CHAPTER 50-24.4
NURSING HOME RATES

50-24.4-01. Definitions.

For the purposes of this chapter:

1. "Actual allowable historical operating cost per diem" means the per diem operating costs allowed by the department for the most recent reporting year.
2. "Actual resident day" means a billable, countable day as defined by the department.
3. "Department" means the department of health and human services.
4. "Direct care costs" means the cost category for allowable nursing and therapy costs.
5. "Fair rental value" means the depreciated replacement value of the building, fixed equipment, moveable equipment, and land based on the facility's effective age. The calculation of the fair rental value of the building and fixed equipment must include a location factor, annual depreciation, and an annual replacement cost inflation factor.
6. "Fair rental value rate" means the per diem rate calculated using the fair rental value and rental rate.
7. "Final rate" means the rate established after any adjustment by the department, including adjustments resulting from cost report reviews and audits.
8. "Fringe benefits" means workforce safety and insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and uniform allowances, and medical services furnished at nursing home expense.
9. "General and administrative costs" means all allowable costs for administering the facility, including salaries of administrators, assistant administrators, accounting personnel, data processing personnel, security personnel, and all clerical personnel; board of directors' fees; business office functions and supplies; travel, except as necessary for training programs for dietitians, nursing personnel, and direct resident care related personnel required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit; professional services such as legal, accounting, and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars.
10. "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the department has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the department has applied appropriate limitations such as the limit on administrative costs.
11. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.
12. "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)].
13. "Margin cap" means a percentage of the price limit which represents the maximum per diem amount a nursing home may receive if the facility has historical operating costs below the price limit.
14. "Nursing home" means a facility, not owned or administered by the state government, defined in section 43-34-01 or a facility owned or administered by the state, which agrees to accept a rate established under this chapter.
15. "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards.
16. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.
17. "Payment rate" means the rate determined under section 50-24.4-06.

18. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.
19. "Private-paying resident" means a nursing home resident on whose behalf the nursing home is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with ratesetting authority, including the veterans' administration or Medicare, or whose payment rate is not negotiated by any managed care organization contracting with a facility to provide services for the resident.
20. "Rate year" means the fiscal year for which a payment rate determined under this chapter is effective, from January first to the next December thirty-first.
21. "Reporting year" means the period from July first to June thirtieth, immediately preceding the rate year, for which the nursing home submits reports required under this chapter.
22. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, nursing home administrators, and other persons performing functions ordinarily performed by such personnel.

50-24.4-01.1. Nursing home resident payment classifications - Procedures for reconsideration.

1. For purposes of this section, "resident's representative" includes the resident's guardian or conservator, a person authorized or required to pay the nursing home expenses of the resident, or any other person designated by the resident in writing.
2. The department shall establish resident payment classifications for the care of residents of nursing homes.
3. The department shall assign nursing home residents to the appropriate payment classification based upon assessments of the residents.
4. The department shall notify each resident, and the nursing home in which the resident resides, of the payment classification established under subsection 3. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the department, and the opportunity to appeal the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home for distribution to the resident in which event the nursing home is responsible for the distribution of the notice to the resident and to the resident's representative, if any. This notice must be distributed to the resident and sent first-class mail or hand-delivered to the resident's representative within three working days after the nursing home's receipt of the notice from the department.
5. The resident or the nursing home may appeal the assigned payment classification to the department. The appeal must be submitted in writing to the department within thirty days of the receipt of the notice of resident classification. For appeals submitted by or on behalf of the resident, the time period for submission of the request begins on the date the classification notice is delivered to the resident, or mailed or delivered to the resident's representative, whichever is latest. The appeal must be accompanied by the name of the resident, the name and address of the nursing home in which the resident resides, the reasons for the appeal, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the appeal is limited to documentation intended to establish that the needs of the resident, at the time of the assessment resulting in the disputed classification, justify a change of classification.
6. Upon written request, the nursing home shall give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's appeal. A

copy of any requested material must be provided within three working days of receipt of a written request for the information. Upon request, the nursing home shall assist the resident in preparing an appeal.

7. In addition to the information required in subsection 5, an appeal by a nursing home must be accompanied by the following information: the date the resident payment classification notices were received by the nursing home; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice of appeal sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that the resident's classification is being appealed, the reason for the appeal, that the resident's rate will change if the appeal is approved by the department and the extent of the change, that copies of the nursing home's appeal and supporting documentation are available for review, and that the resident also has the right to appeal. If the nursing home fails to provide this information with the appeal, the appeal must be denied, and the nursing home may not make further appeals concerning that specific resident payment classification until such time as the resident's payment classification is re-established by the department.
8. The appeal determination of the department must be made by individuals not involved in reviewing the assessment that established the disputed classification. The appeal determination must be based upon the initial assessment and upon the information provided to the department under subsection 5. If the department determines that it is necessary for the appeal determination, it may conduct onsite reviews. Within fifteen working days of receiving the appeal, the department shall affirm or modify the original resident classification. The original classification must be modified if the department determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home must be notified within five working days after the decision is made.
9. The appeal determination under subsection 8 is the final administrative decision of the agency. That decision is subject to appeal to the district court, and for that purpose, the decision must be treated as a decision on a petition for rehearing made pursuant to section 28-32-40. Appeal to the district court must be taken in the manner required by section 28-32-42.

50-24.4-02. Authority.

The department shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance and for implementing the provisions of this chapter. The procedures must be based on methods and standards which the department finds are adequate to recognize the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes. The department shall identify costs that are recognized for establishing payment rates.

50-24.4-03. Federal requirements - Supremacy.

If any provision of this chapter is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements prevail.

50-24.4-04. Payment rates.

Payment rates paid to any nursing home receiving medical assistance payments must be those rates established pursuant to this chapter and rules adopted under it.

50-24.4-05. Requirements.

No medical assistance payments may be made to any nursing home unless the nursing home is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the department meeting the requirements of state and federal statutes and rules. No medical assistance payments may be made to any nursing home unless the nursing home complies with all requirements of North

Dakota law including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing home participates fully in the medical assistance program or is withdrawing from the medical assistance program.

50-24.4-06. Rate determination.

1. The department shall determine prospective payment rates for resident care costs. The department shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs and other factors as determined by the department.
2. The department shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. Compensation for top management personnel must be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.
3. For purposes of determining rates, the department shall:
   a. Include, contingent upon approval of the Medicaid state plan by the centers for Medicare and Medicaid services, allowable bad debt expenses in an amount not to exceed one hundred eighty days of resident care per year or an aggregate of three hundred sixty days of resident care for any one individual; and
   b. Include allowable bad debt expenses in the property cost category in the report year in which the bad debt is determined to be uncollectible with no likelihood of future recovery.
   c. Notwithstanding section 50-24.4-07, include as an allowable cost any tax paid by a basic care or nursing facility due to provisions of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

50-24.4-07. Nonallowable costs.

1. The following costs may not be recognized as allowable: political contributions; salaries or expenses of a lobbyist, as defined in section 54-05.1-02, for lobbying activities; advertising designed to encourage potential residents to select a particular nursing home; fines and penalties; legal and related expenses for unsuccessful challenges to decisions by governmental agencies; memberships in sports, health, or similar social clubs or organizations; and costs incurred for activities directly related to influencing employees with respect to unionization. The department by rule shall exclude the costs of other items or services not directly related to the provision of resident care.
2. Nonallowable costs include the education expense unless:
   a. The education was provided by an accredited academic or technical educational facility;
   b. The education expense was for materials, books, or tuition; and
   c. The amount of education expense claimed for an individual does not exceed fifteen thousand dollars in the aggregate.
3. The education expense may be claimed the year in which it is expended.
4. For any individual who receives education assistance, the facility shall enter a contract with the individual which stipulates a minimum commitment to work for the facility as well as a repayment plan if the individual does not fulfill the contract obligations.
5. An individual who receives the maximum of fifteen thousand dollars of education assistance shall commit to a minimum of six thousand six hundred fifty-six hours of employment after completion of the educational program. The number of hours of employment required may be prorated for an individual who receives less than the maximum of fifteen thousand dollars of education assistance.
6. The facility shall report the education expense separately on the facility's cost report. The expense is allowed as a passthrough and is limited only by the fifteen thousand dollar maximum per individual.

7. If an individual defaults on a contract and education expenses for the individual have previously been claimed in any report year, the facility shall report the amount of repayment on the facility's cost report in the report year in which the default occurs.
8. The department shall exclude sales tax revenue received from a political subdivision or local taxing authority as an offset to costs for facilities located in communities with a population below twelve thousand five hundred people.

50-24.4-08. Notice of increases to private-paying residents.

No increase in nursing home rates for private-paying residents is effective unless the nursing home notifies the resident or person responsible for payment of the increase in writing thirty days before the increase takes effect. A nursing home may adjust its rates without giving the notice required by this section when the purpose of the rate adjustment is to reflect a necessary change in the category of care provided to a resident.

50-24.4-09. Interim rates.

Repealed by S.L. 2005, ch. 432, § 10.

50-24.4-10. Operating costs.

1. The department shall establish procedures for determining per diem reimbursement for operating costs.
2. The department shall analyze and evaluate each nursing home's cost report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective.
3. The department shall establish price limits on actual allowable historical operating cost per diems, increased by the market basket for skilled nursing facility before productivity assessment, based on cost reports of allowable operating costs taking into consideration relevant factors including resident needs, nursing hours necessary to meet resident needs, size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. For the rate year beginning 2022, the department shall establish price limits for cost categories using the June 30, 2021, cost report year as the base period. The price limits must be established using the same percentage of the median used to establish the limits for the June 30, 2020, base period. In determining allowable historical operating cost per diems for purposes of setting price limits, the department shall divide the allowable historical operating costs by the actual number of resident days, except that when a nursing home is occupied at less than ninety percent of licensed capacity days, the department may establish procedures to adjust the computation of the indirect care cost per diem to an imputed occupancy level at or below ninety percent. To encourage the development of home and community-based services as an alternative to nursing home care, the department may waive the imputed occupancy level requirements for a nursing home that the department determines to be providing significant home and community-based services in coordination with home and community-based service providers to avoid duplicating existing services.
4. In establishing payment rates for one or more operating cost categories, the department may establish separate rates for different classes of residents based on their relative care needs.
5. The department shall include in the ratesetting system for nursing homes those costs associated with computer software and any related technology, including cloud-based services. These expenses are allowed as a direct passthrough.
6. A new base period must be established with the cost report period June 30, 2023.
7. The margin cap used for the rate year beginning 2022 price limits must be no less than three and forty-six hundredths percent.
8. The market basket for skilled nursing facility before productivity adjustment is the preferred index to adjust historical operating costs when a new base period is

established and to adjust the price rate in subsequent years until a new base rate period is established.

9. For the rate years beginning 2022 and 2023, the department shall inform the nursing home of the operating rate using historical operating costs and the operating rate using price limits. The nursing home shall inform the department if the nursing home wants to accept the operating rate using historical operating costs as the established rate.

50-24.4-11. Adjustment of historical operating costs.

1. The department may allow a one-time adjustment to historical operating costs of a nursing home that has been found by the department to be significantly below care-related minimum standards appropriate to the mix of resident needs in that nursing home when it is determined by the department that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the department shall specify the terms and conditions governing any additional payments made to a nursing home as a result of the adjustment. The department shall establish procedures to recover amounts paid under this section, in whole or in part, and to adjust current and future rates, for nursing homes that fail to use the adjustment to satisfy care-related minimum standards.
2. If the department learns that unallowable expenditures have been included in the nursing home's historical operating costs, the department shall disallow the expenditures and recover the entire overpayment out of future payments otherwise due to the nursing home under chapter 50-24.1, or otherwise, as the department may determine.

50-24.4-12. Avoiding detrimental effect on quality of care.

If the department learns that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the licensing division shall be notified.

50-24.4-13. Exclusion.

Until procedures for determining operating cost payment rates according to mix of resident needs are established for nursing homes that exclusively provide residential services for nongeriatric individuals with physical disabilities or units within nursing homes which exclusively provide geropsychiatric services, such nursing homes or units within nursing homes may not be included in the calculation of the limits of any cost categories. Each of these nursing homes or units within nursing homes shall receive its actual allowed historical operating cost per diem adjusted by the inflation rate for nursing home services used to develop the legislative appropriation for the department, and which the department determines to be relevant to residential services for nongeriatric individuals with physical disabilities or geropsychiatric services.

50-24.4-14. General and administrative costs.

All general and administrative costs must be included in general and administrative costs in total, without direct or indirect allocation to other cost categories. In a nursing home of sixty or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of consultants required by law in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home. Central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing, medical records, dietary, other care-related services, and plant operations may be allocated to the appropriate operating cost category of a nursing home according to subsections 1 through 5.

1. Only the salaries, fringe benefits, and payroll taxes associated with the individual performing the service may be allocated. No other costs may be allocated.
2. The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services for the nursing home.
3. The cost in subsection 1 for each consultant must not be allocated to more than one operating cost category in the nursing home. If more than one nursing home is served by a consultant, all nursing homes shall allocate the consultant's cost to the same operating category.
4. Top management personnel must not be considered consultants.
5. The consultant's full-time responsibilities are to provide the services identified in this section.

50-24.4-15. Property-related costs.

1. The department shall include in the ratesetting system for nursing homes a fair rental value payment mechanism for the use of real and personal property.
2. The department shall establish a per bed property cost limitation considering single and double occupancy construction. The double room limit effective July 1, 2015, is one hundred fifty-six thousand seven hundred eighty-three dollars and the single room limit is two hundred thirty-five thousand one hundred seventy-six dollars. The per bed property cost limitation must apply to construction or renovation projects currently in process or which have approved financing in place on or before December 31, 2021. The nursing home must have agency approval of the project by December 31, 2022. The nursing home shall notify the department within thirty days of receiving financial approval for any construction or renovation projects that financing is in place on or before December 31, 2022.
3. The maximum allowable movable equipment replacement value per licensed bed must be fifteen thousand dollars when calculating the fair rental value.
4. The maximum allowable square footage per licensed bed must be nine hundred fifty square feet [88.26 square meters] when calculating the fair rental value.
5. The maximum allowable rental rate must be eight percent when calculating the fair rental value rate.
6. Effective with the 2023 rate year, the property rate component of the payment rate, exclusive of startup and passthrough costs, must be the greater of the rate calculated using allowable property-related costs or the fair rental value rate. If the fair rental value rate is greater than the rate calculated using allowable property-related costs, the increase must be phased in over a four-year period.
7. Effective with the 2023 rate year, if the fair rental value rate is greater than the rate calculated using allowable property-related costs, the increase must be reserved until a major renovation or construction is placed in service.
8. Effective with the 2023 rate year and subsequent rate years, if the fair rental value rate is less than the rate calculated using allowable property-related costs, the department shall inform the nursing home of the property rate using allowable property-related costs and the fair rental value. Before the start of each rate year, the nursing home shall inform the department if the nursing home wants to accept the property rate using allowable property-related costs as the established rate. The allowable property-related costs must be calculated using only the allowable depreciation on capital assets and interest on debt as of June 30, 2022, for all rate years. Once the fair rental value rate is equal to or greater than the rate calculated using allowable property-related costs, or the nursing home does not inform the department the nursing home wants to accept the property rate using allowable property-related costs, the department no longer need inform the nursing home of the property rate using allowable property-related costs and the rate must be calculated using the fair rental value methodology.

50-24.4-16. Special rates.

1. For nursing homes with a significant capacity increase and for newly constructed nursing homes, which first provide services on or after July 1, 1988, and which are not included in the calculation of the limits of any cost category, the department shall establish procedures for determining interim operating cost payment rates. The interim payment rate may not be in effect for more than eighteen months. The department shall establish procedures for determining the interim rate and for making a retroactive cost settle-up for periods when an interim rate was in effect.
2. As soon as is practicable following the establishment of the procedures required by subsection 1, the department shall apply the special rates for all affected facilities.

50-24.4-17. Adjustments and reconsideration procedures.

1. Rate adjustments may be made to correct errors subsequently determined and must also be retroactive to the beginning of the facility's rate year except with respect to rates paid by private-paying residents.
2. Any requests for reconsideration of the rate must be filed with the department's medical services division for administrative consideration within thirty days of the date of the rate notification.

50-24.4-18. Appeals.

1. A nursing home dissatisfied with the final rate established may, upon completion of the reconsideration, appeal. An appeal may be perfected by mailing or delivering the information described in subdivisions a through e to the department, at such address as the department may designate, mailed or delivered on or before five p.m. on the thirty-first day after the date of mailing of the determination of the medical services division made with respect to a request for reconsideration. An appeal under this section is perfected only if accompanied by written documents including the following information:
   a. A copy of the letter received from the medical services division advising of that division's decision on the request for reconsideration;
   b. A statement of each disputed item and the reason or basis for the dispute;
   c. A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item;
   d. The authority in statute or rule upon which the appealing party relies for each disputed item; and
   e. The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.
2. Upon assignment, the hearing officer shall set and conduct the hearing within one hundred twenty days of the date of assignment.
3. Within sixty days after all evidence has been received, the department shall make its findings of fact and conclusions of law and enter a decision based upon its findings and conclusions.
4. A nursing home may seek a writ of mandamus to compel the hearing officer to timely set and conduct a hearing or to compel the department to timely issue a decision; however, no writ may be granted to a nursing home contributing to the delay.

50-24.4-18.1. Rates pending reconsideration and appeal.

1. For purposes of this section:
   a. "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 made under section 50-24.4-17, a request for an administrative appeal under section 50-24.4-18, or a request for judicial appeal under chapter 28-32 taken from a decision on an administrative appeal.
   b. "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 nursing home

prevails on a request for reconsideration made under section 50-24.4-17, on a request for an administrative appeal under section 50-24.4-18, or on a request for a judicial appeal under chapter 28-32 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 or through rules adopted under section 50-24.4-02.

2. If a nursing home has made a request for reconsideration under section 50-24.4-17, taken an administrative appeal under section 50-24.4-18, or taken a judicial appeal under chapter 28-32 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 nursing home'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.
3. The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding section 50-24.4-19, the total must be the rate chargeable to private-paying residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal.
4. The nursing home shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-paying resident from the date the nursing home charges a private-paying resident the pending decision rate.
5. If the pending decision rate paid by a private-paying resident exceeds the final decision rate, the nursing home shall refund the difference, plus interest at the legal rate, within sixty days after the final decision is no longer subject to appeal. If a nursing home fails to provide a timely refund to a living resident or former resident, the nursing home shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the nursing home 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 nursing home may make any disposition of the refund permitted by law. Interest paid under this subsection is a nonallowable cost.

50-24.4-19. Prohibited practices.

A nursing home is not eligible to receive medical assistance payments unless it refrains from all of the following:

1. Charging private-paying residents rates for similar services which exceed those rates which are approved by the department for medical assistance recipients, as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may charge private-paying residents a higher rate for a private room and charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the department. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be offered to all residents and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing home in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing home. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing home that charges a private-paying resident a rate in violation of this chapter is subject to an action by the state or any of its subdivisions or agencies for

civil damages. A private-paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this chapter. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorney's fees or their equivalent.

2. Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home.
3. Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home.
4. Providing differential treatment on the basis of status with regard to public assistance.
5. Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance. Admissions discrimination shall include, but is not limited to:
   a. Basing admissions decisions upon assurance by the applicant to the nursing home, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs.
   b. Engaging in preferential selection from waiting lists based on an applicant's ability to pay privately.

   The collection and use by a nursing home of financial information of any applicant pursuant to a preadmission screening program does not raise an inference that the nursing home is utilizing that information for any purpose prohibited by this chapter.
6. Requiring any vendor of medical care, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of the vendor's fee to the nursing home except as payment for the fair market value of renting or leasing space or equipment of the nursing home or purchasing support services, if those agreements are disclosed to the department.
7. Refusing, for more than twenty-four hours, to accept a resident returning to the resident's same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.
8. Violating any of the rights of health care facility residents enumerated in section 50-10.2-02.
9. Charging a managed care organization a rate that is less than the rate approved by the department for a medical assistance recipient in the same classification.

50-24.4-19.1. Rates for private rooms - Payments by a third party on behalf of medical assistance recipients.

1. Notwithstanding section 50-24.4-19, a nursing home may receive a payment, in addition to payment of the rate set under this chapter, for the use of a private room by a resident who receives medical assistance benefits if:
   a. The private room is not medically necessary;
   b. The resident, or another person acting on behalf of the resident, has requested the private room and the nursing home informs the person making the request, at the time of the request, of the amount of the payment; and
   c. The payment does not exceed the amount that the nursing home charges private-paying residents for a private room under subsection 1 of section 50-24.4-19.
2. For purposes of this chapter, a private room is a covered service only if medically necessary for the care of a resident.

50-24.4-19.2. Residents with extraordinary needs.

The department shall develop criteria identifying extraordinary medical needs so severe as to make it difficult for affected persons to secure necessary care in nursing facilities. The department shall consider those extraordinary medical needs that may be associated with

extensive pulmonary disease, specialized rehabilitation, and ventilator dependence. Notwithstanding any other provision of this chapter, the department may determine rates for nursing home residents with extraordinary medical needs. The department shall consider the costs of alternative care or treatment in determining rates for nursing home residents with extraordinary medical needs. A rate so determined by the department is effective for services provided after:

1. The department has agreed that the criteria are met;
2. The facility has agreed to provide necessary services at that rate; and
3. For periods when the person is not eligible for medical assistance, the person or anyone who may lawfully act on the person's behalf, has agreed to the rate.

50-24.4-20. Temporary payments - Correction orders.

For a period not to exceed one hundred eighty days from the date of mailing formal notice, the department may continue to make medical assistance payments to a nursing home which is in violation of this chapter if extreme hardship to the residents would otherwise result. In these cases, the department shall issue an order requiring the nursing home to correct the violation. The nursing home has twenty days from its receipt of the order to correct the violation. If the violation is not corrected within the twenty-day period, the department may reduce the payment rate to the nursing home by up to twenty percent. The amount of the payment rate reduction must be related to the severity of the violation and must remain in effect until the violation is corrected. The nursing home may seek reconsideration of or appeal the department's action pursuant to the provisions of sections 50-24.4-17 and 50-24.4-18.

50-24.4-21. Termination.

If a nursing home terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the nursing home to receive continued reimbursement only on a temporary basis until medical assistance residents can be relocated to nursing homes participating in the medical assistance program.

50-24.4-22. Exception.

In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing home under this chapter, the department may cease medical assistance payments to that nursing home.

50-24.4-23. Reporting requirements.

1. No later than October first of each year, each nursing home that receives medical assistance payments from the department shall:
    a. Except for state-owned facilities, provide the department with a copy of its audited report that meets the reporting standards of the American institute of certified public accountants and includes an audited statement of the rate or rates charged to private-paying residents. The examination by the certified public accountant must be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American institute of certified public accountants;
    b. Provide the department with a statement of ownership for the facility or a certification that ownership has not changed since the most recent statement given pursuant to this subsection;
    c. Provide the department with audited financial statements as specified in subdivision a for every other facility owned in whole or in part by an individual or entity which has an ownership interest in the facility;
    d. Upon request, provide the department with audited financial statements as specified in subdivision a for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

e. Provide the department with copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the nursing facility, or a certification that the content of any such document remains unchanged since the most recent statement given pursuant to this subsection;
f. Upon request, provide the department with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs; and
g. Permit access by the department to the certified public accountant's audit workpapers which support the audited financial statements required in subdivisions a, c, and d.

2. Documents or information provided to the department pursuant to this chapter must be public. If the requirements of subsection 1 are not met, the reimbursement rate may be reduced to eighty percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting year, and the reduction must continue until the requirements are met.

50-24.4-24. Incomplete or inaccurate reports.

The department may reject any annual cost report filed by a nursing home pursuant to this chapter if the department determines that the report or the information required in section 50-24.4-23 has been filed in a form that is incomplete or inaccurate. In the event that a report is rejected pursuant to this chapter, the department may reduce the reimbursement rate to a nursing home to eighty percent of its most recently established rate until the information is completely and accurately filed.

50-24.4-25. Extensions.

The department may grant an extension of the reporting deadline, not to exceed thirty days, to a nursing home for good cause.

50-24.4-26. False reports.

If a nursing home knowingly supplies inaccurate or false information in a required report that results in an overpayment, the department shall:

1. Immediately adjust the nursing home's payment rate to recover the entire overpayment within the rate year;
2. Terminate the department's agreement with the nursing home;
3. Prosecute under applicable state or federal law; or
4. Use any combination of the foregoing actions.

50-24.4-27. Medicare certification.

All nursing facilities certified under the medical assistance program shall participate in Medicare part A and part B with respect to at least thirty percent of the beds in the facility unless, after submitting an application, Medicare certification is denied by the federal health care financing administration. The facility shall file on behalf of each patient or assist each patient in the filing of requests for any third-party benefits to which the patient may be entitled. Charges for Medicare-covered services provided to residents who are simultaneously eligible for medical assistance and medicare must be billed to Medicare part A or part B before billing medical assistance. Medical assistance may be billed only for charges not reimbursed by Medicare.

50-24.4-28. Implementation.

The department shall seek appropriations to implement this chapter during and after the rate year beginning January 1, 1990.

50-24.4-29. Geropsychiatric facilities.

The department may select one or more nursing homes within the state to operate a unit that exclusively provides geropsychiatric services. Admission to one of the nursing homes that exclusively provides geropsychiatric services for the purpose of receiving geropsychiatric services may be granted only after the state hospital has performed an evaluation of the individual being admitted which indicates the individual is in need of nursing home geropsychiatric services. If at any time the department determines that the number of approved geropsychiatric units in the state is insufficient to meet the needs, the department may select a geropsychiatric unit based on the experience, qualification, and capacity of the nursing homes that propose to provide geropsychiatric services. The state hospital may not offer geropsychiatric services through a unit set up exclusively to provide those services.

50-24.4-30. Government nursing facility funding pool.

Repealed by S.L. 2005, ch. 436, § 2.