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 INDIVIDUALS WITH INTELLECTUAL DISABILITIES

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.

~~b.~~e. Each resident in the nursing facility~~,~~ with a completed and submitted assessment, shall be assigned a ~~RUG-III, 34 group, or its successor~~ 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.

~~c.~~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 ~~RUG-III group, or its successor,~~ 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.