DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

MAR 07 2016

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 15-0023

Dear Mrs. Steele:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-0023. Louisiana Department of Health and Hospitals submitted this amendment to suspend the current provisions governing nursing facility payments in order to ensure that the rates in effect do not increase for the state fiscal year 2016 rating period.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-D.

Based upon the information provided by the State, Medicaid State plan amendment 15-0023 is approved effective July 11, 2015. We are enclosing the CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

Kristin Fan
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: **15-0023**

2. STATE: **Louisiana**

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 11 , 2015

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:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** **$0**
b. FFY **2017** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Page 3a	**SAME (TN 06-33)**
Attachment 4.19-D, Page 4	**SAME (TN 06-33)**
Attachment 4.19-D, Page 5	**SAME (TN 09-26)**
Attachment 4.19-D, Pages 6 and 7	**SAME (TN 11-19)**
Attachment 4.19-D, Page 7.a.	**SAME (TN 07-04)**
Attachment 4.19-D, Page 9.a.(2)	**SAME (TN 14-23)**
Attachment 4.19-D, Page 9.a.(3)	**NONE – New Page**

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to amend the provisions governing the reimbursement methodology for nursing facilities in order to suspend the current provisions governing certain nursing facility payments in order to ensure that the rates in effect do not increase for the state fiscal year 2016 rating period.**

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:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 16, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 16, 2015

18. DATE APPROVED: MAR 07 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 11, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

a. 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 percentages that result in the lowest overall rate.

b. No property tax and insurance pass-through reimbursement shall be included in the case-mix rate.

c. The fair rental value rate calculated shall be based on 100 percent occupancy.

C. REIMBURSEMENT TO PRIVATE AND NON-STATE GOVERNMENT OWNED OR OPERATED NURSING FACILITIES

1. Definitions

a. 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.

b. Assessment Reference Date (ARD) – The date on the Minimum Data Set (MDS) used to determine the due date and delinquency of assessments. This date is used in the case-mix reimbursement system to determine the last assessment for each resident present in the facility and is included in the quarterly case-mix report.

c. Base Resident-Weighted Median Costs and Prices the resident-weighted median costs and prices calculated in accordance with section C.2., during rebase years.

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

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

i. attributable to depreciation;
ii. capital related interest;
iii. rent; and/or
iv. lease and amortization expenses.

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f. 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.

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

h. 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

assessment. Two average CMIs will be determined for each facility on a quarterly basis, one using all residents (the facility average CMI) and one using only Medicaid residents (the Medicaid average CMI).

i. **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.

j. **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.

k. **Delinquent MDS Resident Assessment** — an MDS assessment that is more than 121 days old, as measured by the ARDfield on the MDS.

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

   i. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
   ii. a proportionate allocation of allowable employee benefits; and
   iii. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

m. **Facility Cost Report Period Case-Mix Index** — the average of quarterly 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 facility's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR review.

n. **Facility-Wide Average Case-Mix Index** — the simple average, carried to four decimal places, of all resident case-mix indices based on the first day of each calendar quarter. If a facility 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 facility case-mix indices may be used.

o. **Final Case-Mix Index Report (FCIR)** – the final report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter, referred to as the point-in-time.

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p. **Index Factor** — will be based on the Skilled Nursing Home without Capital Market Basket Index published by Data Resources Incorporated (DRI-WEFA).

q. **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 facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the current MDS assessment required and approved by the Centers for Medicare and Medicaid Services (CMS).

r. **MDS Supportive Documentation Guidelines** — the Department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III classification system. These guidelines shall be maintained by the Department and updated and published as necessary.

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

t. **Preliminary Case Mix Index (PCIR)** – the preliminary report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter.

u. **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 (SFY).

v. **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.

w. **RUG-III Resident Classification System** — the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III group, , the RUG-III with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

x. **Summary Review Results Letter** – a letter sent to the nursing facility that reports the final results of the CMDR and concludes the review.

y. **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.

z. **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.

aa. **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 supporting documentation guidelines and a different RUG-III classification would result; therefore, the MDS assessment would be considered "unsupported."

2. Rate Determination

a. 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. Effective January 1, 2003, the cost data used in rate setting will be from cost reporting periods ending July 1, 2000 through June 30, 2001. Effective July 1, 2004, and 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. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

b. Each facility's Medicaid daily rate is calculated as:
   i. the sum of the facility's direct care and care related price;
   ii. the statewide administrative and operating price;
   iii. each facility's capital rate component;
   iv. each facility's pass-through rate component
   v. adjustments to the rate; and
   vi. the statewide durable medical equipment price.

c. Determination of Rate Components
   i. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

(1). 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.

(2). 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

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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.

(3). 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.

(4). The statewide direct care and care related price is established at 110 percent of the direct care and care related resident-day-weighted median cost.

For dates of service on or after 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.

(5). 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 cent 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.

(6). 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 section C.2.c.i.(3). 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.

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(7). 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 section C.2.c.i.(3). 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.

(8). 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.

(9). For dates of service on or after February 9, 2007, the facility-specific direct care rate will be increased by a $4.70 per diem wage enhancement for direct care staff prior to the case-mix adjustment. The $4.70 wage enhancement will be included in the direct care component of the floor calculations.

For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the $4.70 wage enhancement 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. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

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

(1) 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.

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

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(5) Effective for dates of service on or after July 1, 2012, the per diem reimbursement for non-state (includes private) nursing facilities, excluding the provider fee, shall be reduced by $32.37 of the rate on file as of June 30, 2012 (as described in Attachment 4.19-D, §I.C.2.v.(4)) until such time as the rate is rebased on July 1, 2012.

(6) Effective for dates of service on or after July 1, 2012, the average daily rates for non-state (includes private) 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.

(7) Effective for the dates of service on or after July 1, 2012, the average daily rates for non-state (includes private) 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 fiscal year 2013 rebase.

(8) Effective for the dates of service on or after July 20, 2012, the average daily rates for non-state (includes private) 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 fiscal year 2013 rebase.

(9) Effective for dates of service on or after September 1, 2012, the average daily rates for non-state (includes private) 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.

(10) Effective for the dates of service on or after September 1, 2012, the average daily rates for non-state (includes private) 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.

(11) Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state (includes private) 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.

(12) Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state (includes private) 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.

(13) Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state (includes private) nursing facilities, shall be adjusted and rebased which results in an increase of $3.58 in the average daily rate.

(14) Effective for the rate period of July 1, 2015 through June 30, 2016, the Department shall suspend the provisions currently governing the reimbursement methodology for nursing facilities and imposes the following provisions governing reimbursements for nursing facility services.

i. 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.

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

iii. 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.

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

v. 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.

vi. 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.

vii. No other provisions of the current nursing facility reimbursement methodology shall be suspended for this time period.

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

d. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour rated 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 section 6.

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