29. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy and dietary, exclusive of food costs.

30. "In-house resident day" for nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic leave or in the hospital. "In-house resident day" for hospitals means an inpatient day.

31. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

32. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

33. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to NOCC Chapter 50-24.1.

34. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

35. "Other direct care costs" means the cost category for allowable activities, social services, laundry and food costs.

36. "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

37. Vacated

38. "Private-pay resident" means a nursing facility resident on whose behalf the facility is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with rate setting authority including Veteran's Administration or Medicare.

39. "Private room" means a room which is equipped for use by only one resident.

40. "Property costs" means the cost category for allowable real property costs and lease and rental costs.

41. "Provider" means the organization or individual who has executed the provider agreement with the department.

51. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing-bed facility, transitional care unit, subacute unit, an intermediate care facility for individuals with intellectual disabilities, or an acute care setting, or, if not in an institutional setting, is not receiving home and community based waivered services.

52. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

53. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's length transaction. It does not include :

    a. A stock purchase of a facility;

    b. A sale and leaseback to the same licensee;

    c. A transfer of an interest to a trust;

    d. Gifts or other transfers for nominal or no consideration;

    e. A merger of two or more related organizations;

    f. A change in the legal form of doing business;

    g. The addition or deletion of a partner owner or shareholder; or

    h. A sale, merger, reorganization, or any other transfer of interest between related organizations.

54. "Building" means the physical plant including building components and building services equipment licensed as a facility and used directly for resident care and permanently heated auxiliary buildings including sheds garages and storage buildings located on the site used directly for resident care.

55. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

56. "Close relative" means an individual whose relationship by blood marriage or adoption to an individual who is directly or indirectly affiliated with controls or is controlled by a facility is within the third degree of kinship.

57. "Noncovered day" means any bed hold day in excess of the State's bed-hold limit for which the resident may elect to pay.

58. "Depreciation guidelines" means of the American Hospital Association's guidelines as published by American Hospital Publishing, Inc. in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2018 edition.

59. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

60. "Hospice general inpatient care" means short-term inpatient care necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. It does not mean care provided to an individual residing in a nursing facility.

61. "Institutional leave day" means any day that a resident is not in the facility, but is in another nursing facility, swing-bed facility, transitional care unit, subacute care unit, or intermediate care facility for individuals with intellectual disabilities.

62. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

63. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

64. "Respite care" means short-term care provided to an individual when necessary to relieve family members or other persons caring for the individual at home.

65. "Working capital debt" means debt incurred to finance nursing facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

66. "Certified nurse aide" means an individual who has satisfactorily completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR §483.151-483.154 or who has been deemed or determined competent as provided in 42 CFR §483.151 (a) and (b); and is registered on a state-established registry of nurse aides as required by 42 CFR §483.156

67. “Rate adjustment percentage” means the percentage used to determine the minimum adjustment threshold to the rate weight of one for all facilities. The percentage is thirty-sixth hundredths of one percent effective with the June 30, 2019, cost report period.

68. “Margin cap” means a percentage of the price rate limit which represents the maximum per diem amount a facility may receive if the facility has historical operating costs, including adjustment factors, below the price rate.

69. “Peer group” means the grouping of facilities based on their licensed bed capacity available for occupancy as of June thirtieth of the report year to determine the indirect care cost category price rate. The large peer group shall be facilities with licensed capacity greater than fifty-five beds. The small peer group shall be facilities with licensed bed capacity of fifty-five beds or less.

70. “Price rate” means the rate calculated using historical operating costs and adjustment factors up to the limit rate for the direct care, other direct care, and indirect care cost categories.

71. “Effective age” means a facility’s building chronological age reduced by allowable projects for improvements to land, building and fixed equipment. A facility’s effective age will be calculated annually based upon improvements made during the cost report period.

72. “Fair rental value” means the depreciated replacement value of the building, land improvements, and fixed equipment based on the facility’s effective age; land as a percentage of the building replacement value; and a moveable equipment replacement value based on licensed beds. The calculation of the fair rental value of the building, land improvements, and fixed equipment must include a location factor, annual depreciation, and an annual replacement cost inflation factor. The fair rental value must be calculated using any limitations identified in Section 23 – Rate Calculations.

73. “Fair rental value rate” means the per diem rate calculated using the fair rental value.

74. “Passthrough costs” means the cost category for allowable reasonable legal and related expenses, startup costs, bad debt, education expense, and computer software and related technology costs.

Section 5 - Exclusions

1. A facility that exclusively provides residential services for nongeriatric individuals with physical disabilities or a unit within a facility which exclusively provides geropsychiatric services shall not be included in the calculation of the rate limitations.

2. The rate for a unit within a facility which exclusively provides geropsychiatric services must be established using the actual allowable historical costs adjusted by the indices under Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs. Actual allowable historical costs must be determined using the applicable sections of the policies and procedures. An operating margin and incentive determined under Section 25 – Rate Limits and Incentives must be included in the facility's cost rate.

3. The direct care rate for a unit within a facility which exclusively provides geropsychiatric services must be established using the allowable historical operating costs and adjustment factors under Section 37 – Rate Determination for Price. The margin cap for direct care must be included in the facility's direct care rate.

4. The direct care rate for a facility that exclusively provides residential services for nongeriatric individuals with physical disabilities must be established using the allowable historical operating costs and adjustment factors under Section 37 – Rate Determination for Price. The direct care rate must be limited to two times the limit rate under Section 23 – Rate Calculations. The margin cap for direct care must be included in the facility's direct care rate.

5. The other direct rate and indirect rate for a facility that exclusively provides residential services for nongeriatric individuals with physical disabilities must be limited to one and one-half times the limit rate set under Section 23 – Rate Calculations. The margin cap for other direct and indirect must be included in the facility's rate.

7. An adjustment may not be allowed for any depreciable cost that exceeded the basis in effect for rate periods prior to January 1, 1996.

8. A per bed cost limitation based on single and double occupancy must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation or remodeling. The per bed cost limitation applies to construction or renovation projects currently in process or which have approved financing in place on or before December 31, 2021.

    a. The per bed limitation basis for double occupancy effective July 1, 2019 is $253,297.

    b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by 1.5.

    c. The double and single occupancy per bed limitation must be adjusted annually on July 1 using the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May 31.

    d. The per bed limitation in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.

    e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitation.

    f. The per bed limitation is not applicable to projects started or approved by the state health council before July 1, 1994.

Section 23 – Rate Calculations

Cost Rate: Each cost category actual rate is calculated using allowable historical operating costs and adjustment factors, as provided for in Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs, divided by standardized resident days for the Direct Care cost category and resident days for Other Direct Care, Indirect Care, Passthrough and Property cost categories. The actual rate as calculated is compared to the limit rate for each category to determine the lesser of the actual rate or the limit rate. The lesser rate for Direct Care is then multiplied times the weight for each classification in Section 32 – Classifications to establish the Direct Care rate for that classification. The lesser of the actual rate or the limit rate for Other Direct Care, Indirect Care, Passthrough and Property costs and the adjustments provided for in Section 25 – Rate Limits and Incentives are then added to the Direct Care rate for each classification to arrive at the established rate for a given classification. The property rate must be the greater of the fair rental value rate or the rate calculated using allowable property costs. The fair rental value rate must be the rate established in Section 37 – Rate Determination for Price.

Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs

1. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.

2. For the rate year beginning January 1, 2020 the adjustment factor is 2 percent.

3. For the rate year beginning January 1, 2021 the adjustment factor is 2.5 percent.

4. For the rate year beginning January 1, 2022, the adjustment factor is 4.5 percent.

5. For the rate year beginning January 1, 2023, the maximum adjustment factor is 3.75 percent.

7. The actual rate for indirect care costs, passthrough costs, property costs, and the fair rental value rate must be the lesser of the rate established using:

   a. Actual census for the report year; or

   b. Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year.

      (1) Multiplied times three hundred sixty-five; and

      (2) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

8. The department may waive or reduce the application of paragraph 7 if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

   a. The facility has reduced licensed capacity; or

   b. The facility's governing board has approved a capacity decreased to occur no later than the end of the rate year which would be affected by subdivision d.

9. The department shall waive the application of paragraph 7 for nongeriatric facilities for individuals with physical disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department approved referrals or admissions.

Section 28 – Special Rates

1. For a new facility placed into service prior to December 31, 2022, the department shall establish a rate equal to the limit rates for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the projected property rate. The projected property rate is subject to subsection 6. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at 95 percent of licensed beds.

    a. If the effective date of the rate is on or after January 1 and on or before June 30, the rate must be effective for the remainder of that rate year and must continue through June 30 of the subsequent rate year. The facility shall file an interim cost report for the period ending December 31 of the year in which the facility first provides services. The cost report is due March 1 and is used to establish the actual rate effective July 1 of the subsequent rate year. The partial year rates established based on the cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up.

    b. If the effective date of the rate is on or after July 1 and on or before December 31, the rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June 30 of the subsequent rate year. This cost report must be used to establish the rates for the next subsequent rate year. The facility shall file, by March 1, a cost report for the period July 1 through December 31 of the subsequent rate year.

c. The final rates for direct care, other direct care and indirect care will be limited to the lesser of the limit rates for the current rate year or the actual rates.

2. Rates for a facility changing ownership during the rate period are set under this subsection.

   a. The rates established for direct care, other direct care, indirect care, and passthrough costs for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

      (1) For a facility with six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

      (2) For a facility with less than six months of operation under the new ownership during the report year:

         (a) by indexing the rates established for the previous owner forward using the adjustment factor in Section 24; or

         (b) if the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the rate year, by establishing a rate based on the previous owner's cost report.

   b. The fair rental value rate established for the previous owner must be retained through the end of the rate period.

3. For a new facility placed into service after December 31, 2022, the department shall establish a rate equal to the price rate for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the fair rental value rate.

4. For a facility with a major renovation of at least fifteen thousand dollars per licensed bed:

    a. If the renovation is placed into service between July first and December thirty-first a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective July first of the subsequent rate year.

    b. If the renovation is placed into service between January first and June thirtieth a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective January first of the subsequent rate year.

5. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

6. For a projected property in place prior to January 1, 2023, at such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate and the property rate that would otherwise be established based on historical costs must be determined. The property rate established in each of the twelve years, beginning with the first rate year following the use of a property rate reduced by one-twelfth of that difference.

Section 37 - Rate Determination for Price

1. Rate determination.

   a. For the direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factor provided for in Section 24 – Adjustment Factors divided by standardized resident days. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate to determine the lesser of the actual rate or the price rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is multiplied times the weight for each classification in Section 32 – Classifications to establish the direct care rate for that classification.

   b. For the other direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factor provided for in Section 24 – Adjustment Factors divided by resident days. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate to determine the lesser of the actual rate or the price rate.

   c. For the indirect cost category, the actual rate is calculated using allowable historical operating costs and adjustment factor provided for in Section 24 – Adjustment Factors divided by resident days subject to Section 25 – Rate Limits and Incentives. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate to determine the lesser of the actual rate or the price rate.

   d. For the passthrough cost category, the actual rate is calculated using allowable historical operating costs divided by resident days subject to Section 25 – Rate Limits and Incentives.

   e. The property rate must be the greater of the fair rental value rate or the rate calculated using allowable property costs. The property rate must be calculated using resident days subject to Section 25 – Rate Limits and Incentives. The fair rental value rate must be the rate established in subsection 3.

   f. The lesser of the actual rate or the price rate for other direct care and indirect care, the passthrough rate, and the property rate are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. Effective with the 2023 rate year and subsequent rate years:

   a. if the fair rental value rate is greater than the rate calculated using allowable property costs:

      (1) The increase must be phased in over a four-year period.

      (2) The increase must be reserved for renovations or replacements that enhance the fair rental value.

      (3) The increase must be reserved until a renovation or replacement of at least two

thousand dollars per licensed bed is placed in service. Only allowable costs for building, land improvements, and fixed equipment will be used in calculating the amount per licensed bed.

b. if the fair rental value rate is less than the rate calculated using allowable property costs:

(1) The department shall inform the facility of the property rate using allowable property costs and the fair rental value rate.

(2) Annually by November twenty-eighth, the facility shall inform the department if they want to accept the rate calculated using allowable property costs as the property rate.

c. Once the fair rental value rate is equal to or greater than the rate calculated using allowable property costs, or the facility does not inform the department they want to accept the rate calculated using allowable property costs, the department no longer shall inform the facility of the rate calculated using allowable property costs and the property rate must be the fair rental value rate.

3. Limitations

a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any timebased upon information available.

b. The department shall review, on an ongoing basis, aggregate payments to facilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. If aggregate payments to facilities exceed estimated payments under Medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under Medicare payment principles.

c. All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in North Dakota Century Code section 50-24.4-13 must be used to establish a price rate for the direct care and other direct care cost categories. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

d. All facilities must be grouped into peer groups based on the licensed bed capacity available for occupancy as of June thirtieth of the report year. Facilities in each peer group must be used to establish a price rate for the indirect care cost category for that peer group. The base year is the report year ended June 30, 2021. A new base year will be established using the report year ended June 30, 2023. Base year costs may not be

adjusted in any manner or for any reason not provided for in this section.

e. The price rate for each of the cost categories must be established using historical operating costs for the base year. The price rate will be established using the same percentage of the median used to establish the limit rates for the January 1, 2021, rate year.

f. A facility with an actual rate that exceeds the price rate for a cost category shall receive the price rate.

g. The price rate for each of the cost categories for the January 1, 2023, rate year shall be the price rate for the previous rate year increased by the adjustment factor.

h. The price rate for each of the cost categories for the January 1, 2025, rate year shall be the price rate for the previous rate year increased by the adjustment factor.

i. The actual rate for indirect care costs, passthrough costs, property costs and the fair rental value rate must be the lesser of the rate established using:

(1) Actual census for the report year; or

(2) Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:

(a) Multiplied times three hundred sixty-five; and

(b) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

j. The department may waive or reduce the application of subdivision i if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

(1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision i.

k. The department may waive the application of subdivision i for nongeriatric facilities for individuals with disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department-approved referrals or admissions.

l. When calculating the fair rental value rate:

(1) The maximum allowable square footage must be nine hundred fifty square feet per licensed bed.

(2) The replacement value of land will be ten percent of the building replacement cost.

(3) The maximum allowable moveable equipment replacement value must be fifteen thousand dollars per licensed bed.

(4) The maximum annual replacement cost inflation factor for building and land must be two percent.

(5) The maximum annual depreciation factor for building must be two percent.

(6) The location factor must be the city of Minneapolis.

(7) The minimum allowable project to impact a facility's effective age must be one thousand dollars per licensed bed. Only allowable costs for building, land improvements, and fixed equipment will be used in calculating the amount per licensed bed.

(8) The maximum allowable rental rate must be eight percent.

(9) The building replacement cost will be calculated by multiplying a facility's allowable square footage times the cost per square foot adjusted for the location factor. The building replacement cost per square foot will be for a thirty thousand square foot building with exterior walls of precast concrete for the calendar year prior to the end of the cost report year.

(10) A facility's effective age may be updated due to a renovation project reported in the cost report year the project was completed. The following will be used when calculating the update:

(a) The cost per square foot adjusted for the location factor for the cost report year in which the renovation project was completed.

(b) Additional square footage added due to renovation project must be included in the total square footage.

(c) Only allowable renovation project costs for building, land improvements, and fixed equipment.

4. An adjustment factor shall be used for purposes of adjusting historical operating costs for direct care, other direct care, and indirect care under subsection 1 and for purposes of adjusting the price rate for direct care costs, other direct care costs, and indirect care costs under subsection 3, but may not be used to adjust passthrough costs, property costs and the fair rental value under either subsection 1 or 3.

5. Rate adjustments

a. Desk audit rate

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department

shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(4) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least the rate adjustment percentage per day.

b. Final rate

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least the rate adjustment percentage per day that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(4) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least the rate adjustment percentage per day must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least the rate adjustment percentage per day had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

6. Rate payments

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

c. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically provided for in this section.

7. Partial year

a. Rates for a facility changing ownership during the rate period are set under this subdivision.

(1) The rates established for direct care, other direct care, indirect care, and passthrough for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

(a) For a facility with six or more months of operation under the new ownership during the report year, through use of a cost report for the period;

(b) For a facility with less than six months of operation under the new ownership during the report year, by indexing the rates established for the previous owner forward using the adjustment factor in subsection 5; or

(c) If the change of ownership occurred after the report year end, but prior to the beginning of the next rate year, and the previous owner submits and allows audit of a cost report, by establishing a rate based on the previous owner's cost report.

(2) The fair rental value rate for the previous owner must be retained.

b. For a new facility placed in service prior to December 31, 2022, the department shall establish a rate equal to the price rate for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the projected property rate. The projected property rate is subject to subdivision f. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.

(1) If the effective date of the rate is on or after January first and on or before June thirtieth, the rate must be effective for the remainder of that rate year and must continue through June thirtieth of the subsequent rate year. The facility shall file by March first a cost report for the period ending December thirty-first of the year in which the facility first provides services. The cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate established based on this cost report must include applicable margins and adjustment factors and may not be subject to any cost settle-up.

(2) If the effective date of the rate is on or after July first and on or before December thirty-first, the rate must remain in effect through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

c. For a new facility placed into service after December 31, 2022, the department shall establish a rate equal to the price rate for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the fair rental value rate.

d. For a facility with a major renovation of at least fifteen thousand dollars per licensed bed:

(1) If the renovation is placed into service between July first and December thirty-first a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective July first of the subsequent rate year.

(2) If the renovation is placed into service between January first and June thirtieth a fair rental value rate must be calculated including the major renovation. The fair rental value rate must be effective January first of the subsequent rate year.

e. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

f. For a projected property rate in place prior to January 1, 2023, at such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subdivision c or d and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a projected property rate reduced by one-twelfth of that difference.

8. One-time adjustments

a. Adjustments to meet certification standards

(1) The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that must be increased to correct the deficiencies cited in the survey process.

(2) The facility shall submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health. The request must:

(a) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's certification

survey;

(b) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and

(c) Provide a detailed list of any other costs necessary to meet survey standards.

(3) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted to an amount not to exceed the price rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

b. Adjustments for unforeseeable expenses

(1) The department may provide for an increase in the established rate for additional costs incurred to meet major unforeseeable expenses. The expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) Within sixty days after first incurring the unforeseeable expense, the facility shall submit a written request to the medical services division containing the following information:

(a) An explanation as to why the facility believes the expense was unforeseeable;

(b) An explanation as to why the facility believes the expense was beyond the managerial control of the facility; and

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on its background and knowledge of nursing care industry and business trends.

(4) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward not to exceed the price rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

c. Adjustment to historical operating costs

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 and when it has been determined the facility cannot meet the minimum standards through reallocation of costs and use of margin cap.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document, based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day;

(b) The facility shall document all available resources, including margin cap, if used to increase nursing hours, are not sufficient to meet the minimum standards; and

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received, including the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any margin cap included when calculating the established rate. The net increase must be divided by standardized resident days and the amount calculated must be added to the rate. This rate is subject to any price rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in subsection 5.

(5) If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.

d. Adjustments for disaster recovery costs when evacuation of residents occurs

(1) A facility may incur certain costs when recovering from a disaster such as a flood, tornado, or fire. If evacuation of residents was necessary because of the disaster, actual recovery costs during the evacuation period, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs.

(2) When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning with the sixth month after the first resident is readmitted to the facility.

(3) Recovery costs must be identified as startup costs and included as passthrough costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph 4.

(4) If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

(5) Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty-month amortization period must be included as a reduction of deferred charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

e. Adjustments for a significant reduction in census

(1) A facility may request a revised desk rate if the facility has a significant reduction in census. The reduction in census cannot be due to renovation.

(2) For purposes of this section a significant reduction in census is defined as:

(a) At least ten percent of licensed bed capacity for a facility in the large peer group; and

(b) At least five percent of licensed bed capacity for a facility in the small peer group.

(3) The licensed bed capacity will be based on the licensed beds used to establish the peer groups.

(4) The revised desk rate shall be calculated using:

(a) The facility's allowable historical operating costs from the most recent base year increased by the adjustment factors, if any, up to the current report year.

(b) The facility's allowable property costs from the most recent report year.

(c) The standardized resident days and resident days from the most recent report year.

(d) The revised desk rate shall be limited to the price rate for direct care, other direct, and indirect cost categories.

(5) A facility that receives a revised desk rate under this section shall not increase licensed bed capacity during the rate year.