NOTICE OF INTENT

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 proposes to amend 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 proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing amended 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 would not increase for the SFY 2016 rating period (*Louisiana Register*, Volume 42, Number 9).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities in order to revise the method used for nursing facility rate setting (*Louisiana Register,* Volume 42, Number 12). Currently, nursing facility rate setting uses a point-in-time method which determines rates by services utilized at a specific time. The department proposes to adopt provisions

which will utilize a time-weighted methodology which determines rates by services used over a longer period of time.

The January 1, 2017 Emergency Rule also amended the provisions governing the reimbursement methodology for nursing facilities in order to make technical changes to align these provisions with the approved State Plan amendment, LA TN 15-0033, governing reimbursement for nursing facility services which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services on April, 11, 2016. This proposed Rule is being promulgated to continue the provisions of the January 1, 2017 Emergency Rule.

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.

***

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.~~

***

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 average~~ CMIs will be determined for each nursing 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 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 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.

***

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

***

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~~.

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—will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by ~~Data Resources Incorporated~~IHS Global Insight (~~DRI-WEFA~~IHS Economics), or a comparable index if this index ceases to be published.

MDS Supportive Documentation ~~Guidelines~~Requirements—the department's publication of the minimum ~~medical record~~ documentation ~~guidelines~~ and review standard requirements for the MDS items associated with the RUG-III or its successor classification system. These ~~guidelines~~ 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 ~~facilities~~ nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within ~~facilities~~nursing facility providers, between ~~facilities~~nursing facility providers, and between ~~facilities~~ nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment ~~required and~~ 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.

***

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 ~~on the last day of the calendar quarter~~.

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.

***

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 ~~MDS~~ 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.

***

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.

***

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~~ supportive documentation ~~guidelines~~ 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 ~~Medicaid Program~~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 §1305.D.1.c. 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.b. ...

c. Reserved.

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 two dollars, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate in an amount equal to the difference between the rate differential total and the two dollar threshold, in order to ensure the nursing facility provider's reimbursement rate is not increased or decreased more than two dollars as a result of the change 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 two dollar 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 two dollar 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 and Hospitals, Bureau of Health Services Financing, LR 43:

§20007. Case-Mix Index Calculation

[Formerly LAC 50:VII.1307]

A. ...

B. ~~Effective with the January 1, 2011 rate setting, each~~ Each resident in the nursing 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.~~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. ~~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~~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 §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, 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 Subparagraph. 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, Office of the Secretary, Bureau of Health Services Financing, LR 43:

§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 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 ~~policy~~ request process where applicable. The department ~~or its contractor~~ shall provide each nursing facility provider with a Final Case-Mix Index Report (FCIR) ~~(point-in-time)~~ utilizing MDS assessments after allowing the ~~facilities~~ nursing facility providers a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department ~~or its contractor~~ 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 ~~or its contractor~~ shall periodically review the MDS supporting documentation maintained by nursing ~~facilities~~ 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 ~~facilities~~ nursing facility providers of the scheduled 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~~ 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 ~~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 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 ~~or its contractor~~ 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 ~~or its contractor~~, the nursing facility provider 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 nursing facility within 10 business days following the final exit conference date.

5. The following corrective action will apply to those ~~facilities~~ 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 ~~facility's~~ 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 ~~facility's~~ 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 ~~and MDS coordinator~~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 ~~facility's~~ 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 ~~an MDS~~a Documentation Improvement Plan with the ~~Department of Health and Hospitals~~department. Additional follow-up CMDR may be conducted at the discretion of the department.

Table ...

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 ~~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. ...

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 ~~adjustment shall be calculated as follows. For~~for each state fiscal year (SFY)~~, the Medicaid supplemental payment~~ shall be calculated~~ as the difference between~~ 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 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~~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. ~~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.~~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. ~~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.~~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. ~~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~~Repealed.

5. ~~Frequency of Payments and Calculations~~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.

~~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.~~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.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to

the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, January 26, 2017 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary