Subpart 5. Reimbursement

Editor's Note: This Subpart has been moved from LAC 50:VII.Chapter 13 and renumbered.

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Active Assessment—a resident MDS assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until a subsequent minimum data set (MDS) assessment for the same resident has been accepted by CMS, the maximum number of days (121) for the assessment has been reached, or the resident has been discharged.

Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

Assessment Reference Date—the date on the minimum data set (MDS) used to determine the due date and delinquency of assessments.

Base Resident-Weighted Median Costs and Prices—the resident-weighted median costs and prices calculated in accordance with §20005 of this rule during rebase years.

Calendar Quarter—a three-month period beginning January 1, April 1, July 1, or October 1.

Capital Cost Component—the portion of the Medicaid daily rate that is:

a. attributable to depreciation;

b. capital related interest;

c. rent; and/or

d. lease and amortization expenses.

Care Related Cost Component—the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

Case Mix—a measure of the intensity of care and services used by similar residents in a facility.

Case-Mix Documentation Review (*CMDR*)—a review of original legal medical record documentation and other documentation as designated by the department in the MDS supportive documentation requirements, supplied by a nursing facility provider to support certain reported values that resulted in a specific RUG classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Case-Mix Index (*CMI*)—a numerical value that describes the resident's relative resource use within the groups under the resource utilization group (RUG-III) classification system, or its successor, prescribed by the department based on the resident's MDS assessments. CMIs will be determined for each nursing facility on a quarterly basis using all residents.

Case-Mix MDS Documentation Review (*CMDR*)—a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Cost Neutralization—refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment—an MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS.

Department—the Louisiana Department of Health (LDH), or its successor, and the associated work product of its designated contractors and agents.

Direct Care Cost Component—the portion of the Medicaid daily rate that is attributable to:

a. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

b. a proportionate allocation of allowable employee benefits; and

c. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

Final Case-Mix Index Report (FCIR)—the final report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective with the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

Index Factor—based on the *Skilled Nursing Home without Capital Market Basket Index* published by IHS Global Insight (IHS Economics), or a comparable index if this index ceases to be published.

MDS Supportive Documentation Requirements—the department's publication of the minimum documentation and review standard requirements for the MDS items associated with the RUG-III or its successor classification system. These requirements shall be maintained by the department and updated and published as necessary.

Minimum Data Set (MDS)—a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS), or as mandated by the Department of Health through the use of the optional state assessment (OSA).

Nursing Facility Cost Report Period Case Mix Index—the average of quarterly nursing facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the nursing facility provider's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

a. For the cost reporting periods utilized in the next rebase of rates on or after July 1, 2017, the calendar quarter case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of

MDS assessments available as of the date of the applicable quarterly FCIRs. This average includes any revisions made due to an on-site CMDR.

EXAMPLE: A January 1, 2015-December 31, 2015 cost report period would use the time-weighted facility-wide average case mix indices calculated for the four quarters ending March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015.

Nursing Facility-Wide Average Case Mix Index—the simple average, carried to four decimal places, of all resident case mix indices.

a. Prior to the January 1, 2017, rate setting resident case mix indices will be calculated utilizing the point-in-time acuity measurement system. If a nursing facility provider does not have any residents as of the last day of a calendar quarter or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case mix index using occupied and valid statewide nursing facility case mix indices may be used.

i. Effective as of the January 1, 2017 rate setting, resident case mix indices will be calculated utilizing the time-weighted acuity measurement. If a nursing facility provider does not have any residents during the course of a calendar quarter, or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case mix index using occupied and valid statewide nursing facility provider case mix indices may be used.

Optional State Assessment (OSA)—assessment required by Louisiana Medicaid to report on Medicaid-covered stays. Allows nursing facility providers using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until the legacy payment model (RUG-III) ends.

Pass-Through Cost Component—includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department of Health.

Patient Driven Payment Model (PDPM)—the proposed new Medicare payment rule for skilled nursing facilities. The PDPM identifies and adjusts different case-mix components for the varied needs and characteristics of a resident's care and then combines these with a non-case-mix component to determine the full skilled nursing facilities (SNF) prospective payment system (PPS) per diem rate for that resident.

Point-In-Time Acuity Measurement System (*PIT*)—the case mix index calculation methodology that is compiled utilizing the active resident MDS assessments as of the last day of the calendar quarter, referred to as the point-in-time.

Preliminary Case-Mix Index Report (*PCIR*)—the preliminary report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective as of the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI.

Rate Year—a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates are in effect. It corresponds to a state fiscal year.

Resident-Day-Weighted Median Cost—a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

Summary Review Results Letter—a letter sent to the nursing facility that reports the final results of the case-mix documentation review and concludes the review.

a. The summary review results letter will be sent to the nursing facility provider within 10 business days after the final exit conference date.

Supervised Automatic Sprinkler System—a system that operates in accordance with the latest adopted edition of the National Fire Protection Association's *Life Safety Code*. It is referred to hereafter as a *fire sprinkler system*.

Time-Weighted Acuity Measurement System (*TW*)—the case mix index calculation methodology that is compiled from the collection of all resident MDS assessments transmitted and accepted by CMS that are considered active within a given calendar quarter. The resident MDS assessments will be weighted based on the number of calendar days that the assessment is considered an active assessment within a given calendar quarter.

Two-Hour Rated Wall—a wall that meets American Society for Testing and Materials International (ASTM) E119 standards for installation and uses two-hour rated sheetrock.

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supportive documentation requirements and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. Effective for the rate period of July 1, 2015 through June 30, 2016, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following

provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2014.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2014.

4. Base capital values for the Bed Buy-Back program (§20012) purposes will be set equal to the value of these items as of July 1, 2014.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2015.

6. As of the July 1, 2016 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2015 rating period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

C. Effective for the rate period of July 1, 2017 through June 30, 2018, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2016.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2017 state fiscal year (December 31, 2016).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2016.

4. Base capital values for the Bed Buy-Back Program (LAC 50:II.20012) purposes will be set equal to the value of these items as of July 1, 2016.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2017.

6. As of the July 1, 2018 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2017 rate period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020), LR 46:1684 (December 2020), LR 50:219 (February 2024).

§20005. Rate Determination
[Formerly LAC 50:VII.1305]

A. For dates of service on or after July 1, 2002, each nursing facility's rate for skilled nursing (SN), intermediate care I (IC-I) and intermediate care II (IC-II) services shall be the daily rates for these services in effect on June 30, 2002 as adjusted by legislative appropriations for state fiscal year 2003.

B. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price-based reimbursement system. Rates shall be calculated from cost report and other statistical data.

1. Effective July 3, 2009, and at a minimum, every second year thereafter, the base resident-day-weighted median costs and prices shall be rebased using the most recent four month or greater unqualified audited or desk reviewed cost reports that are available as of the April 1, prior to the July 1, rate setting or the department may apply a historic audit adjustment factor to the most recently filed cost reports. The department, at its discretion, may rebase at an earlier time.

a. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

C. Each facility's Medicaid daily rate is calculated as:

1. the sum of the facility's direct care and care related price;

2. the statewide administrative and operating price;

3. each facility's capital rate component;

4. each facility's pass-through rate component;

5. adjustments to the rate; and

6. the statewide durable medical equipment price.

D. Determination of Rate Components

1. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

a. The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's direct care per diem cost by the facility cost report period case-mix index.

b. The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

c. The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

d. Effective July 1, 2011, the statewide direct care and care related price is established at 112.40 percent of the direct care and care related resident-day-weighted median cost.

e. The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. For periods prior to

January 1, 2007 the statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the event that the nursing wage and staffing enhancement add-on is removed. Effective January 1, 2007 the statewide direct care and care related floor shall be reduced by one percentage point for each $.30 reduction in the average Medicaid rate due to a budget reduction implemented by the department. The floor cannot be reduced below 90 percent of the direct care and care related resident-day-weighted median cost.

f. For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

g. For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

i. Effective for rate periods January 1, 2017 through June 30, 2017 each nursing facility providers direct care and care related floor will be calculated as follows.

(a). For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in Subparagraph c of this Paragraph. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each nursing facility provider’s most advantageous average case mix index for the prior quarter. The most advantageous case mix index will be determined by utilizing the nursing facility providers’ calculated point-in-time or time-weighted measurement system case mix index value that results in the lowest direct care and care related floor amount for the associated rate quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the nursing facility-wide average case mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

h. Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related per diem cost and the direct care and care related cost report period per diem floor. If the total direct care and care related per diem cost the facility incurred is less than the cost report period per diem floor, the facility shall remit to the bureau the difference between these two amounts times the number of Medicaid days paid during the cost reporting period. The cost report period per diem floor shall be calculated using the calendar day-weighted average of the quarterly per diem floor calculations for the facility's cost reporting period.

EXAMPLE: A May 1, 2003-April 30, 2004 cost report period would use the average of the per diem floor calculations for April 1, 2003 (weighted using 61 days), July 1, 2003 (weighted using 92 days), October 1, 2003 (weighted using 92 days), January 1, 2004 (weighted using 91 days) and April 1, 2004 (weighted using 30 days).

i. For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the wage enhancement from $4.70 to a $1.30 wage enhancement prior to the case-mix adjustment for direct care staff. The $1.30 wage enhancement will be included in the direct care component of the floor calculations. It is the intent that this wage enhancement be paid to the direct care staff.

i. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

2. The administrative and operating component of the rate shall be determined as follows.

a. The per diem administrative and operating cost for each nursing facility is determined by dividing the facility's administrative and operating cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

b. Each facility's per diem administrative and operating cost is arrayed from low to high and the resident-day-weighted median cost is determined.

c. The statewide administrative and operating price is established at 107.5 percent of the administrative and operating resident-day-weighted median cost.

3. The capital component of the rate for each facility shall be determined as follows.

a. The capital cost component rate shall be based on a fair rental value (FRV) reimbursement system. Under a FRV system, a facility is reimbursed on the basis of the estimated current value, also referred to as the current construction costs, of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. The FRV system shall establish a

nursing facility's bed value based on the age of the facility and its total square footage.

b. Effective January 1, 2003, the new value per square foot shall be $97.47. This value per square foot shall be increased by $9.75 for land plus an additional $4,000 per licensed bed for equipment. This amount shall be trended forward annually to the midpoint of the rate year using the change in the unit cost listed in the three-fourths column of the R.S. means building construction data publication or a comparable publication if this publication ceases to be published, adjusted by the weighted average total city cost index for New Orleans, LA. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Subparagraph. A nursing facility's fair rental value per diem is calculated as follows.

i. Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus $9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. If 15 percent or more of the nursing facility's licensed beds are private rooms compared to the total licensed beds of the nursing facility, then the maximum square footage used shall not be more than 550 square feet per licensed bed. To this value add the product of total licensed beds times $4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent*30)] of the new bed value. There shall be no recapture of depreciation.

ii. A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's current value times a rental factor. The rental factor shall be the 20-year treasury bond rate as published in the *Federal Reserve Bulletin* using the average for the calendar year preceding the rate year plus a risk factor of 2.5 percent with an imposed floor of 9.25 percent and a ceiling of 10.75 percent.

iii. Effective July 1, 2011, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 85 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 85 percent of the annualized licensed capacity of the facility.

iv. The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years. Beginning January 1, 2007 and the first day of every calendar quarter thereafter, the age of each facility will be reduced for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. Changes in licensed beds are only recognized, for rate purposes, at July 1 of a rebase year unless the change in licensed beds is related to a change in square footage. The occupancy rate applied to a facility's licensed beds will be based on the base year occupancy.

v. If a facility performed a major renovation/improvement project (defined as a project with capitalized cost equal to or greater than $500 per bed), the cost of the renovation project will be used to determine the equivalent number of new beds that the project represents. The equivalent number of new beds from a renovation/improvement project will be determined by dividing the cost of the renovation/improvement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation/improvement project. The equivalent number of new beds will be used to determine the weighted average age of all beds for this facility.

(a). Major renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts or other auditable records. Costs must be capitalized in compliance with the Medicare provider reimbursement manual in order to be considered in a major renovation/improvement project. The cost of the project shall only include the cost of items placed into service during a time period not to exceed the previous 24 months prior to a re-aging. Entities that also provide non-nursing facility services or conduct other non-nursing facility business activities must allocate their renovation cost between the nursing facility and non-nursing facility business activities. Documentation must be provided to the department or its designee to substantiate the accuracy of the allocation of cost. If sufficient documentation is not provided, the renovation/improvement project will not be used to re-age the nursing facility.

(b). Weighted average age changes as a result of replacements/improvements and/or new bed additions must be requested by written notification to the department prior to the rate effective date of the change and separate from the annual cost report. The written notification must include sufficient documentation as determined by the department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

4. Pass-Through Component of the Rate. The pass-through component of the rate is calculated as follows.

a. The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The pass-through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

b. Effective August 1, 2005, the pass-through rate will include a flat statewide fee for the cost of durable medical equipment and supplies required to comply with the plan or care for Medicaid recipients residing in nursing facilities. The flat statewide fee shall remain in place until the cost of the durable medical equipment is included in rebase cost reports, as determined under §1305.B, at which time the department may develop a methodology to incorporate the durable medical equipment cost in to the case-mix rate.

c. Effective September 1, 2016, the pass through rate shall be increased as a result of the provider fee increase on nursing facility days from $10.00 per day up to $12.08 per day per occupied bed.

d. Effective for rate periods beginning January 1, 2017 through June 30, 2017, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the time-weighted acuity measurement system. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

i. The nursing facility provider’s rate period reimbursement rate will be calculated in accordance with §20005.B using the point-in-time acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rates.

ii. The nursing facility provider’s rate period reimbursement rate will be calculated in accordance with §20005.B using the time-weighted acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rate.

iii. The reimbursement rate differential will be determined by subtracting the reimbursement rate calculated using the point-in-time acuity measurement system from the reimbursement rate calculated using the time-weighted acuity measurement system.

iv. If the calculated reimbursement rate differential exceeds a positive or negative $2, then a pass-through rate adjustment will be applied to the nursing facility provider’s reimbursement rate in an amount equal to the difference between the rate differential total and the $2 threshold, in order to ensure the nursing facility provider’s reimbursement rate is not increased or decreased more than $2 as a result of the change of the time-weighted acuity measurement system.

(a). Should the nursing facility provider, for the aforementioned rate periods, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have their rate differential recalculated using the revised case mix index values. The $2 reimbursement rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

v. If a nursing facility provider’s calculated rate differential does not exceed the $2 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change.

6. Budget Shortfall. In the event the department is required to implement reductions in the nursing facility program as a result of a budget shortfall, a budget reduction category shall be created. Without changing the parameters established in these provisions, this category shall reduce the statewide average Medicaid rate by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

E. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour walls placed in service on or after July 1, 2006 will be excluded from the renovation/improvement costs used to calculate the FRV to the extent the nursing home is reimbursed for said costs in accordance with §1317.

F. Effective for dates of service on or after January 22, 2010, the reimbursement paid to non-state nursing facilities shall be reduced by 1.5 percent of the per diem rate on file as of January 21, 2010 ($1.95 per day).

G. Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 until such time as the rate is rebased.

H. Effective for dates of service on or after July 1, 2011, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $26.98 of the rate in effect on June 30, 2011 until such time that the rate is rebased.

I. Effective for dates of service on or after July 1, 2012, the per diem rate paid to non-state nursing facilities,

excluding the provider fee, shall be reduced by $32.37 of the rate in effect on June 30, 2012 until such time that the rate is rebased.

J. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $4.11 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and before the state fiscal year 2013 rebase.

K. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $1.15 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

L. Effective for dates of service on or after July 20, 2012, the average daily rates for non-state nursing facilities shall be reduced by 1.15 percent per day of the average daily rate on file as of July 19, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

M. Effective for dates of service on or after September 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $13.69 per day of the average daily rate on file as of August 31, 2012 before the state fiscal year 2013 rebase which will occur on September 1, 2012.

N. Effective for dates of service on or after September 1,2012, the average daily rates for non-state nursing facilities shall be reduced by $1.91 per day of the average daily rate on file as of August 31, 2012 after the state fiscal year 2013 rebase which will occur on September 1, 2012.

O. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $53.05 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

P. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

Q. Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state nursing facilities shall be reduced by $90.26 of the rate in effect on June 30, 2014 until such time that the rate is rebased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:902 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097, 3097 (November 2013), LR 41:707 (April 2015), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 43:526 (March 2017), LR 46:1684 (December 2020).

§20006. Reimbursement Adjustment [Formerly LAC 50:VII.1306]

A. Effective for dates of service on or after January 1, 2004, for state fiscal year 2003-2004 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by $0.67.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:804 (April 2004).

§20007. Case-Mix Index Calculation [Formerly LAC 50:VII.1307]

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34-group, or its successor, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.20, or its successor, case-mix indices developed by CMS shall be the basis for calculating average case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group, or its successor, will be excluded from the average case-mix index calculation.

B. Each resident in the nursing facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor based on the following criteria.

1. Prior to the January 1, 2017 rate setting, the RUG-III group, or its successor, is calculated based on the resident's most current assessment, available on the last day of each calendar quarter, and shall be translated to the appropriate case mix index. From the individual resident case mix indices, two average case mix indices for each Medicaid nursing facility provider shall be determined four times per year based on the last day of each calendar quarter.

2. Effective as of the January 1, 2017 rate setting, the RUG-III group, or its successor, will be calculated using each resident MDS assessment transmitted and accepted by CMS that is considered active within a given calendar quarter. These assessments are then translated to the appropriate case mix index. The individual resident case mix indices are then weighted based on the number of calendar days each assessment is active within a given calendar quarter. Using the individual resident case mix indices, the calendar day weighted average nursing facility-wide case mix index is calculated using all residents regardless of payer type. The calendar day weighted nursing facility-wide average case mix index for each Medicaid nursing facility shall be determined four times per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1475 (June 2002), repromulgated LR

28:1792 (August 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), LR 43:527 (March 2017).

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports
[Formerly LAC 50:VII.1313]

A. The department shall provide each nursing facility provider with the preliminary case-mix index report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. The PCIR will serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility provider to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction request process where applicable. The department shall provide each nursing facility provider with a final case-mix index report (FCIR) utilizing MDS assessments after allowing the nursing facility providers a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department determines that a nursing facility provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case-mix index associated with the RUG-III group "BC1-delinquent" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, classification system.

B. The department shall periodically review the MDS supporting documentation maintained by nursing facility providers for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify nursing facility providers of the scheduled case-mix documentation reviews (CMDR) not less than two business days prior to the start of the review date and a fax, electronic mail or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying possible documentation that will be required to be available at the start of the on-site CMDR.

1. The department shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the nursing facility or 10 assessments and shall include those transmitted assessments posted on the most current FCIR. The CMDR will determine the percentage of assessments in the sample that are unsupported MDS resident assessments. The department may review additional or alternative MDS assessments, if it is deemed necessary.

2. When conducting the CMDR, the department shall consider all MDS supporting documentation that is provided by the nursing facility provider and is available to the RN reviewers prior to the start of the exit conference. MDS supporting documentation that is provided by the nursing facility provider after the start of the exit conference shall not be considered for the CMDR.

3. Upon request by the department, the nursing facility provider shall be required to produce a computer-generated copy of the MDS assessment which shall be the basis for the CMDR.

4. After the close of the CMDR, the department will submit its findings in a summary review results (SRR) letter to the nursing facility within 10 business days following the final exit conference date.

5. The following corrective action will apply to those nursing facility providers with unsupported MDS resident assessments identified during an on-site CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 20 percent, the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

b. If the percentage of unsupported MDS assessments in the total sample is equal to or less than the threshold percentage as shown in column (B) of the table in Subparagraph e below, no corrective action will be applied.

c. If the percentage of unsupported MDS assessments in the total sample is greater than the threshold

percentage as shown in column (B) of the table in Subparagraph e below, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. A follow-up CMDR process described in Subparagraphs d and e may be utilized at the discretion of the department.

d. Those nursing facility providers exceeding the thresholds (see column (B) of the table in Subparagraph e) during the initial on-site CMDR will be given 90 days to correct their assessing and documentation processes. A follow-up CMDR may be performed at the discretion of the department at least 30 days after the nursing facility provider's 90-day correction period. The department or its contractor shall notify the nursing facility provider not less than two business days prior to the start of the CMDR date. A fax, electronic mail, or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying documentation that must be available at the start of the on-site CMDR.

e. After the follow-up CMDR, if the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the following table, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. In addition, facilities found to have unsupported MDS resident assessments in excess of the threshold in column (B) of the table below may be required to enter into a documentation improvement plan with the department. Additional follow-up CMDR may be conducted at the discretion of the department.

Effective Date (A)	Threshold Percent (B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006	25%
February 20, 2019 and beyond	20%

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017), LR 45:274 (February 2019).

§20029. Supplemental Payments

A. Non-State Governmental Organization Nursing Facilities

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO), and that has entered into an agreement with the department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities are:

a. Gueydan Memorial Guest Home;

b. LaSalle Nursing Home;

c. Natchitoches Parish Hospital LTC Unit; and

d. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment for each state fiscal year (SFY) shall be calculated immediately following the July quarterly Medicaid rate setting process. The total Medicaid supplemental payment for each individual NSGO will be established as the individual nursing facility differential between the estimated Medicare payments for Medicaid nursing facility residents, and the adjusted Medicaid payments for those same nursing facility residents. A more detailed description of the Medicaid supplemental payment process is described below.

a. The calculation of the total annual Medicaid supplemental payment for nursing facilities involves the following four components:

i. calculate Medicare payments for Louisiana Medicaid nursing facility residents using Medicare payment principles;

ii. determining Medicaid payments for Louisiana Medicaid nursing facility residents;

iii. adjust payments for coverage difference between Medicare payment principles and Louisiana Medicaid payment principles; and

iv. calculating the differential between the calculated Medicare payments for Medicaid nursing facility residents, and Medicaid payments for those same residents.

b. Calculating Medicaid Rates Using Medicare Payment Principles. With Medicare moving to the prospective payment system (PPS), Medicare rates will be calculated based on Medicaid acuity data. The following is a summary of the steps involved.

i. Using each resident's minimum data set assessment, the applicable RUG-III grouper code for Medicaid residents was identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories is then generated.

(a). The resident minimum data set assessments will be from the most recently available minimum data set assessments utilized in Medicaid rate setting processes as of the development of the Medicaid supplemental payment calculation demonstration.

ii. After the Medicaid resident frequency distribution was developed, rural and urban rate differentials and wage index adjustments will be used to adjust the Medicare rate tables. Medicare rate tables will be applicable to SFY periods.

(a). Medicare rate tables will be established using information published in 42 CFR part 483 where available. Should the finalized Medicare rate tables for any portion of the applicable SFY period be unavailable, the most recent preliminary Medicare rate adjustment percentage published in the *Federal Register* available as of the development of the Medicaid supplemental payment calculation demonstration will be utilized as the basis of the Medicare rate for that portion of the SFY period.

(b). The resulting Medicare rates are multiplied by the number of Medicaid residents in each RUG category, summed and then averaged. The Medicare rate tables applicable to each period of the SFY will be multiplied by an estimate of Medicaid paid claims days for the specified period. Medicaid paid claims days will be compiled from the state's Medicaid Management Information System's (MMIS) most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration.

c. Determining Medicaid Payments for Louisiana Medicaid Nursing Facility Residents. The most current Medicaid nursing facility reimbursement rates as of the development of Medicaid supplemental payment calculation demonstration will be utilized. These reimbursement rates will be multiplied by Medicaid paid claims compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish total Medicaid per diem payments. Total calculated Medicaid payments made outside of the standard nursing facility per diem are summed with total Medicaid reimbursement from the per diem payments to establish total Medicaid payments. Payments made outside of the standard nursing facility per diem are reimbursement for the following services.

i. Specialized Care Services Payments. Specialized care services reimbursement is paid outside of the standard per diem rate as an add-on payment to the current facility per diem rate. The established specialized care add-on per diems will be multiplied by Medicaid paid claims for specialized care days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish projected specialized care services payments for the applicable SFY.

ii. Home/Hospital Leave Day (Bed Hold) Payments. Allowable Medicaid leave days were established using Medicaid paid claims days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration. Allowable Medicaid Leave days will be multiplied by the most recent Medicaid leave day quarterly reimbursement rates as of the of the Medicaid supplemental payment calculation demonstration to established projected Medicaid Leave day payments for the SFY.

iii. Private Room Conversion Payments. Private room conversion (PRC) Medicaid days will be established utilizing the most recently reviewed or audited Medicaid supplemental cost reports as of the development of the Medicaid supplemental payment calculation demonstration. The applicable cost reporting period information will be annualized to account for short year cost reporting periods. Allowable PRC Medicaid days will be multiplied by the PRC incentive payment amount of $5 per allowable day to

establish the total projected Medicaid PRC payments for the SFY.

d. Adjusting for Differences between Medicare Principles and Louisiana Medicaid Nursing Facility Residents. An adjustment to the calculation of the Medicaid supplemental payment limit will be performed to account for the differences in coverage between the Medicare PPS rate and what Louisiana Medicaid covers within the daily rate provided above. To accomplish this, an estimate will be calculated for pharmacy, laboratory, and radiology claims that were paid on behalf of nursing facility residents for other than their routine daily care. These estimates will then be added to the total calculated Medicaid payments.

e. Calculating the Differential Between the Calculated Medicare Payments for Medicaid Nursing Facility Residents, and Medicaid Payments for Those Same Residents. The total annual Medicaid supplemental payment will be equal to the individual NSGO nursing facility's differential between their calculated Medicare payments and the calculated adjusted Medicaid payments for the applicable SFY, as detailed in the sections above.

4. Frequency of Payments and Calculations. The Medicaid supplemental payments will be reimbursed through a calendar quarter based lump sum payment. The amount of the calendar quarter lump sum payment will be equal to the SFY total annual Medicaid supplemental payment divided by four. The total annual Medicaid supplemental payment calculation will be performed for each SFY immediately following the July quarterly Medicaid rate setting process.

5. No payment under this section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017), LR 47:476 (April 2021).