DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
(LAC 50:II.20001)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:II.20001 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides reimbursement to nursing facilities, through vendor payments, for services rendered to Medicaid eligible individuals who reside in nursing facilities.

For state fiscal year (SFY) 2015-16, state general funds were required to continue nursing facility rates at the rebased level. Because of the fiscal crisis facing the state, the state general funds were not available to sustain the increased rates. Consequently, the department now proposes to amend the provisions governing the reimbursement methodology for nursing

facilities in order to suspend the provisions of LAC 50:II.Chapter 200, and to impose provisions to ensure that the rates in effect do not increase for the SFY 2016 rating period.

This action is being taken to avoid a budget deficit in the Medical Assistance Program. It is estimated that implementation of this Emergency Rule will have no fiscal impact to the Medicaid Program for state fiscal year 2015-2016.

Effective July 11, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20001. ~~Definitions~~General Provisions

A. ~~Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.~~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-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 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 Data Resources Incorporated (DRI-WEFA), or a comparable index if this index ceases to be published.

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).

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.

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 and Hospitals.

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. ~~*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~~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 imposes 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.

Base Resident-~~*Weighted Median Costs and Prices*-the resident-weighted median costs and prices calculated in accordance with §1305 of this rule during rebase years~~*Repealed*.

Calendar Quarter—~~a three-month period beginning January 1,~~

~~April 1, July 1, or October 1~~Repealed.

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

~~1. attributable to depreciation;~~

~~2. capital related interest;~~

~~3. rent; and/or~~

~~4. lease and amortization expenses~~1. - 4. Repealed.

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~~Repealed.

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

Case-Mix Index-~~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 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)~~Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

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

~~1. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;~~

~~2. a proportionate allocation of allowable employee benefits; and~~

~~3. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies~~1. - 3. Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

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

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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)~~Repealed.

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~~Repealed.

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 and Hospitals~~Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

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~~Repealed.

1. ~~The Summary Review Results letter will be sent to the nursing facility within 10 business days after the final exit conference date~~Repealed.

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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."~~Repealed.

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 28:1790 (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), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert

Secretary