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State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **10-0009**

This file contains the following documents in the order listed:

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

Division of Medicaid and Children's Health Operations
Financial Management Group

JUN 30 2015

Valerie Harr
State Medicaid Director
Department of Human Services
Division of Medical Assistance and Health Services
State of New Jersey
P.O. Box 712
Trenton, NJ 08625-0712

RE: State Plan Amendment (SPA) NJ 10-0009

Dear Ms. Harr:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-0009. Effective July 1, 2010 this amendment , this amendment re-writes the reimbursement provisions for nursing home services and recodifies this Attachment.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New Jersey 10-0009 is approved effective July 1, 2010. I have enclosed the CMS-179 and the approved plan pages

The state must continue to work with CMS to resolve the issue of political subdivision funding compliance raised by Health and Human Services Office of Inspector General report #A-02-11-01039.

If you have any questions, please call Tom Brady at 518-396-3810 x109 or Rob Weaver at 410-786-5914.

Sincerely

[redacted]

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-09-MA	2. STATE: New Jersey
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act section 1902(a)(13)	7. FEDERAL BUDGET IMPACT: a. FFY 2010 ($0) b. FFY 2011 ~~($0)~~ ($21.066m)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pages ~~2~~ 1 through ~~39~~ 27	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, pages 2 through 197 SEE ATTACHED

10. SUBJECT OF AMENDMENT: Nursing Facility Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☒ OTHER, AS SPECIFIED: Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Division of Medical Assistance and Health Services P.O. Box 712, #26 Trenton, NJ 08625-0712
13. TYPED NAME: Jennifer Velez	
14. TITLE: Commissioner	
15. DATE SUBMITTED: September 30, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN 30 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 01, 2010	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: KRISTIN FAN	22. TITLE: Deputy Director, FMG

23. REMARKS:

The State requested "Pen + Ink" changes to Boxes 7, 8, 9

FORM HCFA-179 (07-92)

Transmittal Number 10-09-MA
CMS 179

Box 8
Attachment 4.19-D Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 21, 22, 23, 24, 25, 26, 27.

CMS 179
Box 9
Attachment 4.19-D Pages 1, 1.a , 2, 3, 3.1, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 81.1, 82, 83, 84, 85, 86, 87, 88, 88.1, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 101.1, 102, 103, 104, 105, 106, 106.1, 107,108,109, 109.1, 110, 110.1, 110.2, 110.3, 111, 112, 113, 114, 114.1, 114.2, 115, 116, 117, 117.1, 118, 119, 120, 121, 121.1, 121.2, 122, 123, 124, 124.1, 125, 126, 126.1,127, 128, 129, 130, 131, 132, 133, 134, 134.1, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 144.1, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 171.1, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 191.10, 191.11, 191.12, 191.13, 191.14,192, 193, 194, 195, 196, and 197.

NURSING FACILITY REIMBURSEMENT
COST REPORT, RATE CALCULATION AND REPORTING SYSTEM
FOR LONG-TERM CARE FACILITIES

NURSING FACILITY REIMBURSEMENT

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act

CONTENTS

Section 1. Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey, Department of Health and Senior Services (Department), to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program.

(b) The Department believes that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The Department recognizes, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the Department is prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the Department reserves the right to question and exclude any unreasonable costs.

(e) All rates established pursuant to these rules will be subject to onsite audit verification of costs and statistics reported by NFs.

(f) For dates of service on or after July 1, 2010, the rates for Class I proprietary and voluntary NFs and Class II governmental NFs shall be based on the prospective case mix system required by these sections.

Section 2. Cost report preparation and timing of submission

(a) Nursing facilities shall furnish required cost reports to the Department of Health and Senior Services, Office of Nursing Facility Rate Setting and Reimbursement, by May 31 following the end of each calendar year for a cost reporting period ending December 31.

(1) Effective for periods ending on or after December 31, 2010, the cost report form shall be the Medicare cost report and supplemental Medicaid schedules

designated by the Department and incorporated herein by reference as Appendix U.

(2) A nursing facility shall file separate cost reports for each central/home office when costs of the central/home office are reported on the facility's cost report.

(3) Prospectively determined payment rates for Class I and II facilities shall be redetermined quarterly by the Department.

(b) Where a properly completed cost report, and other required documents, are received beyond the filing requirements of (a) above, the following schedule of penalties shall be applied to current and/or subsequent reimbursement rates as the particular circumstances dictate:

Number of days after due date	Amount of penalty	Month(s) of penalty
1-15	.25 percent of the NF's rate per patient day	1st month
16-30	.50 percent of the NF's rate per patient day	1st month
31-60	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
61-90	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
	2 percent of the NF's rate per patient day	3rd month
91 and thereafter	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
	2 percent of the NF's rate per patient day	3rd month
	3 percent of the NF's rate per patient day	4th and subsequent months

(c) Penalties shall remain in force until such time that a properly completed cost report and all other required documents have been received. Penalties are not recoverable and are not allowable costs.

(d) The Assistant Commissioner, Division of Senior Benefits and Utilization Management, or a designee of the Assistant Commissioner, may mitigate or waive the penalties specified in (b) above, for "good cause" shown:

(1) "Good cause" shall include but shall not be limited to, circumstances beyond the control of the nursing care facility, such as fire, flood or other natural disaster;
(2) Acts of omission and/or negligence by the nursing facility, its employees, or its agents, shall not constitute "good cause" for waiving the penalty provisions;
(3) All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the Assistant Commissioner may require.

(e) The penalty rates indicated in (b) above shall be applied to cost reports commencing with the reporting periods ending December 31, 2010.

(f) A nursing facility cost report cannot be substituted or revised by a NF except if such substitution or revision would prevent an overpayment to the NF.

(g) Nursing facilities shall report allowable costs for cost report periods ending on or after December 31, 2010, using allowable cost criteria contained within the Medicare Provider Reimbursement Manual.

Section 3. Rate classes

(a) For dates of service on or after July 1, 2010, Class I and Class II prospective rates shall be case mix rates for two classes of NFs:
(1) Class I Proprietary and Voluntary NFs:
(i) To qualify as a Class I NF, the NF shall meet all of the contractual requirements of the Department of Health and Senior Services;
(2) Class II Governmental NFs:
(i) To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the Department of Health and Senior Services and be a governmental operation.

Section 4. Resident rosters and case mix index calculation

(a) A NF shall electronically transmit MDS assessment information in a complete, accurate and timely manner.
(1) The Department shall provide a Preliminary Resident Roster to a NF based on the NF's transmitted MDS assessment information for a calendar quarter when that information is transmitted by the twentieth day following the end of the calendar quarter.
(2) The Department shall provide a Final Resident Roster to a NF based on the NF's transmitted MDS assessment information for a calendar quarter when that

information is transmitted by the end of the second calendar month following the end of the calendar quarter.

(3) The Department shall not consider MDS assessment information for the purpose of reimbursement rate calculations under this subchapter for a calendar quarter that is not submitted by the end of the second calendar month following the end of the calendar quarter except as provided in (a)4 below.

(4) The Department may only grant an exception to the electronic MDS assessment transmission due date for the following reasons:

(i) A showing by the nursing facility that fraud may have occurred;

(ii) An intervening natural disaster making timely compliance impossible or unsafe;

(iii) Technical failure of the NF system used to encode and transmit MDS information;

(iv) Technical failure of the central MDS data collection system; or

(v) A new NF not previously certified by either the Medicare or Medicaid program that can substantiate to the Department circumstances that preclude timely electronic transmission.

(b) The Department shall use the resource utilization group to adjust direct care case mix costs and to determine each NF's direct care rate component.

(1) The Department shall adjust a nursing facility's case mix reimbursement rates on a quarterly basis based on the change in case mix of each facility according to the following schedule:

(i) Case mix measure obtained from January 1 through March 31 shall be used to adjust rates effective July 1 through September 30 of the same calendar year.

(ii) Case mix measure obtained from April 1 through June 30 shall be used to adjust rates effective October 1 through December 31 of the same calendar year.

(iii) Case mix measure obtained from July 1 through September 30 shall be used to adjust rates effective January 1 through March 31 of the following calendar year.

(iv) Case mix measure obtained from October 1 through December 31 shall be used to adjust rates effective April 1 through June 30 of the following calendar year.

(c) The Department or its designated contractor shall distribute preliminary and final resident rosters to Class I NFs, Class II NFs and SCNFs according to the following schedule:

Resident Roster Quarter	Preliminary Resident Roster Distributed	Final Resident Roster Distributed
January 1- March 31	May 10 for submissions through April 20	June 20 for submissions through May 31
April 1 – June 30	August 10 for submissions through July 20	September 20 for submissions through August 31
July 1 – September 30	November 10 for submissions through October 20	December 20 for submissions through November 30
October 1 – December 31	February 10 for submissions through January 20	March 20 for submissions through February 28

(d) A nursing facility that has a SCNF unit shall notify the Department of the room numbers of the beds in the SCNF unit so that the residents in these units may be identified separately on the resident roster.

(e) A nursing facility shall review preliminary resident rosters for completeness and accuracy.

(1) If data reported on the preliminary resident roster is in error or if there is missing data, NFs shall have two calendar months following the end of the calendar quarter to transmit additional MDS records, inactivations or modifications needed to obtain a correct resident roster.

(f) For each resident roster quarter, the Department shall calculate a statewide average case mix index and a statewide average Medicaid case mix index from all final resident rosters from Class I and Class II nursing facilities.

Section 5. Fringed costs

(a) In order to equitably develop and calculate limits and prices the following computation shall be made for all cost reports effective for periods ending before December 31, 2010:

(1) General fringe benefits shall be allocated to function as a percentage of salaries reported to develop total compensation. General fringe benefits shall include the raw food value of free and subsidized meals to employees.

(2) The term "fringed costs" means the net amount of compensation costs (salary and fringe benefits) plus other expenses, less expense recoveries and nonallowable costs.

(3) For NFs which provide residential, sheltered or domiciliary care, fringed nursing facility costs shall be determined by apportioning fringed cost in the same ratio as the apportionment of unfringed net expenses.

Section 6. Inflation

(a) For the purpose of calculating the limit and price as set forth in Section 9 and for adjusting the operating and administrative price between rebasing years as set forth in Section 8(c)2, the Department shall calculate an index factor using the most recent index factor publication based on the Skilled Nursing Home without Capital Market Basket Index published by Global Insight, which is available from CMS at www.cms.gov, or a comparable index available from, and used by, CMS, if this index ceases to be published.

(b) The Department shall calculate the index factor by dividing the index associated with the quarter ending on the mid point of the rate year for which the index is being established by the index associated with the quarter ending on the mid point of the cost reporting period for purposes of setting the limit and price in Section 9 or the mid point of the prior rate year for purposes of adjusting the operating and administrative price in Section 8(c)2.

Section 7. Case mix rate components

(a) Effective for dates of service on or after July 1, 2010, for Class I and Class II NFs, each facility's rate shall be comprised of:

(1) The facility's direct care case mix rate component and direct care non-case mix rate component;

(2) The operating and administrative price;

(3) The facility-specific fair rental value (FRV) allowance; and

(4) The provider tax pass-through per diem provided by Section 12.

(b) The NF's direct care case mix rate component shall be based on the following costs:

(1) RN Nursing salaries, payroll taxes and general benefits;

(2) LPN Nursing salaries, payroll taxes and general benefits; and

(3) Nurse Aides salaries, payroll taxes and general benefits.

(c) The NF's direct care non-case mix rate component shall be based on the following costs:

(1) Medical director salaries, payroll taxes and general benefits;
(2) Patient activities salaries, payroll taxes and general benefits;
(3) Pharmaceutical consultant salaries, payroll taxes and general benefits;
(4) Non-legend drugs;
(5) Routine medical supplies;
(6) Social services salaries, payroll taxes and general benefits; and
(7) Routine oxygen.

(d) For purposes of (b) and (c) above for cost reports ending on or after December 31, 2010, if these services are acquired through a contract, only the actual wages, payroll taxes and general employee benefits associated with those individuals providing direct care services for the nursing facility may be included in the direct care rate component, and all of the contracting entity's overhead, other costs and fees charged to the nursing facility shall be reported as other general services costs on the cost report. Such contracts shall include a requirement for a detailed breakdown of the costs as follows:

(1) Wages paid to the contract staff performing the direct care services for the nursing facility;
(2) Payroll taxes of the contract staff performing the direct care services for the nursing facility;
(3) General employee benefit expense for the staff performing the direct care services for the nursing facility;
(4) Special employee benefit expense for the staff performing the direct care services for the nursing facility; and
(5) The contractor's costs for all other costs, including overhead related costs and service fees.

(i) If the contractor is a related party, all other costs, including overhead related costs, shall be identified separately from service fees.

(1.) Failure to provide these cost breakdowns shall result in the entire contract cost being disallowed for reimbursement purposes, and these cost breakdowns shall be part of the cost report when filed.

(ii) If the contractor is not a related party, the costs listed under (d)1, (d)2 and (d)3 above may be reported as a lump sum for each contract, and costs listed under (d)4 and (d)5 above may be reported as a second lump sum for each contract.

(e) The operating and administrative price shall be based on all allowable costs that are not directly recognized in the direct care rate component, the provider tax pass-through or the FRV allowance and shall include the costs of the following listed items:

(1) Management,
(2) Administrator,
(3) Assistant administrator,
(4) Other administrative,
(5) Home office and/or management company costs properly allocated to the NF,
(6) Dietary,
(7) Food,
(8) Laundry and linen,
(9) Housekeeping,
(10) Other general services costs, including contract staffing costs other than those reported costs listed in (b) and (c) above,
(11) Maintenance (non capital portion),
(12) Utilities,
(13) Property insurance,
(14) Other property operating costs,
(15) Property taxes for the land and building, and
(16) All other allowable costs not directly recognized in the direct care case mix adjusted or non-case mix adjusted cost center or reimbursed through the FRV allowance.

(f) The facility-specific fair rental value (FRV) allowance shall reimburse a NF on the basis of the estimated depreciated value of its capital assets in lieu of direct reimbursement for allowable depreciation, amortization, capital related interest, rent expenses and lease expenses.

(1) The Department shall establish a NF's bed value based on the age of the NF re-aged to reflect replacements, major renovation or additions placed into service since the NF's facility was built, to the extent those replacements, renovations and additions are reported to the Department and documented by the NF.
(2) A nursing facility shall provide documentation to the Department upon request for these items to be considered in the calculation of the initial effective age and annual re-age calculations.
(3) The FRV allowance for dates of service July 1, 2010, through June 30, 2011, shall be based on the Fair Rental Value Data Report, provided there is sufficient documentation to support the historical information.
(4) The FRV allowance for dates of service after June 30, 2011, shall incorporate any capitalized assets placed into service during the prior year and submitted on the Fair Rental Value Re-age Request.

(i) A nursing facility shall submit a Fair Rental Value Re-age Request to the Department by June 15 to be considered in the next July 1 annual rate setting process.

(ii) Requests received by the Department after June 15, shall be considered in the rate setting process the following year.

Section 8. Limit and price database

(a) The Department shall establish the database used to derive the direct care limit and operating and administrative price used in rates for dates of service July 1, 2010, through June 30, 2011, as follows:

(1) Each Class I NF and Class II NF in operation as a Medicaid certified NF as of May 1, 2010, shall be identified.

(2) The most recent validated cost report for each identified Class I NF and Class II NF, or a prior owner of that NF, that is available on May 1, 2010, with a cost reporting period covering at least six months ending on or before November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

(i) In the event of a change of ownership after November 30, 2007, and the new owner has a more recent validated cost report covering at least six months and that validated cost report is available on May 1, 2010, the more recent validated cost report shall be selected as the basis for establishing nursing facility rates under this chapter.

(ii) If no validated cost report fitting these criteria is available, the closest validated cost report covering at least a six-month period ending after November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

(iii) If no validated cost report covering at least a six-month period is available for the identified Class I NF and Class II NF, that NF shall be excluded from the limit and price database.

(b) On an annual basis beginning for rates for dates of service after June 30, 2011, the Department shall establish the direct care limit using the most recent validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF and Class II NF in operation as a Medicaid certified NF.

(1) If no validated cost report is available for a Class I NF and Class II NF, that NF shall be excluded from the limit database.

(c) Every third year, beginning for rates for dates of service after June 30, 2013, the Department shall establish the operating and administrative price using the most recent

validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF in operation as a Medicaid certified NF.

(1) If no validated cost report is available for a Class I NF, that NF shall be excluded from the price database.

(2) For the second and third year between periods when the operating and administrative price is reestablished, the Department shall adjust by one year the operating and administrative price used for the prior rate year, prior to making any adjustments pursuant to Section 13(d)1, using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in Section 6, from the mid-point of the prior rate year to the mid-point of the rate year for which the price is used to establish rates.

Section 9. Limit and price calculation

(a) The Department shall establish the direct care limit for each nursing facility as follows:

(1) For each cost report identified in Section 8, the Department shall fringe the direct care case mix costs and direct care non-case mix costs, as set forth in Section 5, for all cost reports effective for periods ending before December 31, 2010.

(i) For periods ending on or after December 31, 2010, the Department shall select the direct care case mix costs and direct care non-case mix costs from the version of the cost report form used for the cost reporting period.

(2) The Department shall adjust the costs identified in (a)1 above using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in Section 6, from the mid-point of each cost reporting period to the mid-point of the rate year for which the limit is used to establish rates.

(3) The Department shall calculate a per diem adjusted cost as follows:

(i) The adjusted direct care case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care case mix cost per diem;

(ii) The adjusted direct care non-case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care non-case mix cost per diem; and

(iii) The results of i. and ii. above shall be summed to establish the adjusted total direct care cost per diem.

(4) For each cost report, the normalization ratio shall be calculated as the statewide average case mix index divided by the cost report period case mix index.

(5) Each cost report's adjusted direct care case mix cost per diem shall be multiplied by the normalization ratio to arrive at the normalized direct care case mix cost per diem.

(6) Each cost report's normalized direct care case mix cost per diem shall be added to the adjusted direct care non-case mix cost per diem established in (a)3ii above to arrive at the total normalized direct care per diem.

(7) For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the total normalized direct care per diems.

(8) The direct care limit for Class I NFs shall be 115 percent of the Medicaid day weighted median, and the direct care limit for Class II NFs shall be 105 percent of the Class I NF direct care limit.

(b) The Department shall establish the operating and administrative price for each Class I and Class II nursing facility:

(1) For each Class I NF cost report identified in Section 8, the operating and administrative costs shall be fringed as set forth in Section 5 for all cost reports effective for periods ending before December 31, 2010.

(i) For periods ending on or after December 31, 2010, the Department shall select the operating and administrative costs from the version of the cost report form used for the cost reporting period.

(2) The costs identified in (b)1 above shall be adjusted using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year as identified in Section 6, from the mid-point of each cost reporting period to the mid-point of the rate year for which the price is being established.

(3) Each cost report's adjusted operating and administrative costs shall be divided by the total resident days identified on the cost report to arrive at the operating and administrative per diem.

(4) For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the operating and administrative per diems.

(5) The operating and administrative price for Class I NFs shall be 100 percent of the Medicaid day weighted median, and the operating and administrative price for Class II NFs shall be 104.50 percent of the Class I NF operating and administrative price.

Section 10. Direct care and operating and administrative rate component

(a) For each cost report identified in Section 8, the Department shall establish the direct care rate component as follows:

(1) A case mix portion percentage shall be established by dividing the cost report's normalized direct care case mix cost per diem established in Section 9(a)5 by the total normalized direct care per diem established in Section 9(a)6.

(i) A non-case mix portion percentage shall be calculated as 100 percent minus the case mix portion percentage.

(2) A facility-specific direct care limit shall be established as follows:

(i) Multiply each NF's case mix portion percentage by the direct care limit for the NF's Class designation established pursuant to Section 9(a) to determine the facility-specific direct care case mix portion of the limit.

(ii) Multiply the result from 2i above by the ratio of the cost report period case mix index divided by the statewide average case mix index to determine the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index.

(iii) Multiply each NF's non-case mix portion percentage by the direct care limit for the NF's Class designation to determine the facility-specific direct care non-case mix portion of the limit.

(iv) The results of 2ii and iii above shall be summed to determine the facility-specific direct care limit.

(3) For each rate year, the direct care rate component shall be the facility-specific direct care limit or the adjusted total direct care cost per diem established in Section 9(a)3iii, whichever is less.

(4) For each rate quarter, a nursing facility's direct care rate component shall be adjusted for the facility average Medicaid case mix index as follows:

(i) If the direct care rate component is the adjusted total direct care cost per diem established in Section 9(a)3iii, the adjusted direct care case mix cost per diem established in Section 9(a)3i shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index plus the adjusted direct care non-case mix cost per diem established in Section 9(a)3ii.

(ii) If the direct care rate component is the facility-specific direct care limit established in Section 10(a)2iv, the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index according to Section 10(a)2ii shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index average plus the facility-specific direct care non-case mix portion of the limit established in Section 10(a)2iii.

(iii) To prevent any aggregate increase or decrease in expected Medicaid program expenditures between July rate setting quarters, for resident roster quarters used in the October, January and April rate quarter, the facility average Medicaid case mix index for use in the quarterly rate adjustments for each NF shall be increased or decreased proportionately so that the statewide average Medicaid case mix index equals the statewide average Medicaid case mix index for the resident roster quarter used in the July rate quarter.

(5) Except for a new Class I NF or Class II NF, the following shall apply to each Class I NF and Class II NF not included in the Section 8 database and to each Class I NF and Class II NF included in this database but where the NF's cost report filing status subjects that NF to penalties pursuant to Section 2(b):

(i) If the NF has had a validated cost report included in the database for rate setting purposes under this chapter, the direct care rate component shall be the lowest direct care rate for the applicable Class of NF for the rate quarter.

(1.) The direct care rate in (a)5i above shall remain in effect until such time that a properly filed cost report is received and validated, and a direct care rate established using that validated cost report shall be used to retrospectively adjust the rate quarters in which the lowest direct care rate was used; or

(ii) If the NF does not have a validated cost report included in the database for rate setting purposes under this chapter, the rate paid to the NF, including any applicable add-ons, shall be its reimbursement rate in effect on June 30, 2010.

(b) Each NF's operating and administrative rate component shall be the price established for the NF's class designation for the rate year.

Section 11. Fair rental value rate allowance

(a) The Department shall determine the facility fair rental value allowance for each Class I NF and Class II NF as follows:

(1) The new construction value per bed shall be $89,000.

(2) The age of each NF for the July 1, 2010, through June 30, 2011, rate year shall be determined using the FRV Data Report adjusted to calculate the initial effective age as of 2010.

(3) If complete auditable FRV Data Reports are not available for each facility by June 15, 2010, the nursing facility shall be assigned an initial age of 40 years that can only be adjusted by a complete auditable FRV Data Report.

(4) For years after 2010, the age of each facility shall be adjusted each July 1 to make the facility one year older to a maximum of 40 years as well as to make the following adjustments for allowable capitalized costs and other data submitted on the FRV Re-age Request:

(i) If a NF places new beds in service during the cost report period, these new beds shall be averaged into the adjusted age of the prior existing beds to arrive at the facility's re-age.

(a) New licensed beds that have allowable capitalized costs of at least the new construction value per bed noted in paragraph (a)1 above shall be re-aged using zero as their age. Allowable capitalized costs in excess of the construction value per bed shall be considered for additional re-aging pursuant to (a)4ii below.

(b) New licensed beds that have allowable capitalized costs less than the new construction value per bed as noted in paragraph (a)1 above shall be considered to be the same age as the existing licensed beds for the purpose of the re-aging process described below. Allowable capitalized costs in excess of the construction value per bed related to the calculated age of the beds prior to submission of the FRV Re-age Request shall be considered for re-aging pursuant to (a)4ii below.

(ii) If a NF completes a major renovation project or major replacement project, defined as a project with allowable capitalized costs equal to or greater than $1,000 per bed in service during the cost report period, the cost of the project shall be represented by an equivalent number of new beds.

(5) A major renovation or replacement project shall have been started within the 24 months preceding the completion date reported on an FRV Re-age Request for the reporting period used for the July 1 rate year, and shall be related to the reasonable functioning of the NF.

(i) Major renovations and replacement projects unrelated to either the direct or indirect functioning of the NF shall not be used to adjust the facility's age.

(ii) Adjustments to a facility's age due to major renovations or replacement projects that result in fewer licensed beds at completion of the project shall be calculated using the number of licensed beds at the beginning of the project.

(6) The equivalent number of new beds shall be determined by dividing the capitalized cost of the project, exclusive of the costs attributable to the construction of new beds, by the accumulated depreciation per bed of two

percent per year of the facility's existing beds immediately before the project was completed.

(7) The Department shall calculate an adjusted age of the facility by taking the equivalent number of new beds determined in (a)6. above plus the number of new beds aged at zero pursuant to (a)4ia. above and the result shall be subtracted from the total licensed beds, and the result therefor shall be multiplied by the age of the facility, as adjusted for prior additions, major renovations and replacements. The product of this calculation shall then be divided by the number of licensed beds after the completion of the project to arrive at the adjusted age of the facility.

(i) An example of the calculation follows:

Licensed Beds Before Re-aging – 100
Licensed Beds After Re-aging – 110
Number of New Licensed Beds - 10
Age of Beds Prior to Re-age – 10
Allowable Capitalized Costs - $1,150,000

Calculations:
Are Allowable Capitalized Costs greater than or equal to New construction value?
10 beds × $89,000 = $890,000; Answer is "yes."

Additional re-aging:
$1,150,000 - $890,000 = $260,000 (greater than $1,000 per bed)
Current Accumulated Depreciation per Bed: 10 Years @ 2% = 20%

Bed Value:
$89,000 × 20% = $17,800 Depreciation per Bed

Equivalent New Beds:
$260,000 ÷ $17,800 = 14.61

Old Beds:
110 beds – 14.61 equivalent new beds – 10 new beds = 85.39 at 10 years old
24.61 beds zero years old – Accum. Age = 0 years
85.39 beds 10 years old – Accum. Age = 853.90 years
853.90 years ÷ 110 licensed beds = 7.76 (Round to 8)

(8) If an existing structure is converted for use as a nursing facility, the provider must submit a completed FRV data report.

(i) If a complete auditable FRV data report is not submitted, that nursing facility shall be deemed to have an age of 40 years for the purposes of the FRV calculation.

(9) For each nursing facility, the facility per bed value shall be calculated as the difference between the new bed value and the new bed value multiplied by the weighted age of the NF (not to exceed 40 years) multiplied by 2 percent depreciation.

(10) The facility total value shall be calculated as the facility per bed value multiplied by the number of licensed beds for the nursing facility.

(11) The fair rental value allowance shall be calculated by multiplying the facility total value by an 8 percent rental factor and dividing that result by the higher of actual resident days or 95 percent of available days from the cost report used in the database established at Section 8 for the direct care limit.

(i) For Class I NFs and Class II NFs not represented in the database established at Section 8 for the direct care limit, the fair rental value allowance shall be calculated by dividing the facility fair rental value by 95 percent of available days, calculated as licensed beds times 365 days.

Section 12. Adjustments and pass-throughs

(a) The provider tax pass-through per diem for the rate year shall equal the total tax paid by all nursing facilities for the calendar year preceding the rate year divided by the total resident days, including all taxable and non-taxable days, as reported on the NHA-100s encompassing that calendar year for facilities not exempt from the provider tax program. The provider tax pass-through shall be paid to each nursing facility required to pay the provider tax.

(b) NFs may request interim adjustments to rates during a prospective rate period for either legally mandated matters or for extraordinary factors beyond their control.

(1) Interim adjustments, if approved by the Department, shall not apply retroactively unless, for reasons beyond the control of the NF, costs are affected retroactively.

(2) Interim adjustments shall not be in effect for a period longer than 12 months.

Section 13. Total adjusted case mix rate

(a) For each rate year, the total adjusted case mix rate for each Class I NF and Class II NF shall be the sum of the direct care rate component, the operating and administrative

rate component, the fair rental value allowance, phase-in provisions identified in Section 16 and the provider tax pass-through per diem.

(1) The Department shall compare the statewide Medicaid day weighted average Class I NF, Class II NF and Class III NF July rate to a target rate calculated from the legislative appropriations for nursing facility Medicaid reimbursement according to (c) below.

(2) To the extent that the Medicaid day weighted average comparison rate for all Classes exceeds the target rate, each Class I NF and Class II NF total adjusted case mix rate and Class III NF rate, exclusive of the provider tax pass-through per diem, shall be reduced in accordance with (d) below.

(b) The Department shall determine the statewide Medicaid day weighted average comparison rate of Class I NF, Class II NF and Class III NF rate as follows:

(1) The most recent full state fiscal year NF and SCNF paid claims days available on May 1 prior to the rate year shall be identified, and bed hold days shall be included by weighting the days to reflect the percentage of the nursing facility rate paid for bed hold.

(2) Each nursing facility's comparison rate identified in (a) above shall be multiplied by the nursing facility's paid claims days, and the sum of the results shall be divided by the sum of the paid claims days to determine the statewide Medicaid day weighted average comparison rate.

(c) The Department shall determine the target rate as follows:

(1) The total amount of State legislative appropriations for nursing facility Medicaid reimbursement for the rate year July 1 to June 30, excluding the State share of funding for the provider tax pass-through per diems, shall be divided by one minus the Federal Medical Assistance Percentage (FMAP) applicable for the NF rate year to determine the total amount available for nursing facility reimbursement.

(i) If more than one FMAP is applicable for the rate year, these FMAPs shall be weighted for the rate year using the number of days each FMAP is effective during the rate year.

(ii) If State legislative appropriations change subsequent to the initial calculation of the target rate, these changes shall be used to modify the subsequent quarterly target rate calculations.

(iii) If an unanticipated change in the FMAP occurs subsequent to the initial calculation of the target rate, to the extent that FMAP passes on to the nursing facilities, the subsequent quarterly target rate shall be recalculated.

(2) The amount calculated in (c)1 above shall be reduced by nursing facility payments that are included in the NF reimbursement but are paid outside of the NF per diem rates addressed in these sections.

(3) The target rate calculated in (c)1 and 2 above shall be increased for expected resident contributions to Medicaid care provided by the Medicaid NF and SCNF residents, and by other payers on their behalf, as follows.

(i) The most recent four state fiscal years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year for resident contributions shall be identified.

(ii) For each year, the total resident contributions shall be summed and divided by the sum of the Medicaid days to determine a statewide resident contribution per day.

(1) Simple regression shall be used to trend the statewide resident contribution per day for each year to the mid point of the current rate year.

(iii) Expected Medicaid days for the rate year shall be calculated from the most recent four years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year.

(1) Simple regression shall be used to trend the statewide Medicaid days to the mid point of the current rate year.

(iv) The trended Statewide resident contribution per day shall be multiplied by the expected Medicaid days for the rate year to determine the statewide expected resident contributions for the rate year.

(4) The combined State funds, Federal Funds, and statewide expected resident contributions shall be divided by total expected Medicaid days calculated in (c)3iii above to determine the target rate.

(d) If the statewide Medicaid day weighted average comparison rate exceeds the target rate, the Department shall make the following adjustments to the calculated rates.

(1) The operating and administrative price shall be reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal to the target rate up to a maximum reduction to 95 percent of the Class I NF median.

(2) If the adjustment of the operating and administrative price to 95 percent of the Class I NF median still results in the statewide Medicaid day weighted average comparison rate exceeding the target rate, the direct care limit shall be reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal the target rate up to a maximum reduction to 112 percent of the Class I NF median.

(3) If the adjustment of the operating and administrative price to 95 percent of the Class I NF median and the reduction of the direct care limit to 112 percent of the Class I NF median still results in the statewide Medicaid day weighted average comparison rate exceeding the target rate, then a budget adjustment factor shall be calculated by dividing the target rate, exclusive of the Medicaid day weighted average provider tax pass-through per diem, by the statewide Medicaid day weighted average comparison rate, exclusive of the provider tax pass-through per diem as adjusted for (d)1 and 2 above.

(i) This budget adjustment factor shall be multiplied by each nursing facility's rate as adjusted for (d)1 and 2 above and exclusive of the provider tax pass-through per diem.

(ii) These adjusted rates shall be the rates paid during the rate year, as adjusted for changes in the facility average Medicaid case mix index recognized on a quarterly basis, plus the provider tax pass-through per diem.

(4) The budget adjustment factor shall be determined annually effective July 1, and shall be utilized in all Class I NF, Class II NF and Class III NF rates during the entire year.

(i) If new or improved data becomes available, subsequent to the budget adjustment calculation process and its use in rate setting, this new data shall be utilized in subsequent budget adjustment calculations, but it shall not be utilized to recalculate or otherwise adjust the current rate year budget adjustment factor.

(5) The application of the provisions in this Section results in the following budget adjustment factor.

(i) For SFY 2011, the budget adjustment factor is 1.00000; provisions of (d)(1) above resulted in a Class I operating and administrative price set at 100 percent of the Class I NF median; and, provisions of (d)(2) above resulted in a Class I direct care limit set at 115 percent of the Class I NF median.

(ii) For SFY 2012 and thereafter, the budget adjustment factor is .92180; provisions of (d)(1) above resulted in a Class I operating and administrative price set at 95 percent of the Class I NF median; and, provisions of (d)(2) above resulted in a Class I direct care limit set at 112 percent of the Class I NF median.

Section 14. Full cost rates

(a) Effective for dates of service on or after July 1, 2010 or public owned or operated governmental NFs, SNFs and SCNFs, the Department shall make a full cost rate calculation that is equal to 100 percent of the facility's allowable Medicaid costs divided by total Medicaid patient days.

(b) To determine a public hospital-based or freestanding nursing facility's full cost rate the following steps must be taken to ensure Federal financial participation (FFP):

(1) Interim Medicaid Full Cost Rates
The process of determining allowable Medicaid nursing facility routine costs eligible for FFP begins with the use of each public nursing facility's most recently filed cost report. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10, or 2552-96. For freestanding nursing facilities, such costs are reported on the CMS-2540-10, or 2540-96.

On the latest as-filed (validated) cost report, the allowable hospital-based nursing facility routine per diem cost is identified on the CMS-2552-10 (or equivalent schedules and lines from the 2552-96), worksheet D-1, Part III, line 71. This amount represents the allowable NF cost from worksheet B, Part I, line 44 and/or 45, column 26; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part I, Line 36; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 19 and/or 20, column 8.

On the latest as-filed (validated) cost report, the allowable freestanding nursing facility routine per diem cost is identified on the CMS-2540-10 (or equivalent schedules and lines from the 2540-96), worksheet D-1, Part I, line 16. This amount represents the allowable NF cost from worksheet B, Part I, line 30 and/or 31, column 18; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part 1, Line 14; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 1 and/or 2, column 7.

The routine per diems above are computed in accordance with Medicare cost principles and adjusted pursuant to Section 6.

The above computation is performed separately for the NF component and, if applicable, SNF and SCNF components to arrive at separate NF, SNF and SCNF routine per diems. Since separate NF and SNF full cost rates are not used by the New Jersey Medicaid program, when a facility has both a NF and a SNF, a day weighted

routine per diem for the two units will be determined. Medicaid FFS NF days will be multiplied by the NF routine per diem, and Medicaid FFS SNF days will be multiplied by the SNF routine per diem. These total Medicaid NF and SNF costs will then be divided by total Medicaid FFS NF and SNF days to calculate the weighted routine full cost rate. A separate SCNF rate is paid by the New Jersey Medicaid program, so those days and routine cost would not be included in the weighted routine cost per diem. The Medicaid NF, SNF and SCNF FFS days will come from state MMIS paid claims report for the cost report period being used to determine the interim rates.

In addition to the routine cost, the Medicaid program will also include the Medicaid ancillary per diem cost in the full cost rates. Medicaid ancillary costs will be determined by multiplying the Medicaid ancillary charges for each ancillary cost center by the cost-to-charge ratios for each ancillary cost center. The cost to charge ratios will be from CMS-2552-10 Worksheet C, Part I, Column 9 or CMS-2540-10 Worksheet C, Column 3. Total Medicaid FFS NF/SNF ancillary cost will be divided by total Medicaid FFS NF/SNF days to determine the NF/SNF per diem ancillary cost. This per diem will be added to the routine NF/SNF routine per diem to determine the NF/SNF full cost rate. Similarly, a Medicaid SCNF ancillary per diem will be computed, but using Medicaid FFS SCNF ancillary charges and Medicaid FFS SCNF days. The Medicaid ancillary SCNF per diem cost will be added to the SCNF routine cost per diem to calculate the SCNF full cost rates.

Medicaid FFS ancillary charges used in these calculations will exclude ancillary charges associated with Medicare Part A and Medicare Part B services. The charges must be documented in the facility's patient billing system, reported on the supplemental Medicaid schedules, and must be services provided to inpatients of the nursing facility or skilled nursing facility units during the cost reporting period used. Any ancillary charges not meeting these requirements will be excluded from the ancillary per diem calculation.

The full cost rates computed in this section will be used as interim rates for reimbursing public NF/SNF/SCNF days furnished during the expenditure period, net of any other payer payments such as third party liability payments and resident self payments.

2) Interim Reconciliation to As-Filed Cost Report
Each public nursing facility's payments made using the interim full cost rate established in 14(b)(1) will be reconciled to actual cost based on its as-filed CMS-2552-10 or 2540-10 (or equivalent 2552-96, or 2540-96) for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were

overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The interim reconciliation is calculated using each public nursing facility's allowable routine and ancillary cost from its as-filed and validated cost report for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10 (or equivalent 2552-96). For freestanding nursing facilities, such costs are reported on the CMS-2540-10 (or equivalent 2540-96).

The same cost finding methodology detailed in the interim Medicaid Full Cost rate section above will be used for the interim reconciliation in determining the routine cost per diem for NF, SNF and SCNF levels of care. The cost finding methodology described above to arrive at ancillary per diem costs for each level will also be utilized in the reconciliation process. The per diems computed using the as-filed cost report covering the expenditure period will be applied to Medicaid FFS NF and SNF days (or SCNF days if applicable) furnished during the expenditure period. For the interim reconciliation, Medicaid FFS NF and SNF days (or SCNF days if applicable) will come from State MMIS paid claims reports. Medicaid FFS ancillary charges for the expenditure period will be derived from auditable provider records as described above. This calculated total cost will then be compared to the Medicaid paid amount for the claims, including the interim payments made under 14(b)(1), any third party payments, supplemental and enhanced Medicaid payments or resident contribution. The State will perform this interim reconciliation within twelve months from the filing of the cost report for the expenditure period.

3) Final Reconciliation to Finalized Cost Report

Each public nursing facility's payments made using the interim full cost rate established in 14(b)(1) and any interim reconciliation amounts in 14(b)(2) will also be reconciled to actual cost based on its finalized CMS-2552-10 or 2540-10 (or equivalent 2552-96, or 2540-96) for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation is calculated using each public nursing facility's allowable routine and ancillary cost from its finalized cost report (finalized/settled by the Medicare fiscal intermediary with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10 (or equivalent 2552-96).

For freestanding nursing facilities, such costs are reported on the CMS-2540-10 (or equivalent 2540-96).

The same cost finding methodology and reconciliation method detailed in the Interim Reconciliation section above will be utilized for the final reconciliation Except, it will use the finalized cost report covering the expenditure period which will be applied to Medicaid FFS NF and SNF days and charges (or SCNF days and charges if applicable) furnished during the expenditure period. For the final reconciliation, such Medicaid FFS NF, SNF and SCNF days must agree with State MMIS paid claims reports. Medicaid FFS ancillary charges for the expenditure period will be derived from auditable provider records as described above. The State will perform this final reconciliation within twelve months from the finalization of the cost report for the expenditure period.

Section 15. Special Care Nursing Facility (SCNF) rates

(a) Effective for dates of service between July 1, 2010, and June 30, 2011, the rates for a Class III NF, Special Care Nursing Facility (SCNF), shall be the facility rate as of June 30 preceding the rate year adjusted by the percent change allowed for in Section 13(c).

(1) To qualify as a SCNF, the NF must meet all of the Department's contractual requirements and be approved by the Department as a SCNF.

(2) SCNFs shall be grouped by:

(i) Ventilator/Respirator,
(ii) TBI/Coma,
(iii) Pediatric,
(iv) HIV,
(v) Neurologically Impaired, and
(vi) Behavioral Management.

(b) Effective for dates of service on or after July 1, 2011, the Department shall calculate preliminary SCNF reimbursement rates based on the total allowable costs of providing SCNF services as identified on cost reports filed by SCNFs pursuant to Section 2.

(1) The preliminary reimbursement rates shall be limited to the lesser of the rate in effect for each SCNF during the preceding year prior to the application of Section 13(d) or its rate based on total allowable costs determined pursuant to (b) above.

Section 16. Phase in of case mix rates

(a) For dates of service from July 1, 2010, through June 30, 2011, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than $5.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010, and no less than $5.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

(1) The Department shall apply the rate change protection in (a) above after any reduction in the operating and administrative price and the direct health care limit pursuant to Section 3.13(d)1 and (d)2 before the requirements of Section 13(c) are applied.

(b) For dates of service from July 1, 2011, through June 30, 2012, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than $10.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010, and no less than $10.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

(1) The Department shall apply the rate change protection in (b) above after any reduction in the operating and administrative price and the direct health care limit pursuant to Section 2 13(d)1 and (d)2 but before the requirements of Section 13(c) are applied.

Section 17. Appeals process

(a) When a NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of Section 2(f)), two levels of appeals are available: a Level I appeal heard by representatives of the Department; and a Level II appeal heard before an Administrative Law Judge.

(1) A request for a Level I appeal should be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ, 08625-0715.

(i) Requests for Level I appeals shall be submitted in writing within 60 days of the receipt of notification of the rate by the facility and shall include as follows:

(1) A letter requesting a Level I appeal from the facility and/or from the facility's designated representative;

(2) A specific description of each appeal issue; and

(3) Appropriate documentation that will be sufficient for the Department to understand the nature of each issue of the appeal. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

(ii) Adjustments resulting from the Level I appeal submitted in accordance with (a)1i above shall be effective as follows:

(1) At the beginning of the prospective reimbursement period if either an error in computation was made by the Department or the appeal was submitted within the specified period.

(2) On the first day of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

(iii) The date of submission shall be defined as the date received by the Department of Health and Senior Services.

(2) If the NF is not satisfied with the results of the Level I appeal, the NF may request a hearing before an Administrative Law Judge. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

(i) Request for an administrative hearing must be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ 08625-0715.

(ii) Requests for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level 1 appeal.

(iii) The Administrative hearing will be scheduled by the Office of Administrative Law and the facility will be notified accordingly.

(iv) At the Level II hearing, the burden is upon the NF to demonstrate entitlement to cost adjustments under these sections.

Section 18. Transfer of ownership and new facilities

(a) For any facility that transfers ownership, the rate, cost reports and case mix indices established for the old owner shall pass to the new owner.

(b) New Class I NFs and Class II NFs shall be subject to the following:

(1) The direct care limit for the applicable Class of NF shall be used to establish the direct care rate component.

(2) The NFs' case mix portion percentage shall be the simple average of all Class I NFs' case mix portion percentages, and the NFs' non-case mix portion

percentage shall be 100 percent minus the simple average of all Class I NFs' case mix portion percentages.

(3) For each rate quarter, the direct care rate component shall be the direct care limit for the applicable Class of NF multiplied by the simple average case mix portion percentage multiplied by the ratio of the facility average Medicaid case mix index to the statewide average case mix index plus the simple average non-case mix portion percentage multiplied by the direct care limit.

(i) Until the new NF has a final resident roster for the quarter, the Department shall use the statewide average Medicaid case mix index for the quarter to establish the direct care rate component.

(4) The operating and administrative rate component shall be the price established for that NF's class designation for the rate year.

(5) The Department shall calculate the FRV allowance using 40 years of age for the NF unless a verifiable FRV Re-age Request is submitted and has the effect of re-aging the NF for the purposes of the FRV calculation.

(c) New Class III NFs as defined in Section 15(a)1 the rate shall be the simple average rate of the SCNFs in the group for which the new Class III NF qualifies.

Section 19. Effect of Federal rules incorporated by reference

(a) Any changes to the Federal MDS required by 42 C.F.R. 483.20 and set forth in the Resident Assessment Instrument (RAI) published by CMS, and available at www.cms.gov, which are incorporated herein by reference, as amended and supplemented, shall only apply to rate quarters subsequent to the date of amendment and/or supplement.

Section 20. Final audited rate calculation

(a) The Department will calculate final per diem rates based on audit adjustment reports.

(b) The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c) Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.