# CHAPTER 75-02-06
# RATESETTING FOR NURSING HOME CARE



**SECTION 1.** Section 75-02-06-01 is amended as follows:

**75-02-06-01. Definitions.**

In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment factor" means the centers for Medicare and Medicaid services skilled nursing facility market basket index four-quarter moving average percent change for quarter two of the applicable rate year from the current market basket data file publicly available as of August thirty-first of the year preceding the rate year. The adjustment factor also shall include any legislatively approved inflation increase for nursing facilities.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "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 purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 3 of section 75-02-06-07;

    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.

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

8. "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.

9. "Certified nurse aide" means:

   a. 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 through 483.154 and is registered on a state-established registry of nurse aides as required by 42 CFR 483.156; 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; or

   b. An individual who has worked less than four months as a nurse aide and is enrolled in a training and evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154.

10. "Chain organization" means a group of two or more health care facilities owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

11. "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.

12. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. It does not include a donation to a charity.

13. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, the determination of cost limitations, and determination of rates.

14. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a facility are divided for purposes of cost assignment and allocations.

15. "Cost rate" means the rate calculated using historical operating costs and adjustment factors up to the limit rate for direct care, other direct care, and indirect care. The cost rate shall include an efficiency incentive and operating margin.

16. "Cost report" means the department approved form for reporting costs, statistical data, and other relevant information of the facility.

17. "Department" means the department of human services.

18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

19. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

20. "Depreciation guidelines" means the American hospital association's guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2018 edition.

21. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

22. "Direct care costs" means the cost category for allowable nursing and therapy costs.

23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the nursing facility premises.

25. "Employment benefits" means fringe benefits, other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

26. "Established rate" means the rate paid for services.

27. "Facility" means a nursing facility not owned or administered by state government or a nursing facility, owned or administered by state government, which agrees to accept a rate established under this chapter. It does not mean an intermediate care facility for individuals with intellectual disabilities.

28. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

29. <u>“Fair rental value” means the depreciated replacement value of the building, land improvements, and fixed equipment; moveable equipment; and land based on the facility’s effective age. 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</u>

cost inflation factor. The fair rental value must be calculated using any limitations identified in sections 75-02-06-16 and 75-02-06-16.3.

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

31. "Final decision rate" means the amount, if any, determined on a per day basis, by which a rate otherwise set under this chapter is increased as a result of a request for reconsideration, a request for an administrative appeal, or a request for judicial appeal taken from a decision on an administrative appeal.

~~30.~~32. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

~~31.~~33. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

~~32.~~34. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

~~33.~~35. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, uniform allowances, and medical services furnished at nursing facility expense.

~~34.~~36. "Highest market-driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

~~35.~~37. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

~~36.~~38. "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.

~~37.~~39. "Hospice inpatient respite care" means short-term inpatient care provided to an individual when necessary to relieve family members or other persons caring for the individual at home. Care may be provided for no more than five consecutive days. For purposes of the definition, home does not include nursing facility.

~~38.~~40. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient or has been identified in a resident assessment instrument as "discharged anticipated to return".

~~39.~~41. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

~~40.~~42. "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.

~~41.~~43. "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.

~~42.~~44. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

~~43.~~45. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

~~44.~~46. "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.

~~45.~~47. "Managed care organization" means a Medicaid managed care organization as that term is defined in section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)].

~~46.~~48. "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.

~~47.~~49. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to North Dakota Century Code chapter 50-24.1.

~~48.~~50. "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.

~~49.~~51. "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.

~~50.~~52. "Noncovered day" means a resident day that is not payable by medical assistance but is counted as a resident day.

~~51.~~53. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.

~~52.~~54. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act (FICA) taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

55. "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.

~~53.~~56. "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 must be facilities with licensed bed capacity greater than fifty-five beds. The small peer group must be facilities with licensed bed capacity of fifty-five beds or fewer.

~~54.~~57. "Pending decision rate" means the amount, determined on a per day basis, by which a rate otherwise set under this chapter would increase if a facility prevails on a request for reconsideration, on a request for an administrative appeal, or on a request for a judicial appeal taken from a decision on an administrative appeal; however, the amount may not cause any component of the rate to exceed rate limits established under this chapter.

~~55.~~58. "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.

~~56.~~59. "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 ratesetting authority, including veterans' administration or Medicare, or whose payment rate is not negotiated by any managed care organization contracting with a facility to provide services to the resident.

~~57.~~60. "Private room" means a room equipped for use by only one resident.

~~58.~~61. "Property costs" means the cost category for allowable real property costs and ~~other~~lease and rental costs ~~which are passed through~~.

~~59.~~62. "Provider" means the organization or individual who has executed a provider agreement with the department.

~~60.~~63. "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 reporting period.

~~61.~~64. "Rate year" means the calendar year from January first through December thirty-first.

~~62.~~65. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

~~63.~~66. "Related organization" means a close relative or person or an organization which a provider is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

~~64.~~67. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

~~65.~~68. "Resident" means a person who has been admitted to the facility, but not discharged.

~~66.~~69. "Resident day" in a nursing facility means all days for which service is provided or for which payment is ordinarily sought, including hospital leave days and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought.

~~67.~~70. "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.

~~68.~~71. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

~~69.~~72. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater; but does not mean an increase by a facility which reduces the

number of its licensed beds and thereafter relicenses those beds, and does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.

~~70.~~73. "Standardized resident day" means a resident day times the classification weight for the resident.

~~71.~~74. "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.

~~72.~~75. "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.

~~73.~~76. "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.

**History:** Effective September 1, 1980; amended effective December 1, 1983; June 1, 1985; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; July 2, 2002; July 2, 2003; December 1, 2005; October 1, 2010; July 1, 2012; January 1, 2014; July 1, 2016; January 1, 2020; January 1, 2022; October 1, 2022.
**General Authority:** NDCC 50-24.1-04, 50-24.4-02
**Law Implemented:** NDCC 50-24.4; 42 USC 1396a(a)(13)

**SECTION 2.** Subsection 7 of section 75-02-06-03 is amended as follows:

7. 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. Effective July 1, 2019, the per bed limitation basis for double occupancy is $168,864 and for a single occupancy 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 first, using the increase, if any, in the consumer price index for all urban consumers, United States city

average, all items, for the twelve-month period ending the preceding May thirty-first.

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.

g. For rate years beginning after December 31, 2007, the limitations of subdivision a do not apply to the valuation basis of assets acquired as a result of a natural disaster before December 31, 2006. The provisions of this subsection may not be applied retroactively to any rate year before January 1, 2008.

**History:** Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; July 2, 2003; September 7, 2007; July 1, 2009; January 1, 2014; July 1, 2016; January 1, 2020; October 1, 2022.
**General Authority:** NDCC 50-24.1-04, 50-24.4-02
**Law Implemented:** NDCC 50-24.4; 42 USC 1396a(a)(13)

**SECTION 3.** Section 75-02-06-16 is amended as follows:

**75-02-06-16. Rate determinations for cost.**

1. This section is applicable for establishing a cost rate for direct care, other direct care, and indirect care for the June 30, 2021, report year.

2. Rate determination.

   a. For ~~each~~the direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 5 divided by standardized resident days ~~for the direct care cost category and resident days for other direct care, indirect care, and property cost categories~~. The actual rate as calculated is compared to the limit rate ~~for each cost category~~ to determine the lesser of the actual rate or the limit rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 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 factors provided for in subsection 4 divided by resident days. The actual rate as calculated is compared to the limit rate to determine the lesser of the actual rate or the limit rate.

c. For the indirect cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by resident days subject to the adjustments provided for in subdivision g of subsection 4. The actual rate as calculated is compared to the limit rate to determine the lesser of the actual rate or the limit rate.

d. For the passthrough costs category, the actual rate is calculated using allowable historical operating costs divided by resident days subject to the adjustments provided for in subdivision g of subsection 4.

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 the adjustments provided for in subdivision g of subsection 4. The fair rental value rate must be the rate established under subdivision e of subsection 1 of section 75-02-06-16.3.

f. The lesser of the actual rate or the limit rate for other direct care~~,~~ and indirect care, ~~and property costs~~the passthrough rate, the property rate, and the adjustments provided for in subsections 3 and 4 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

3. a. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to seventy percent times the difference between the actual rate, exclusive of the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of two dollars and sixty cents or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs, whichever is less, must be included as part of the indirect care cost rate.

b. A facility shall receive an operating margin of four and four-tenths percent, effective January 1, 2020, through December 31, 2021, and four and four-tenths percent effective January 1, 2022, through December 31, 2023, based on the lesser of the actual direct care and other direct care rates, exclusive of the adjustment factor, or the limit rate in effect at the end of the year immediately preceding

the rate year. The operating margin must be added to the rate for the direct care and other direct care cost categories.

4. 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 time based 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 limit rate for the direct care, other direct care, and indirect care cost categories. The base year is the report year ended June 30, 2021. The limit rates for the direct care, other direct care, and indirect care cost categories must be established using the June 30, 2021, base year. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

   d. The limit rate for each of the cost categories must be established as follows:

      (1) Historical costs for the report year ended June 30, 2020, as adjusted, must be used to establish rates for all facilities in the direct care, other direct care, and indirect care cost categories. The rates as established must be ranked from low to high for each cost category.

      (2) For the rate year beginning January 1, 2021, the limit rate for each cost category is:

(a) For the direct care cost category, two hundred four dollars and eighty-four cents;

(b) For the other direct care cost category, twenty-nine dollars and eighty-four cents; and

(c) For the indirect care cost category, eighty-four dollars and fifty-one cents.

e. A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate. f. The cost rate for the January 1, 2023, rate year must be the previous rate year's cost rate increased by the adjustment factor.

g. The actual rate for indirect care costs, passthrough costs, and ~~property costs~~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.

h. The department may waive or reduce the application of subdivision g 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 g.

i. The department may waive the application of paragraph 2 of subdivision g 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.

5. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care under subsection

2 and for purposes of adjusting the limit rates for direct care costs, other direct care costs, and indirect care costs under subsection 4, but may not be used to adjust ~~property~~passthrough costs and the fair rental value under either subsection 2 or 4. The adjustment factor for the January 1, 2023, rates must be reduced by one-half percent.

6. 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) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. No decision on the request for reconsideration of the desk rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

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

(6) 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 private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c.

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

(5) 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.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a

decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if

the rate paid by the private-pay resident exceeds the final rate by at least one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

7. 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. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

   c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

   d. 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.

   e. 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.

8. 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, passthrough, operating margins, and incentives 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) ~~Unless a facility elects to have a property rate established under paragraph 3, the~~The fair rental value rate established for ~~property for~~ the previous owner must be retained ~~through the end of the rate period and the property rate 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 using the rate established for the previous owner for the previous rate year; 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.~~

~~(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference~~.

b. 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 ~~must be calculated using projected property costs and projected census. The rate must be in effect for no less than ten months and no more than eighteen months. A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs~~is subject to subdivision d of subsection 8. 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 the cost report must include applicable incentives, margins, phase-ins, 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. The facility shall file by March first a cost report for the period July first through December thirty-first of the subsequent rate year.

(3) The final rate for direct care, other direct care, and indirect care costs established under this subdivision must be limited to the lesser of the limit rate for the current rate year or the actual rate.

c. ~~For a facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first day of the month beginning after the date the project is completed and placed into service or the first day of the month beginning after the date the request for a projected property rate is received by the department, whichever is later. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing prior to renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing prior to the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.~~

d. ~~For a facility with a significant capacity increase, the rate established for direct care, other direct care, indirect care, operating margins, and incentive based on the last report year, must be applied to all licensed beds. A projected property rate must be established based on projected property costs and projected census. The projected property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health or the first day of the month beginning after the date when the request for a projected property rate is made to the department, whichever is later, through the end of the rate year. The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather~~

~~than on property costs actually incurred during the report year; and may not be subject to retroactive cost settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.~~

~~e. For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.~~

~~f.~~ 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.

~~g.~~d. ~~At~~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 ~~established using subdivision c or d may not exceed the property rate otherwise allowable,~~ reduced by one-twelfth of that difference.

9. 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 limit 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 6.

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 limit 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 6.

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 efficiency incentives.

(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 efficiency incentives, 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 operating margins and incentives 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 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 6.

(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.

10. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds the rate adjustment percentage per day.

**History:** Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; January 1, 2002; July 2, 2003; December 1, 2005; January 1, 2010; July 1, 2010; January 1, 2012; January 1, 2014; July 1, 2016; April 1, 2018; January 1, 2020; January 1, 2022; October 1, 2022.
**General Authority:** NDCC 50-24.1-04, 50-24.4-02
**Law Implemented:** NDCC 50-24.4; 42 USC 1396a(a)(13)

**SECTION 4.** Section 75-02-06-16.3 is amended as follows:

**75-02-06-16.3. Rate determinations for price.**

1. Rate determination.

   a. For ~~each~~the direct cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection ~~3~~4 divided by standardized resident days ~~for the direct care cost category and resident days for other direct care, indirect care, and property cost categories~~. The actual rate must include the margin cap. The actual rate as calculated is compared to the price rate ~~for each cost category, excluding property,~~ 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 then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 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 factors provided for in subsection 5 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 factors provided for in subsection 5 divided by resident days subject to the adjustments provided for in subdivision i of subsection 3. 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 costs category, the actual rate is calculated using allowable historical operating costs divided by resident days subject to the adjustments provided for in subdivision i of subsection 3.

e. The property rate must be the greater of the fair rental value rate or the rate calculated using allowable property costs subject to subsection 2. The property rate must be calculated using resident days subject to the adjustments provided for in subdivision i of subsection 3.

f. The lesser of the actual rate or the price rate for other direct care and indirect care, the passthrough rate, the property ~~costs~~rate, and the adjustments provided for in subsection ~~2~~3 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 time based 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 subsection or subsection ~~3~~4.

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 subsection or subsection ~~3~~4.

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 must 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 must be the price rate for the previous rate year increased by the adjustment factor.

i. The actual rate for indirect care costs, passthrough costs, and ~~property costs~~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 that 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 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.

~~3.~~4. An adjustment factor must 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 ~~2~~3, but may not be used to adjust ~~property~~passthrough costs and the fair rental value under either subsection 1 or ~~2~~3.

~~4.~~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) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate, except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. A decision on the request for reconsideration of the desk rate may not be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

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

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year which 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 a field audit is not 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 which are found during a field audit or are reported by the facility within twelve months of the rate year end.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive, except as provided for in subdivision c.

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

(5) 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, which 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.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per-day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information

furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

~~5.~~6. Rate payments.

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. Payments may not be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility immediately shall report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility, within thirty days, shall refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. 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.

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

~~6.~~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, ~~and~~ 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 ~~4~~5; or

(c) If the change of ownership occurred after the report year end, but before 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) ~~Unless a facility elects to have a property rate established under paragraph 3, the~~The fair rental value rate established ~~for property~~ for the previous owner must be retained ~~through the end of the rate period and the property rate 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 using the rate established for the previous owner for the previous rate year; or~~

~~(c) If the change of ownership occurred after the report year end, but before 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.~~

~~(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent~~

~~rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference~~.

b. For a new facility placed into 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 ~~must be calculated using projected property costs and projected census. A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs~~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 facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, and indirect care based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first day of the month beginning after the date the project is completed and placed into service or the first day of the month beginning after the date the request for a projected property rate is received by the department, whichever is later. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing before renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing before the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.~~

d. ~~For a facility with a significant capacity increase, the rate established for direct care, other direct care, and indirect care based on the last report year, must be applied to all licensed beds. A projected property rate must be established based on projected property costs and projected census. The projected property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health or the first day of the month beginning after the date when the request for a projected property rate is made to the department, whichever is later, through the end of the rate year. The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year; and may not be subject to retroactive cost settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.~~

e. ~~For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be~~

~~applied throughout the rate year for all licensed beds~~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.

~~f.~~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.

~~g.~~f. ~~At~~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 ~~established using subdivision c or d may not exceed the property rate otherwise allowable,~~ reduced by one-twelfth of that difference.

~~7.~~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 ~~4~~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 ~~4~~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 ~~4~~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 must 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 must be limited to the price rate for direct care, other direct care, and indirect cost categories.

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

~~8.~~9. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds the rate adjustment percentage per day.

**History:** Effective January 1, 2022; amended effective October 1, 2022.
**General Authority:** NDCC 50-24.1-04, 50-24.4-02
**Law Implemented:** NDCC 50-24.4

**SECTION 5.** Section 75-02-06-24 is amended as follows:

**75-02-06-24. 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 subsection 5 of section 75-02-06-16. Actual allowable historical costs must be determined using the applicable sections of the policies and procedures. An operating margin and incentive determined under subsection 3 of section 75-02-06-16 must be included in the facility's cost rate.

3. The direct care rate for a unit within a facility that exclusively provides geropsychiatric services must be established using the allowable historical operating costs and adjustment factors under subsection ~~3~~4 of section 75-02-06-16.3. 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 subsection ~~3~~4 of section 75-02-06-16.3. The margin cap for direct care must be included in the facility's direct care rate.

5. A facility may establish a rate for respite care, hospice inpatient respite care, or hospice general inpatient care services.

**History:** Effective January 1, 1996; amended effective July 1, 1999; January 1, 2022; October 1, 2022.
**General Authority:** NDCC 50-24.1-04, 50-24.4-02
**Law Implemented:** NDCC 50-24.4; 42 USC 1396a(a)(13) 75-02-06-25.