RULE

Department of Health
Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Louisiana Low-Income Academic Hospitals
(LAC 50:V.2501 and Chapter 31)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.2501 and adopted LAC 50:V.Chapter 31 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

TITLE 50

PUBLIC HEALTH–MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment Methodologies

§2501. General Provisions

A. – C. ...

D. – E. Repealed.

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 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing, LR 36:65 (January 2010), LR 36:512 (March 2010), LR 40:790 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Chapter 31. Louisiana Low-Income Academic Hospitals

§3101. Qualifying Criteria

A. Hospitals Located Outside of the Baton Rouge and New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located outside of the Baton Rouge and New Orleans metropolitan statistical area (MSA)which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership change to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 18.9 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during

state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident full time equivalents (FTEs) to total inpatient beds that is greater than .08. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

B. Hospitals Located In the New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located in the New Orleans MSA which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision

of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership changed to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 45 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident FTEs to total inpatient beds that is greater than 1.25. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding

nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

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, Bureau of Health Services Financing, LR 43:

§3103. Payment Methodology

A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

B. Payment Calculation

1. For the initial year’s payment calculation, each qualifying hospital shall submit interim actual cost data calculated utilizing Medicaid allowable cost report principles, along with actual Medicaid and uninsured patient charge data. Annual Medicaid costs shortfalls and unreimbursed uninsured patient costs are determined based on review and analysis of these submissions.

2. For subsequent year's payment calculations, the most recent Medicaid filed cost report along with actual Medicaid and uninsured patient charge data annualized from the most recent calendar year completed quarter is utilized to calculate hospital specific uncompensated care costs.

C. The department shall review cost data, charge data, lengths of stay and Medicaid claims data per the Medicaid Management and Information Systems (MMIS) for reasonableness before payments are made.

D. The first payment of each fiscal year will be made by October 15 and will be 80 percent of the annual calculated uncompensated care costs. The remainder of the payment will be made by June 30 of each year

1. Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed.

2. Additional payments or recoupments, as needed, shall be made after the finalization of the Centers for Medicare and Medicaid Services (CMS) mandated DSH audit for the state fiscal year.

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

1. A pro rata decrease necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all qualifying hospitals in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment. Additional payments shall only be made after finalization of the CMS mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals in this Section based on these reported audit results. If the hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid shall be paid on a pro rata basis calculated using each hospital’s amount underpaid divided by the sum of underpayments for all hospitals in this Section.

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, Bureau of Health Services Financing, LR 43:

Rebekah E Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Developmental Disabilities Licensing Standards
(LAC 48:I.8595 and 8599)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.8595 and §8599 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2180-2180.5. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, 49:950 et seq.

Title 48

PUBLIC HEALTH - GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 85. Intermediate Care Facilities for Persons with Developmental Disabilities

Subchapter G. Emergency Preparedness

§8595. Emergency Preparedness Plan

A. The ICF/DD shall incorporate an all hazards risk assessment into the facility's emergency preparedness plan which is designed to manage the consequences of medical emergencies, power failures, fire, natural disasters, declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the

residents. The facility shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency. This plan shall be reviewed, updated and approved by the governing body at least annually. Upon the department's request, a facility shall present its emergency preparedness plan for review.

B. – B.13. ...

14. The facility's plan shall include how the ICF/DD will notify OHSEP and LDH when the decision is made to shelter in place and whose responsibility it is to provide this notification.

15. – 15.f. ...

C. An ICF/DD shall electronically enter current facility information into the department's ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting.

1. The following information shall be entered or updated before the fifteenth of each month:

a. operational status;

b. census;

c. emergency contact and destination location information; and

d. emergency evacuation transportation needs categorized by the following types:

i. *red*–high risk residents who will need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. *yellow*–residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance; however, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; and

iii. *green*-residents who do not need specialized transportation may be transported by car, van, bus or wheelchair accessible transportation.

2. An ICF/DD shall also enter or update the facility's information upon request, or as described per notification of an emergency declared by the secretary. Emergency events may include, but are not limited to:

a. hurricanes;

b. floods;

c. fires;

d. chemical or biological hazards;

e. power outages;

f. tornados;

g. tropical storms; and

h. severe weather.

3. Effective immediately, upon notification of an emergency declared by the secretary, all ICFs/DD shall file an electronic report with the ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting.

a. The electronic report shall be filed, as prescribed by department, throughout the duration of the emergency declaration.

b. The electronic report shall include, but is not limited to, the following:

i. status of operation;

ii. availability of beds;

iii. generator status;

iv. evacuation status;

v. shelter in place status;

vi. mobility status of clients;

vii. range of ages of clients;

viii. intellectual levels/needs of clients; and

ix. any other client or facility related information that is requested by the department.

NOTE: The electronic report shall not be used to request resources or to report emergency events.

D. The facility's plan shall include a process for tracking during and after the emergency/disaster for on-duty staff and sheltered clients.

E. The facility's plan shall also include a process to share with the client, family, and representative appropriate information from the facility's emergency plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3207 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§8599. Notification of Evacuation, Relocation, or Temporary Cessation of Operations

A. In the event that an ICF/DD evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish OHSEP, the ICF/DD must immediately give notice to the Health Standards Section as well as the Office for Citizens with Developmental Disabilities (OCDD) and OHSEP as directed by filing an electronic report with the ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting:

A.1. – E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3208 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
(LAC 50:Chapter 200)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.Chapter 200 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

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

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Active Assessment—a resident MDS assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until a subsequent Minimum Data Set (MDS) assessment for the same resident has been accepted by CMS, the maximum number of

days (121) for the assessment has been reached, or the resident has been discharged.

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Assessment Reference Date—the date on the minimum data set (MDS) used to determine the due date and delinquency of assessments.

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

Case-Mix Documentation Review (CMDR)—a review of original legal medical record documentation and other documentation as designated by the department in the MDS supportive documentation requirements, supplied by a nursing facility provider to support certain reported values that resulted in a specific RUG classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

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. CMIs will be determined for each nursing facility on a quarterly basis using all residents.

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Department—the Louisiana Department of Health (LDH), or its successor, and the associated work product of its designated contractors and agents.

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Facility Cost Report Period Case-Mix Index-Repealed.

Example: Repealed.

Facility-Wide Average Case-Mix Index—Repealed.

Final Case-Mix Index Report (FCIR)—the final report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective with the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

Index Factor—based on the *Skilled Nursing Home without Capital Market Basket Index* published by IHS Global Insight (IHS Economics), or a comparable index if this index ceases to be published.

MDS Supportive Documentation Requirements—the department's publication of the minimum documentation and review standard requirements for the MDS items associated with the RUG-

III or its successor classification system. These requirements 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 nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS).

Nursing Facility Cost Report Period Case Mix Index—the average of quarterly nursing facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the nursing facility provider's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

a. For the cost reporting periods utilized in the next rebase of rates on or after July 1, 2017, the calendar

quarter case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of MDS assessments available as of the date of the applicable quarterly FCIRs. This average includes any revisions made due to an on-site CMDR.

EXAMPLE: A January 1, 2015-December 31, 2015 cost report period would use the time-weighted facility-wide average case mix indices calculated for the four quarters ending March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015.

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

1. Prior to the January 1, 2017, rate setting resident case mix indices will be calculated utilizing the point-in-time acuity measurement system. If a nursing facility provider 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 nursing facility case mix indices may be used.

a. Effective as of the January 1, 2017 rate setting, resident case mix indices will be calculated utilizing the time-weighted acuity measurement. If a nursing facility provider does not have any residents during the course 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 nursing facility provider case mix indices may be used.

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Point-In-Time Acuity Measurement System (PIT)—the case mix index calculation methodology that is compiled utilizing the active resident MDS assessments as of the last day of the calendar quarter, referred to as the point-in-time.

Preliminary Case-Mix Index Report (PCIR)—the preliminary report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective as of the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

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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 nursing facility provider's total residents average CMI and Medicaid residents average CMI.

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

a. The summary review results letter will be sent to the nursing facility provider within 10 business days after the final exit conference date.

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Time-Weighted Acuity Measurement System (TW)—the case mix index calculation methodology that is compiled from the collection of all resident MDS assessments transmitted and accepted by CMS that are considered active within a given calendar quarter. The resident MDS assessments will be weighted based on the number of calendar days that the assessment is considered an active assessment within a given calendar quarter.

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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 supportive documentation requirements and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. – B.7. ...

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), LR 43:

§20003. Cost Reports

[Formerly LAC 50:VII.1303]

A. – B.1. ...

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 department 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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§20005. Rate Determination

[Formerly LAC 50:VII.1305]

A. – B. ...

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 or the department may apply a historic audit adjustment factor to the most recently filed cost reports. The department, at its discretion, may rebase at an earlier time.

B.1.a. – D.1.g. ...

i. Effective for rate periods January 1, 2017 through June 30, 2017 each nursing facility providers

direct care and care related floor will be calculated as follows:

(a). 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 Subparagraph c of this Paragraph. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each nursing facility provider’s most advantageous average case mix index for the prior quarter. The most advantageous case mix index will be determined by utilizing the nursing facility providers’ calculated point-in-time or time-weighted measurement system case mix index value that results in the lowest direct care and care related floor amount for the associated rate quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the nursing 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.

1.h. - 4.c. ...

d. Effective for rate periods beginning January 1, 2017 through June 30, 2017, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the time-weighted acuity measurement system. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows:

i. The nursing facility provider's rate period reimbursement rate will be calculated in accordance with §20005.B using the point-in-time acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rates.

ii. The nursing facility provider's rate period reimbursement rate will be calculated in accordance with §20005.B using the time-weighted acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rate.

iii. The reimbursement rate differential will be determined by subtracting the reimbursement rate calculated using the point-in-time acuity measurement system

from the reimbursement rate calculated using the time-weighted acuity measurement system.

iv. If the calculated reimbursement rate differential exceeds a positive or negative $2, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate in an amount equal to the difference between the rate differential total and the $2 threshold, in order to ensure the nursing facility provider's reimbursement rate is not increased or decreased more than $2 as a result of the change of the time-weighted acuity measurement system.

(a). Should the nursing facility provider, for the aforementioned rate periods, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have their rate differential recalculated using the revised case mix index values. The $2 reimbursement rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation;

v. If a nursing facility provider's calculated rate differential does not exceed the $2 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

D.5. – Q. ...

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR:43:

§20007. Case-Mix Index Calculation

[Formerly LAC 50:VII.1307]

A. ...

B. Each resident in the nursing facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor based on the following criteria:

1. Prior to the January 1, 2017 rate setting, 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 provider shall be determined four times per year based on the last day of each calendar quarter.

2. Effective as of the January 1, 2017 rate setting, the RUG-III group, or its successor, will be calculated using each resident MDS assessment transmitted and accepted by CMS that is considered active within a given calendar quarter. These assessments are then translated to the appropriate case mix index. The individual resident case mix indices are then weighted based on the number of calendar days each assessment is active within a given calendar quarter. Using the individual resident case mix indices, the calendar day weighted average nursing facility-wide case mix index is calculated using all residents regardless of payer type. The calendar day weighted nursing facility-wide average case mix index for each Medicaid nursing facility shall be determined four times per year.

C. 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 28:1475 (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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

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

A. – C.3. ...

4. Base Capital Amount Updates. On July 1 of each year, the base capital amounts (as defined in Paragraph 1 of this Subsection) 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, or its successor, 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 Paragraph. Adjustments to the base capital amount will only be applied to purchase and closure transactions occurring after the adjustment date.

D. – E.4. ...

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports

[Formerly LAC 50:VII.1313]

A. The department shall provide each nursing facility provider 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 provider to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction request process where applicable. The department shall provide each nursing facility provider with a final case-mix index report (FCIR) utilizing MDS assessments after allowing the nursing facility providers a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department determines that a nursing facility provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments

shall be assigned the case-mix index associated with the RUG-III group "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 shall periodically review the MDS supporting documentation maintained by nursing facility providers for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify nursing facility providers of the scheduled case-mix 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 or other nursing facility provider designee 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 shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the nursing 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 shall consider all MDS supporting documentation that is provided by the nursing facility provider and is available to the RN reviewers prior to the start of the exit conference. MDS supporting documentation that is provided by the nursing facility provider after the start of the exit conference shall not be considered for the CMDR.

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

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

5. The following corrective action will apply to those nursing facility providers with unsupported MDS resident assessments identified during an on-site CMDR.

a. – b. ...

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 nursing facility provider'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 nursing facility 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 nursing facility provider's 90-day correction period. The department or its contractor shall notify the nursing facility provider 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 or other nursing facility provider designee 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 nursing facility provider'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 a documentation improvement plan with the department. Additional follow-up CMDR may be conducted at the discretion of the department.

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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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§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 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 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. ...

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§20029. Supplemental Payments

A. – A.2. ...

3. Payment Calculations. The Medicaid supplemental payment for each state fiscal year (SFY) shall be calculated immediately following the July quarterly Medicaid rate setting process. The total Medicaid supplemental payment for each individual NSGO will be established as the individual nursing

facility differential between the estimated Medicare payments for Medicaid nursing facility residents, and the adjusted Medicaid payments for those same nursing facility residents. A more detailed description of the Medicaid supplemental payment process is described below:

a. The calculation of the total annual Medicaid supplemental payment for nursing facilities involves the following four components:

i. calculate Medicare payments for Louisiana Medicaid nursing facility residents using Medicare payment principles;

ii. determining Medicaid payments for Louisiana Medicaid nursing facility residents;

iii. adjust payments for coverage difference between Medicare payment principles and Louisiana Medicaid payment principles; and

iv. calculating the differential between the calculated Medicare payments for Medicaid nursing facility residents, and Medicaid payments for those same residents.

b. Calculating Medicaid Rates Using Medicare Payment Principles. With Medicare moving to the prospective payment system (PPS), Medicare rates will be calculated based on Medicaid acuity data. The following is a summary of the steps involved:

i. Using each resident's minimum data set assessment, the applicable RUG-III grouper code for Medicaid residents was identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories is then generated.

(a). The resident minimum data set assessments will be from the most recently available minimum data set assessments utilized in Medicaid rate setting processes as of the development of the Medicaid supplemental payment calculation demonstration.

ii. After the Medicaid resident frequency distribution was developed, rural and urban rate differentials and wage index adjustments will be used to adjust the Medicare rate tables. Medicare rate tables will be applicable to SFY periods.

(a). Medicare rate tables will be established using information published in 42 CFR part 483 where available. Should the finalized Medicare rate tables for any portion of the applicable SFY period be unavailable, the most recent preliminary Medicare rate adjustment percentage published in the federal register available as of the development of the Medicaid supplemental payment calculation demonstration will be utilized as the basis of the Medicare rate for that portion of the SFY period.

(b). The resulting Medicare rates are multiplied by the number of Medicaid residents in each RUG category, summed and then averaged. The Medicare rate tables applicable to each period of the SFY will be multiplied by an estimate of Medicaid paid claims days for the specified period. Medicaid paid claims days will be compiled from the state's Medicaid Management Information System's (MMIS) most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration.

c. Determining Medicaid Payments for Louisiana Medicaid Nursing Facility Residents. The most current Medicaid nursing facility reimbursement rates as of the development of Medicaid supplemental payment calculation demonstration will be utilized. These reimbursement rates will be multiplied by Medicaid paid claims compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish total Medicaid per diem payments. Total calculated Medicaid payments made outside of the standard nursing facility per diem are summed with total Medicaid reimbursement from the per diem payments to establish total Medicaid payments. Payments made outside of the standard nursing facility per diem are reimbursement for the following services:

i. Specialized Care Services Payments. Specialized care services reimbursement is paid outside of the standard per diem rate as an add-on payment to the current facility per diem rate. The established specialized care add-on per diems will be multiplied by Medicaid paid claims for specialized care days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish projected specialized care services payments for the applicable SFY.

ii. Home/Hospital Leave Day (Bed Hold) Payments. Allowable Medicaid Leave days were established using Medicaid paid claims days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration. Allowable Medicaid Leave days will be multiplied by the most recent Medicaid leave day quarterly reimbursement rates as of the of the Medicaid supplemental payment calculation demonstration to established projected Medicaid leave day payments for the SFY.

iii. Private Room Conversion Payments. Private room conversion (PRC) Medicaid days will be established utilizing the most recently reviewed or audited Medicaid supplemental cost reports as of the development of the Medicaid

supplemental payment calculation demonstration. The applicable cost reporting period information will be annualized to account for short year cost reporting periods. Allowable PRC Medicaid days will be multiplied by the PRC incentive payment amount of $5 per allowable day to establish the total projected Medicaid PRC payments for the SFY.

d. Adjusting for Differences between Medicare Principles and Louisiana Medicaid Nursing Facility Residents. An adjustment to the calculation of the Medicaid supplemental payment limit will be performed to account for the differences in coverage between the Medicare PPS rate and what Louisiana Medicaid covers within the daily rate provided above. To accomplish this, an estimate will be calculated for pharmacy, laboratory, and radiology claims that were paid on behalf of nursing facility residents for other than their routine daily care. These estimates will then be added to the total calculated Medicaid payments.

e. Calculating the Differential Between the Calculated Medicare Payments for Medicaid Nursing Facility Residents, and Medicaid Payments for Those Same Residents. The total annual Medicaid supplemental payment will be equal to the individual NSGO nursing facility's differential between their calculated Medicare payments and the calculated adjusted

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

4. Frequency of Payments and Calculations. The Medicaid supplemental payments will be reimbursed through a calendar quarter based lump sum payment. The amount of the calendar quarter lump sum payment will be equal to the SFY total annual Medicaid supplemental payment divided by four. The total annual Medicaid supplemental payment calculation will be performed for each SFY immediately following the July quarterly Medicaid rate setting process.

a. Repealed.

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

5.a. – 6. Repealed.

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

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.

Rebekah E. Gee MD, MPH

Secretary