

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).

*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.

*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.

*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.

Example: A January 1, 2011-December 31, 2011 cost report period would use the facility-wide average case-mix indices calculated for March 31, 2011, June 30, 2011, September 30, 2011 and December 31, 2011.

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

*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.

*Index Factor*—will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by

## 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

*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. 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.

*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 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. Two

Data Resources Incorporated (DRI-WEFA), or a comparable index if this index ceases to be published.

*MDS Supportive Documentation Guidelines*—the department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III or its successor classification system. These guidelines 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 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).

*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.

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

*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.

*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 facility average CMI and Medicaid average CMI.

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

a. The summary review results letter will be sent to the nursing facility 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*.

*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 supporting documentation guidelines 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.

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).

**§20003. Cost Reports****[Formerly LAC 50:VII.1303]**

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

1. Providers of nursing facility level of care are required to report all reasonable and allowable 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, hereafter referred to as the Medicare cost report. 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.

2. 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.

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

B. 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 Manuals, with the following exceptions.

1. 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. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the Medicaid Program prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

**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 32:2263 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:541 (March 2014).

**§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. 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 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.

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.

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. 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.

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).

**§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. Effective with the January 1, 2011 rate setting, each resident in the facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor, on the last day of each calendar quarter. 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 shall be determined four times per year based on the last day of each calendar quarter.

C. Effective with the January 1, 2011 rate setting, the facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

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).

**§20009. Non-State, Government Owned or Operated Facilities and State-Owned or Operated Facilities**

A. Non-state, government-owned or operated nursing facilities will be paid a case-mix reimbursement rate in accordance with §1305.

B. State-owned or operated nursing facilities will be paid a prospective per diem rate. The per diem payment rate for each of these facilities will be calculated annually on July 1, using the nursing facility's allowable cost from the most recently filed Medicaid cost report trended forward from the midpoint of the cost report year to the midpoint of the rate year using the index factor.

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 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), LR 36:520 (March 2010).

**§20010. Additional Payments and Square Footage Adjustments for Private Room Conversion**  
**[Formerly LAC 50:VII.1310]**

A. Effective for dates of service on or after September 1, 2007, Medicaid participating nursing facilities that convert a semi-private room to a Medicaid-occupied private room are eligible to receive an additional \$5 per diem payment. Facilities that participate will have their fair rental value per diem revised based on the change in licensed beds.

**B. Qualifying Facilities**

1. In order for a nursing facility's beds to qualify for an additional \$5 per diem payment, a revised fair rental value (FRV), a revised property tax pass-through, and revised property insurance pass-through, all of the following conditions must be met.

a. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

b. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the \$5 per diem payment.

c. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

d. The nursing facility must submit the following information to the department within 30 days of the private room conversion:

i. the number of rooms converted from semi-private to private;

ii. the revised bed license;

iii. a resident listing by payer type for the converted private rooms; and

iv. the date of the conversions.

C. The additional \$5 per diem payment determination will be as follows.

1. An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.

2. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in §1310.B.1.

3. A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of this Section have been met.

D. The revised fair rental value per diem will be calculated as follows.

1. After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.

2. After a qualifying private room conversion, the allowable square footage per bed used in §1305.D.3.b. will be determined as follows.

a. **No Change in Total Square Footage.** The total allowable square footage after a qualifying private room conversion will be equal to the total allowable square footage immediately prior to the conversion, provided no other facility renovations or alterations changing total square footage occur concurrently or subsequently to the private room conversion.

b. **Square Footage Changes to Existing Buildings.** If a change in total nursing square footage occurs in a building existing on the effective date of this rule and that change is concurrent or subsequent to a private room conversion, the allowable square footage will be determined in accordance with §1305.D.3.b.i as if the private room conversion did not occur.

c. **Square Footage Changes Due to New Buildings.** Replacement buildings constructed or first occupied after the effective date of this rule will have their allowable square footage calculated in accordance with §1305.D.3.b.i.

3. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 85 percent of the revised annual bed days available after the change in licensed beds.

4. A revised fair rental value per diem will be calculated under §1305.D.3.b. using the allowable square footage according to §1310.D.2, remaining licensed beds, and the revised minimum occupancy calculation.

5. The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria in paragraph §1310.B.1.

#### E. Reporting

1. To remain eligible for the conversion payments and the allowable square footage calculations, facilities must report Medicaid-occupied private rooms with every annual cost report.

2. The department may also require an alternate billing procedure for providers to receive the additional \$5 private room rate.

**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 33:1646 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:794 (April 2014).

### **§20011. New Facilities, Changes of Ownership of Existing Facilities and Existing Facilities with Disclaimer or Non-Filer Status [Formerly LAC 50:VII.1311]**

A. New facilities are those entities whose beds have not previously been certified to participate, or otherwise participated, in the Medicaid program. New facilities will be reimbursed in accordance with this rule using the statewide average case mix index to adjust the statewide direct care component of the statewide price and the statewide direct care component of the floor. 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 statewide average of the facility-specific percentages determined in §1305.D.1.c. After the second full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with §1305.D.1.f-g and §1307 of this rule. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the start of a calendar quarter two months or more after the facility has submitted sufficient age and square footage documentation to the department. Following receipt of the age and square footage documentation, the new facility's capital rate will be calculated using the facility's actual age and square footage and the statewide occupancy from the most recent base year and will be effective at the start of the first calendar quarter two months or more after receipt. New facilities will receive the statewide average property tax and property insurance rate until the facility has a cost report included in a base year rate setting. New facilities will also receive a provider fee that has been determined by the department.

B. 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 this rule.

C. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under §1305.B. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the secretary of the department.

D. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with §1303. These facilities will have their case-mix rates adjusted as follows.

1. 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.

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

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

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 28:1793 (August 2002), amended LR 32:2265 (December 2006).

**§20012. Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities [Formerly LAC 50:VII.1312]**

A. On or after July 20, 2007, a Louisiana Medicaid participating nursing facility [buyer(s)] that purchases and closes an existing Louisiana Medicaid participating nursing facility (seller) will be eligible to receive fair rental value, property tax and property insurance incentive payments for five years after the legal transfer of ownership and closure of the seller's nursing facility.

B. Qualifying Buyer(s). In order for the buying facility to qualify for the incentive payments described in this Section, the following conditions must be met.

1. Buyer(s) must purchase and close a Medicaid-certified nursing facility within 90 days after the legal transfer of ownership from the seller to buyer(s).

2. After closing the facility, all buyer(s) must permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state.

3. The buyer(s) must be a Medicaid-certified nursing facility operator(s) at the time of purchase and continue their Medicaid participation throughout the entire five year payment period. A change in ownership of a buyer facility will not be considered a break in Medicaid participation provided the new owner of the nursing facility continues participation in the Medicaid Program as a Medicaid-certified nursing facility.

4. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 30 days after the legal transfer of ownership:

- a. a list of all buyer(s);
- b. a list of all seller(s);
- c. the date of the legal transfer of ownership;
- d. each buyer's percentage share of the purchased facility; and
- e. each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.

5. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 110 days after the legal transfer of ownership:

a. a list of the nursing facility residents that transferred from the seller facility and were residents of the buyer facility as of 90 days after the legal transfer of ownership date. The nursing facility resident list must include the payer source for each resident;

b. the date that the seller's facility was officially closed and no longer operating as a nursing facility.

C. Incentive Calculation. The total annual Medicaid incentive payment for each transaction will be based on the number of beds surrendered from the closed facility and the cumulative percentage increase in occupancy for all buyers involved in the purchase.

1. Beds surrendered will be based on the licensed beds surrendered for the closed facility. The number of beds surrendered will determine the base capital amount used in the incentive payment calculation as follows.

a. Under 115 beds surrendered will result in a base capital amount of \$303,216.

b. 115 through 144 beds surrendered will result in a base capital amount of \$424,473.

c. 145 beds or more surrendered will result in a base capital amount of \$597,591.

2. The cumulative increase in total nursing facility occupancy for all buyers involved in the transaction will be calculated based on the total occupancy reported for all buyers at the purchase date as required by §1312.B.4.e and the reported increase in total residents received from the seller as required by §1312.B.5.a.

a. Cumulative occupancy increases for all buyers will determine the percentage of the base capital amount used in the incentive payment calculation as follows:

i. less than 5.00 percent will result in 67 percent of the base capital amount;

ii. 5.00 percent through 9.99 percent will result in 78 percent of the base capital amount;

iii. 10.00 percent through 14.99 percent will result in 89 percent of the base capital amount;

iv. 15.00 percent and up will result in 100 percent of the base capital amount.

3. Annual Medicaid Incentive Payment Calculation. The payment amount that corresponds to the cumulative occupancy increase for all buyers and the number of beds surrendered will be multiplied by each buyer's percentage share in the transaction as reported in accordance with §1312.B.4.d. The result will be each buyer's total annual Medicaid incentive payment for five years.

4. Base Capital Amount Updates. On July 1 of each year, the base capital amounts (as defined in §1312.C.1) will be trended forward annually to the midpoint of the rate year

using the change in the per diem unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication, adjusted by the weighted average total city cost index for New Orleans, Louisiana. 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. Adjustments to the base capital amount will only be applied to purchase and closure transactions occurring after the adjustment date.

D. Re-Base of Buyers' Fair Rental Value, Property Tax, and Property Insurance per Diems. All buyers will have their fair rental value, property tax, and property insurance per diems re-based using the number of residents reported by each buyer as required by §1312.B.5.a. The re-base will be retroactive to the date of closure of the purchased facility. The calculation will be as follows.

1. Prior to application of the minimum occupancy calculation, the actual number of total resident days used in the calculation of each buyer's current fair rental value per diem as described in §1305.D.3.b.iii will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the total number of current rate year days.

2. The number of total resident days used in the calculation of each buyer's current pass through property tax and insurance per diem as described under §1305.D.4.a will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the number of calendar days included in the buyer's most recent base-year cost report.

3. The resident day adjustment to each buyer's fair rental value, property tax, and property insurance per diem will continue until the buyer's base-year cost report, as defined under §1305.B, includes a full 12 months of resident day data following the closure of the acquired facility (seller). If a buyer's base year cost report overlaps the closure date of the acquired facility, a proportional adjustment to that buyer's resident days will be made for use in the fair rental value, property tax, and property insurance per diem calculations.

#### E. Payments

1. The fair rental value, property tax and property insurance incentive payment will be paid to the buyer(s) as part of their Medicaid per diem for current services billed over five years (20 quarters), effective the beginning of the calendar quarter following the closure of the seller's facility and the surrender of the seller's licensed beds to the department. The per diem will be calculated as the buyer's annual Medicaid incentive payment as defined under §1312.C.3 divided by annual Medicaid days. Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility, as determined under §1312.B.5.a, multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report. If the most recent base year cost report includes or overlaps the period of the transfer, an adjustment will be made to avoid including the transferred days twice.

2. The revised fair rental value per diem and revised property tax and insurance per diem for the buyer(s) will be effective the first day of the month following the closure of the acquired facility (seller).

3. The incentive per diems, the revised fair rental value per diem, and revised property tax and insurance per diem will be updated at every case-mix rebase effective date.

4. The incentive payments when combined with all other Medicaid nursing facility payments shall not exceed the Medicare upper payment limit.

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 33:1349 (July 2007), amended LR 34:1033 (June 2008).

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

A. The department or its contractor shall provide each nursing facility 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 to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction policy where applicable. The department or its contractor shall provide each nursing facility with a Final Case-Mix Index Report (FCIR) (point-in-time) utilizing MDS assessments after allowing the facilities a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department or its contractor determines that a nursing facility 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 or its contractor shall periodically review the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify facilities of the Case-Mix MDS 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 and MDS coordinator 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 or its contractor shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the 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 or its contractor shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the RN reviewers prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered for the CMDR.

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

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

5. The following corrective action will apply to those facilities 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 25 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 facility'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 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 facility's 90-day correction period. The department or its contractor shall notify the facility 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 and MDS coordinator 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 facility'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 an MDS Documentation Improvement Plan with the Department of Health and Hospitals. 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 and beyond	25%

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 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012).

**§20015. Appeal Process**  
**[Formerly LAC 50:VII.1315]**

A. If the facility disagrees with the CMDR findings, a written request for an informal reconsideration must be submitted to the department or its contractor within 15 business days of the facility's receipt of the CMDR findings in the SRR letter. Otherwise, the results of the CMDR findings are considered final and not subject to appeal. The department or its contractor will review the facility's informal reconsideration request within 10 business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility. No appeal of findings will be accepted until after communication of final results of the informal reconsideration process.

B. The provider has the right to request an appeal within 30 days of the written notice of the results of the informal reconsideration. Such request must be in writing to the Appeals Section. The request must contain a statement and be accompanied by supporting documents setting forth with particularity those asserted discrepancies which the provider contends are in compliance with the agency's regulations and the reasons for such contentions.

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 28:2538 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:827 (March 2012).

**§20017. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations**  
**[Formerly LAC 50:VII.1317]**

A. All nursing facilities are required to be protected throughout by a fire sprinkler system by January 1, 2008. Where means of egress passes through building areas outside of a nursing facility, those areas shall be separated from the nursing facility by a two-hour rated wall or shall be protected by a fire sprinkler system.

**B. Nursing Facility Procedure and Documentation Requirements**

1. A completed fire sprinkler system plan or two-hour rated wall plan, or both, must be submitted to the department for review and approval by December 31, 2006.

2. Upon approval of the plans and after installation is completed, nursing facilities must submit auditable depreciation schedules and invoices to support the installation cost of all fire sprinkler systems and two-hour rated walls. The documentation must be submitted to the department or its designee.

a. All supporting documentation, including depreciation schedules and invoices, must indicate if the cost was previously included in a fair rental value re-age request.

C. Medicaid participating nursing facilities that install or extend fire sprinkler systems or two-hour rated walls, or both, after August 1, 2001, and in accordance with this section, may receive Medicaid reimbursement for the cost of installation over a five year period beginning the later of July 1, 2007 or the date of installation. The Medicaid reimbursement shall be determined as follows.

1. The annual total reimbursable cost is equal to a nursing facility's total installation cost of all qualified fire sprinkler systems and two-hour rated walls divided by five.

2. The per diem cost is calculated as the annual total reimbursable cost divided by total nursing facility resident days as determined by the nursing facility's most recently audited or desk reviewed Medicaid cost report as of April 30, 2007. If a cost report is not available, current nursing facility resident day census records may be used at the department's approval.

3. The per diem cost is reduced by any fair rental value per diem increase previously recognized as a result of the costs being reimbursed under this section. This adjusted per diem cost shall be paid to each qualifying nursing facility as and additional component of their Medicaid daily rate for five years.

**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 32:2266 (December 2006).

**§20019. Evacuation and Temporary Sheltering Costs**  
**[Formerly LAC 50:VII.1319]**

A. Nursing facilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. Nursing facilities must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid nursing home residents to the department.

**B. Eligible Expenses.** Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following.

1. **Evacuation Expenses.** Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a) the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs as defined in the CMS Publication 15-1, last modified 9/8/2005, that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. **Non-Nursing Facility Temporary Sheltering Expenses.** Non-nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-nursing facility temporary shelter to the date all Medicaid residents leave the shelter. A non-nursing facility temporary shelter includes shelters that are not part of a licensed nursing facility and are not billing for the residents under the Medicaid case-mix reimbursement

system or any other Medicaid reimbursement system. Non-nursing facility temporary sheltering expenses may include:

- a. additional nursing staff expenses including:
  - i. lodging; and
  - ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses as defined in LAC 50:VII.1305 and incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents, and:

- i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;
- ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as defined in the CMS Publication 15-1, last modified 9/8/2005, that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. Host Nursing Facility Temporary Sheltering Expenses. Host nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed nursing facility to the date all temporary sheltered Medicaid residents are discharged from the nursing facility, not to exceed a six-month period.

a. The host nursing facility shall bill for the residents under Medicaid's case-mix reimbursement system.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

#### C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §1319 will be removed from allowable expense when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §1319.B.2c. may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1 guidelines, last modified 9/8/2005, then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for nursing facilities.

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 34:879 (May 2008).

#### §20021. Leave of Absence Days [Formerly LAC 50:VII.1321]

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days for nursing facilities with occupancy rates equal to or greater than 90 percent shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

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 35:1899 (September 2009), amended LR 41:133 (January 2015).

**§20023. Transition of State-Owned or Operated Nursing Facility to a Private Facility**

A. A state owned or operated nursing facility that changes ownership (CHOW) in order to transition to a private nursing facility will be exempt from the case-mix direct care and care-related spending floor for a period of 12 months following the effective date of the CHOW under the following conditions:

1. the state-owned or operated facility is located in the DHH administrative region 1; and
2. the change of ownership is the result of a leasing arrangement.

**B. Cost Reports**

1. The previous owner of the nursing facility must file a closing cost report within 60 days of the CHOW for the time period that spans from the beginning of the facility's cost report period to the date of the CHOW.

2. The initial cost report period following the CHOW will be determined based on the elected fiscal year end of the new facility.

3. The closing and initial cost reports must be filed in accordance with the provisions of §20003, including the filing of all Medicaid supplemental schedules.

C. A capital data survey must be filed with the department within 60 days of the effective date of the CHOW. The capital data survey must include the nursing facility's date of construction, current square footage, and all renovations made since the facility's opening.

**D. Rate Determination**

1. During the transition period (12 months following the effective date of the change of ownership), the Medicaid reimbursement rate for the transitioned nursing facility shall be the per diem rate on file as of March 19, 2010 for the state-owned or operated facility.

2. The transitioned nursing facility will be transferred to the case-mix reimbursement system at the end of the 12 month transition period.

3. The Medicaid reimbursement rate and direct care/care-related floor shall be calculated in accordance with the provisions of §20005.

a. The direct care/care-related floor will be effective on the date of transition to the case mix reimbursement system.

b. For purposes of this initial floor calculation, direct care and care-related spending will be determined by apportioning cost report period costs based on calendar days.

4. Under the case mix reimbursement methodology, the facility will file cost reports in accordance with the provisions of §20003, including all Medicaid supplemental schedules.

a. If the nursing facility's cost report period overlaps the date of transition to the case mix reimbursement methodology, the case mix direct care and care-related floor will only be applied to the portion of the cost report period that occurs after the date of transition to case mix.

5. Until the nursing facility has an audited or desk reviewed cost report that is available for use in a case mix rebase in accordance with the provisions of §20005.B, the case mix reimbursement rate components will be based on the following criteria except as noted in Subsection D.6 of this Section.

a. The facility's acuity as determined from its specific case mix index report for the quarter prior to the effective date of the rate.

b. The direct care and care-related statewide median prices in effect for that period.

i. 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 nursing facility's most recent non-disclaimed audited or desk reviewed cost report.

ii. The facility-specific percentages will be determined using the methodology described in §20005.D.1.c.

c. The administrative and operating statewide median prices in effect for that period.

d. The capital data for the fair rental value rate component will be calculated from the facility-submitted capital data survey and the occupancy percentage from the most recent non-disclaimed audited or desk reviewed cost report as of the effective date of the rate.

e. The facility's property insurance cost will be calculated from the most recent non-disclaimed audited or desk reviewed cost report as of the rate effective date.

f. The property tax cost will be collected in the form of an interim property tax report specified by the department.

i. The interim property tax report must be filed within 30 days after the beginning of the nursing facility's cost reporting period.

ii. Failure to provide the interim property tax report within the specified time frame will result in a \$0 reimbursement rate for the property tax rate component.

iii. The facility must continue to file an interim property tax report until the facility is able to produce a non-disclaimed audited or desk reviewed cost report that contains property tax cost.

g. Provider fee and budget adjustments in effect for all other case mix facilities will be applicable.

6. A disclaimed cost report that would otherwise be used in a rebase will result in a rate calculated in accordance with the provisions of §20011 and the provisions contained in Subsection D.3.a-b and D.4.a of this Section will no longer be applicable.

7. If additional data is needed, the department may request that the facility submit Medicaid supplemental cost report schedules for those cost report period year ends for which the facility has not previously submitted Medicaid supplemental schedules.

E. If there is a subsequent CHOW which results in the nursing facility reverting to a state-owned or operated facility, then the reimbursement methodology for a state-owned or operated nursing facility will be reinstated following the effective date of the CHOW and all other provisions of this Section will no longer be applicable.

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 37:903 (March 2011).

#### **§20025. Low Income and Needy Care Collaboration**

A. Effective for dates of service on or after November 1, 2011, quarterly supplemental payments shall be issued to qualifying nursing facilities for services rendered during the quarter. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment limit per state fiscal year.

B. Qualifying Criteria. In order to qualify for the supplemental payment, the nursing facility must be affiliated with a state or local governmental entity through a low income and needy care nursing facility collaboration agreement.

1. A nursing facility is defined as a currently licensed and certified nursing facility which is owned or operated by a private entity or non-state governmental entity.

2. A low income and needy care nursing facility collaboration agreement is defined as an agreement between a nursing facility and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Each qualifying nursing facility shall receive quarterly supplemental payments for nursing facility services. Quarterly payment distribution shall be limited to one-fourth of the aggregated difference between each qualifying nursing facility's Medicare rate and Medicaid payments the nursing facility receives for covered services provided to Medicaid recipients during a 12 consecutive month period. Medicare rates in effect for the dates of

service included in the supplemental payment period will be used to establish the upper payment limit. Medicaid payments will be used for the same time period.

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 40:793 (April 2014).

#### **§20027. Specialized Care Reimbursement**

A. A specialized care reimbursement rate shall consist of a nursing facility's Medicaid case-mix reimbursement rate plus an add-on amount. These rates can be established by the department for a specialized care unit.

##### **B. Nursing Facility Specialized Care Unit Reimbursement**

1. Effective with the January 1, 2014 rate period, infectious disease (ID) specialized care costs will no longer be reimbursed through a separate per diem add-on payment. ID costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter.

2. Effective with the January 1, 2014 rate period, technologically dependent care (TDC) costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. TDC services will continue to be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the TDC per diem add-on payment.

3. Effective with the January 1, 2014 rate period, Neurological Rehabilitation Treatment Program (NRTP) costs and days for both rehabilitative and complex services will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. NRTP services will be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the NRTP per diem add-on payment.

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, Bureau of Health Services Financing, LR 40:541 (March 2014).

#### **§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 effective for January 20, 2016 are:

- a. Gueydan Memorial Guest Home;
- b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);
- c. LaSalle Nursing Home;
- d. Natchitoches Parish Hospital LTC Unit; and
- e. 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 adjustment shall be calculated as follows. For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

- a. the amount that the department reasonably estimates would have been paid to nursing facilities that are owned or operated by a NSGO using the Medicare resource utilization groups (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the minimum data set (MDS) assessment that is in effect on that date is classified using the Medicare RUGs system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid resident in the facility and dividing by total Medicaid residents in the facility; and

- b. the Medicaid per diem rate for nursing facilities that are owned or operated by a NSGO. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide

average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

4. Each participating nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in §20029.A.3.a and the adjusted Medicaid rate calculated in §20029.A.3.b.

- a. Each facility's UPL gap is multiplied by the Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

#### 5. Frequency of Payments and Calculations

- a. For each calendar quarter, an estimated interim supplemental payment will be calculated as described in this Section utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and available Medicaid payment rates. Payments will be made to each nursing facility that is owned or operated by a NSGO and that has entered into an agreement with the department to participate in the supplemental payment program.

- b. Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and Medicaid payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments, and the difference, if positive, will be paid to the NSGO, and if negative, collected from the NSGO.

6. 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).