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Jeff Landry
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Louisiana Department of Health

Office of the Secretary

August 11, 2025

Courtney Miller, Director
CMS/Center for Medicaid & CHIP Services
Medicaid & CHIP Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106

RE: Louisiana Title XIX State Plan
Transmittal No. 25-0010

Dear Ms. Miller:

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan. Should you have any questions or concerns regarding this matter, please contact Marjorie Jenkins at (225) 342-3881 or via email at Marjorie.Jenkins@la.gov.

Sincerely,

DocuSigned by:
Drew Maranto
F2B21E16F2284B1...

Drew Maranto, designee for Bruce D. Greenstein
Undersecretary

Attachments (3)

DM:KS:KF

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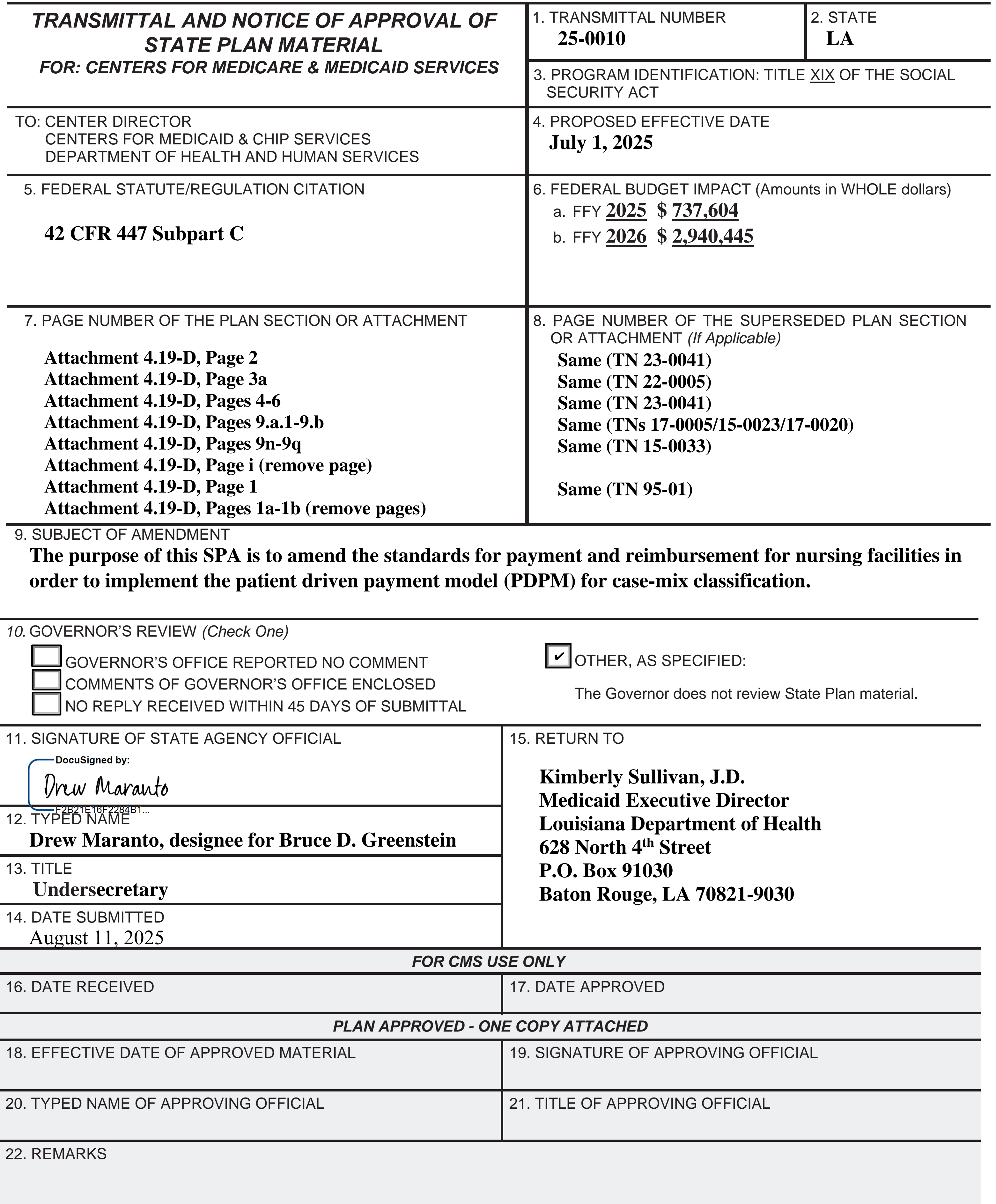

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
25-0010

2. STATE
LA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2025** $ **737,604**
b. FFY **2026** $ **2,940,445**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Page 2
Attachment 4.19-D, Page 3a
Attachment 4.19-D, Pages 4-6
Attachment 4.19-D, Pages 9.a.1-9.b
Attachment 4.19-D, Pages 9n-9q
Attachment 4.19-D, Page i (remove page)
Attachment 4.19-D, Page 1
Attachment 4.19-D, Pages 1a-1b (remove pages)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Same (TN 23-0041)
Same (TN 22-0005)
Same (TN 23-0041)
Same (TNs 17-0005/15-0023/17-0020)
Same (TN 15-0033)

Same (TN 95-01)

9. SUBJECT OF AMENDMENT
The purpose of this SPA is to amend the standards for payment and reimbursement for nursing facilities in order to implement the patient driven payment model (PDPM) for case-mix classification.

10. 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.

11. SIGNATURE OF STATE AGENCY OFFICIAL
DocuSigned by:
Drew Maranto
F2B21E16F2284B1...

12. TYPED NAME
Drew Maranto, designee for Bruce D. Greenstein

13. TITLE
Undersecretary

14. DATE SUBMITTED
August 11, 2025

15. RETURN TO

Kimberly Sullivan, J.D.
Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

LA TITLE XIX SPA
TRANSMITTAL #: **25-0010**
TITLE: **Nursing Facilities - RUG To PDPM**
EFFECTIVE DATE: **July 1, 2025**

FISCAL IMPACT:
Increase

	year	% inc.		fed. match	*# mos	range of mos.	dollars
1st SFY	2026				12	July 2025 - June 2026	$4,335,021
2nd SFY	2027				12	July 2026 - June 2027	$4,335,021
3rd SFY	2028				12	July 2027 - June 2028	$4,335,021

*#mos-months remaining in fiscal year

Total increase or decrease cost FFY **2025**

$4,335,021 /	12 X	3 months	July 2025 - September 2025			=	$1,083,755
			$1,083,755	**X**	**68.06%**	=	$737,604
		FFP (FFY 2025) =					**$737,604**

Total increase or decrease cost FFY **2026**

$4,335,021 /	12 X	9 months	October 2025 - June 2026			=	$3,251,266
			$3,251,266	**X**	**67.83%**	=	$2,205,334
$4,335,021 /	12 X	3 months	July 2026 - September 2026			=	$1,083,755
			$1,083,755	**X**	**67.83%**	=	$735,111
		FFP (FFY 2026)=					**$2,940,445**

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES AND INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED

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

I. REIMBURSEMENT METHODOLOGY

The Louisiana Department of Health, Office of the Secretary, Bureau of Health Services Financing, establishes a system of prospective payment for nursing facilities based on recipient care needs that incorporates acuity measurements as determined under the Resource Utilization Group III (RUG-III) resident classification methodology. This system establishes a facility specific price for the Medicaid nursing facility residents served. It also provides for enhanced reimbursement for Medicaid residents who require skilled nursing services for an infectious disease and technology dependent care. Facilities may furnish any or all of these levels of care to residents. Every nursing facility must meet the requirements for participation in the Medicaid program.

Effective for assessments with assessment reference dates of October 1, 2023 and after, the Department mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the assessment it was performed in conjunction with.

A. COST REPORTS

1. Nursing facility providers under Title XIX are required to file annual cost reports as follows:

   a. Providers of nursing facility level of care are required to report all reasonable and allow-able cost on a regular nursing facility cost report. Effective for periods ending on or after June 30, 2002, the regular nursing facility cost report will be the skilled nursing facility cost report adopted by the Medicare Program. This cost report is frequently referred to as the Health Care Financing Administration (HCFA) 2540. The cost reporting period begin date shall be the later of the first day of the facility's fiscal period or the facility's certification date. The cost reporting end date shall be the earlier of the last day of the facility's fiscal period or the final day of operation as a nursing facility.

   b. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the Bureau. Facilities shall submit their Medicare cost report and their state Medicaid supplemental cost report in accordance with procedures established by the Department.

   c. Providers of skilled nursing-infectious disease (SN-ID), skilled nursing-technology dependent care (SN-TDC), and skilled nursing neurological rehabilitation treatment (SN-NRT) program services must file additional supplemental schedules designated by the Bureau documenting the incremental cost of providing SN-ID, SN-TDC, and SN-NRT services to Medicaid beneficiaries.

   d. Separate cost reports must be submitted by central/home offices when the costs of the central/home office are reported in the facility's cost report.

2. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and non allowable cost contained in the CMS Publication 15-1 Provider Reimbursement Manual, with the following exceptions:

   a. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity, costs, capital data, and pass-through of the prior owner. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures specified in section C.2.c.

3. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under section C.2.a. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the Secretary of the Department.

4. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with section A. These facilities will have their case-mix rates adjusted as follows:
   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

   Active Assessment: A resident minimum data set (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. a subsequent MDS assessment for the same resident has been accepted by CMS;
   b. the maximum number of days (121) for the assessment has been reached;
   c. the record has been replaced by a modified assessment;
   d. the record has been inactivated; or
   e. 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 (ARD): The last day of the MDS observation period, denoted at MDS item A2300. This date is 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 section C.2., 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:

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

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 patient driven payment model (PDPM) classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the PDPM classification being supported or unsupported.

Case Mix Index (CMI): A numerical value that describes the resident's resource needs within the groups under the PDPM classification system, prescribed by the Department based on the resident's MDS assessment. CMIs will be determined for each nursing facility provider on a quarterly basis using all residents.

Cost Neutralization: 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 active 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:

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.

Final Case-Mix Index Report (FCIR): The final report that reflects the acuity of the residents in the nursing facility during the reporting period.

Index Factor: Generated pursuant to 42 CFR 413.333.

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 through the use of the optional state assessment (OSA).

MDS Supportive Documentation Requirements: The Department's publication of the minimum documentation and review standard requirements for the MDS items associated with the PDPM classification system. These requirements shall be maintained by the Department and updated and published as necessary.

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.

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

Optional State Assessment (OSA): Assessment required by the Medicaid program. Allows nursing facility providers using resource utilization group (RUG) RUG-III 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.

Patient Day: A unit of time, a full 24-hour period, during which a Medicaid beneficiary is receiving care in a hospital or skilled nursing facility.

Patient Driven Payment Model (PDPM): The 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): Repealed.

Preliminary Case Mix Index (PCIR): The preliminary report that reflects the acuity of the residents in the nursing facility during the reporting period.

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).

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.

RUG-III Resident Classification System: The resource utilization group used to classify residents. When a resident is sorted into more than one classification group using RUG-III group, the RUG-III group with the greatest CMI will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI.

Effective June 30, 2025, the RUG-III Resident Classification System will no longer be utilized to classify residents except for the purposes of calculating the phase-in.

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.

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 PDPM classification, resident classification systems are not supported according to the MDS Supportive Documentation Requirements and a different PDPM classification, would result; therefore, the MDS assessment would be considered "unsupported."

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:

1. The nursing facility provider's rate period reimbursement rate will be calculated 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;
2. The nursing facility provider's rate period reimbursement rate will be 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;
3. 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;
4. If the calculated reimbursement rate differential exceeds a positive or negative two dollars, 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 two dollar threshold, in order to ensure the nursing facility provider's reimbursement rate is not increased or decreased more than two dollars as a result of the change to the time-weighted method acuity measurement system.
5. 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 two dollar reimbursement rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation;
6. If a nursing facility provider's calculated rate differential does not exceed the two dollar rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

Effective for rate periods coinciding with the phase-in, July 1, 2025 through December 31, 2026, the statewide direct care and care-related floor is established at 90 percent of the direct care and care related resident-day-weighted median cost.

Effective for rate periods beginning July 1, 2025, through December 31, 2026, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the PDPM resident classification system used for determining case-mix indices. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows:

1. For each rate period during the phase-in, the nursing facility provider's direct care and care-related rate components will be calculated using the PDPM resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

2. For use in calculating a differential, the nursing facility provider's July 1, 2025, direct care and care-related rate components will also be calculated using the RUG-III resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.
3. For each rate period during the phase-in, the direct care and care-related rate components differential will be determined by subtracting the direct care and care-related rate components calculated for July 1, 2025, using the RUG-III resident classification system from the direct care and care-related rate components calculated using the PDPM resident classification system for determining the case-mix indices.
4. If the calculated direct care and care-related rate components differential exceeds a positive or negative $5, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate. The pass-through rate will be applied in an amount equal to the difference between the rate differential total and the ±$5 threshold. This will be done in order to ensure the nursing facility provider's direct care and care-related rate components are not increased or decreased more than $5 as a result of the change to the PDPM resident classification system for determining the case-mix indices.

   Should the nursing facility provider, for the rate periods used in calculating the rate differential, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have its direct care and care-related rate components differential recalculated using the revised case mix index values. The ±$5 rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.
5. If a nursing facility provider's calculated direct care and care-related rate components differential does not exceed the ±$5 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

v. Adjustment to the Rate

Effective for dates of service on or after July 1, 2004, for state fiscal year 2005 and state fiscal year 2006, each private nursing facility's per diem case mix adjusted rate shall be reduced by $0.85.

Effective for dates of service on or after July 1, 2005, for state fiscal year 2006 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by $2.99.

Effective for dates of service on or after January 1, 2006, the previous reduction of $2.99 in each private nursing facility's per diem case mix adjusted rate is restored for the remainder of state fiscal year 2006.

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. This category shall reduce the statewide average Medicaid rate, without changing the established parameters, by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

(1) Effective for dates of service on or after January 22, 2010, the case-mix adjusted nursing facility rate of each non-State nursing facility shall be reduced by $1.95 per day (1.5 percent of the per diem rate on file as of January 21, 2010) until such time as the rate is rebased on July 1, 2010.

(2) 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 10.52 percent of the non-state owned nursing facilities statewide average daily rate in effect on June 30, 2010 until such time as the rate is rebased on July 1, 2010.

(3) Effective for dates of service on or after July 1, 2010, the per diem reimbursement for 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 (as described in Attachment 4.19-D, §I.C.2.v (2)) until such time as the rate is rebased on July 1, 2010.

(4) Effective for dates of service on or after July 1, 2011, the per diem reimbursement for non-state nursing facilities, excluding the provider fee, shall be reduced by $26.98 of the rate on file as of June 30, 2011 (as described in Attachment 4.19-D, §I.C.2.v.(3)) until such time as the rate is rebased on July 1, 2011.

(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.
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.

(15) Effective for the rate period of July 1, 2017 through June 30, 2018, the Department shall suspend the provisions currently governing the reimbursement methodology for nursing facilities and impose 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, 2016.

ii. All costs and cost components that are required to be trended forward will only be trended forward to the midpoint of the 2017 state fiscal year (December 31, 2016).
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 component will be set equal to the value of these items as of July 1, 2016.
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, 2016.
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, 2017.
vi. 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 rating period.
vii. No other provisions of the current nursing facility reimbursement methodology shall be suspended for this time period.

In the event the Department is required to implement positive adjustments in the nursing facility program, a separate nursing facility add-on shall be created and calculated as follows:

Without changing the parameters established in these provisions, if the average Medicaid program rates established annually at each July 1 are below the previous state fiscal year's average Medicaid program rates (simple average of the four quarters), the Department shall implement an increase to the average Medicaid rate. This will be done by adding to the reimbursement rate paid to each nursing facility an amount equal to the difference between the July 1 Medicaid program rate and the previous state fiscal year's average Medicaid program rates. The add-on will be paid to each nursing facility using an equal amount per patient day.

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.

3. Case Mix Index Calculation
   a. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34 group, 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 case-mix indices developed by the Centers for Medicare and Medicaid Services (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 will be excluded from the average case-mix index calculation.

      Prior to the July 1, 2025, rate setting, the RUG-III, Version 5.20, 34-group index maximizer model is used as the resident classification system to determine all case-mix indices.

   b. Effective as of the July 1, 2025 rate setting, PDPM case-mix groups and case-mix index weights effective October 1, 2024, as listed in table 5 from the final SFY PPS payment rule for FY 2025 (CMS-1802-F) are used as the resident classification system to determine all case-mix indices, using data from the MDS submitted by each facility. PDPM case-mix index weights effective October 1, 2024, developed by CMS, shall be used to adjust the direct care cost component. A hierarchal methodology is used to determine the

individual CMIs. A blended approach is used to determine the case-mix indices to adjust the direct care cost component. The percentages used for blended approach are as follows:

i. physical therapy: 15 percent;
ii. occupational therapy: 15 percent;
iii. speech language pathology: 8 percent;
iv. non-therapy ancillary: 12 percent; and
v. nursing: 50 percent.

c. Assessments completed prior to January 1, 2025 that cannot be classified to a PDPM case-mix group, will be excluded from the average case mix index calculations.

d. Assessments completed on or after January 1, 2025 that cannot be classified to a PDPM case-mix group, will be assigned the lowest CMI value relative for each PDPM component.

e. Each resident in the nursing facility with a completed and submitted assessment, shall be assigned a PDPM case-mix group, based on the following criteria:

Effective with the January 1, 2017, rate setting, the RUG-III group, or its successor, or PDPM group, 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 weight 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.

f. Case-Mix Documentation Reviews and Case-Mix Index Reports

i. The Department or shall provide each nursing facility provider with a Preliminary Case Mix Index Report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. This PCIR will serve as notice of the MDS assessments transmitted.
ii. After giving the nursing facility provider a reasonable opportunity (approximately two weeks) 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.
iii. 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 PDPM group "BC1-Delinquent" for all PDPM components. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in each PDPM component, classification system.
iv. 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.

(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

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) The applicable PDPM classification for Medicaid residents is identified using each resident's minimum data assessment. A full listing of Medicaid residents with the applicable Medicare PDPM classification is then generated.

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) Rural and urban rate differentials, wage index adjustments, and value-based purchasing adjustments will be used to adjust the Medicare rate tables for each component of PDPM after the Medicaid listing is developed. The non-therapy ancillary component of PDPM will be adjusted to exclude the estimated portion of payments related to pharmacy, laboratory, and radiology services based on a statewide percentage derived from Medicare cost report data to account for differences between what the Medicare PPS rate covers and what the Medicaid program reimburses. 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

b. 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.

c. Medicare rates for each Medicaid resident in the listing are calculated using the relevant Medicare rate tables for each period of the SFY and then averaged by nursing facility. The nursing facility's average rates are then pro-rated based on the length of active time of each Medicare rate table during the SFY. The calculated rate 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 Medicaid nursing facility residents

The most current Medicaid nursing facility reimbursement rates as of the development of the 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. Calculating the differential between the calculated Medicare payments for Medicaid nursing facility residents, and Medicaid payments for those same residents

(i) 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 Medicaid payments for the applicable SFY, as detailed in the sections above.

4. Frequency of Payments and Calculations

a. 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.