§10123. Comprehensive Assessment

A. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and needs, in relation to a number of specified areas. Comprehensive assessments must:

1. be based on a uniform data set (resident assessment instrument); and

2. describe the resident's capability to perform daily life functions and significant impairments in functional capacity;

3. include the following information:

a. medically defined conditions and prior medical treatment;

b. medical status measurements;

c. physical and mental functional status;

d. sensory and physical impairments;

e. nutritional status and requirements;

f. special treatment and procedures;

g. mental and psychosocial status;

h. discharge potential;

i. dental condition;

j. activities potential;

k. rehabilitation potential;

l. cognitive status; and

m. drug therapy.

B. Frequency. The assessment must be conducted no later than 14 days after admission for new admissions.

1. A reassessment must be completed after a significant change in the resident's physical and/or mental condition.

2. A reassessment must be conducted at least once every 12 months/annually.

3. Residents must be examined and assessments must be reviewed every three months and revised as appropriate to assure the continued accuracy of the assessment.

C. Coordination of Assessments with Pre-admission Screening. The facility must coordinate assessments with the state-required pre-admission screening program to the maximum extent practicable to avoid duplicate testing and effort.

D. Accuracy of Assessments. To assure accuracy, the assessments:

1. must be conducted or coordinated with the appropriate participation of health professional;

2. must be conducted or coordinated by a registered nurse who signs and certifies completion of the assessment; and

3. must have each individual who completes a portion of the assessment sign and certify the accuracy of that portion of the assessment.

E. Penalty for Falsification

1. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties.

2. Clinical disagreement does not constitute a material and false statement.

3. If the state determines under survey, or otherwise, that there has been knowing and willful certification of false statements, the state may require that the residents' assessments be conducted by individuals independent of the facility. The independent assessors must be approved by the state. The total cost of this independent assessment is the sole responsibility of the facility. Additionally, all independent assessments are not considered necessary expenditures of the facility.

F. Utilization—Resident Assessment Instrument (RAI)

1. Components of comprehensive assessment (RAI):

a. minimum data set (MDS);

b. triggers legend;

c. care area assessment; and

d. utilization guidelines;

e. alteration of MDS information—MDS information collected may be altered until the twenty-first day after admission for the following reasons:

i. information not available to staff completing section because the resident is unable to provide necessary information and family members must make an appointment to participate;

ii. further observation and interaction with the resident reveals a need to alter the assessment;

iii. at admission, the resident's condition is unstable and the illness or chronic problem is controlled by the twenty-first day.

2. If the MDS must be altered up to the twenty-first day, then the assessor shall show these changes on the admission assessment and shall initial and date such amendments.

3. The MDS may not be altered after the twenty-first day. If a change has occurred, a new MDS must be completed.

4. Significant change defined:

a. deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear permanent;

b. loss of ability to freely ambulate or to use hands to grasp a small object to feed or groom oneself, such as spoon, toothbrush or comb;

c. deterioration in behavior, mood, and/or relationships that has not been reversed;

d. deterioration in a resident's health status where this change places the resident's life in danger, is associated with serious clinical complications, or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;

e. onset of a significant weight loss (five percent in last 30 days or ten percent in last 180 days); and

f. a marked and sudden improvement in the resident's status.

5. Document in medical record the initial identification of a significant change in status. Once it has been determined that the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of that determination.

6. Quarterly Assessment and Optional Progress Notes—to track resident status between assessments and to ensure monitoring of critical indicators of the gradual onset of significant declines in resident status, a registered nurse:

a. must examine the resident;

b. review the MDS core elements as outlined in the HSS Form Quarterly RA Review:

i. Section B—Items 2 and 4;

ii. Section C—Items 4 and 5;

iii. Section E—Items 1 b-f and 3A;

iv. Section F—Item 1;

v. Section J—Note only disease diagnosis in last 90 days;

vi. Section L—Item 2C;

vii. Section O—Item 4;

viii. Section P—Item 3;

7. Triggers—Level of measurement (coding categories) of MDS elements that identify residents who require evaluation using the care area assessment (CAA) process.

G. Care Area Assessment (CAA) Process and Care Planning

1. CAAs are triggered responses to items coded on the MDS specific to a resident’s possible problems, needs or strengths.

2. The CAA process provides:

a. a framework for guiding the review of triggered areas;

b. clarification of a resident’s functional status and related causes of impairments; and

c. a basis for additional assessment of potential issues, including related risk factors.

3. The CAA must:

a. be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals;

b. have input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice; and

c. address each care area identified under CMS’s RAI Version 3.0 Manual, section 4.10, Table 10 (The Twenty Care Areas).

4. CAA documentation should indicate:

a. the basis for decision making;

b. why the finding(s) require(s), or does not require, an intervention; and

c. the rationale(s) for selecting specific interventions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended by the

Department of Health, Bureau of Health Services Financing, LR 46:695 (May 2020), LR 46:1684 (December 2020).

Subpart 5. Reimbursement

Editor's Note: This Subpart has been moved from LAC 50:VII.Chapter 13 and renumbered.

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

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.

Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

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

Base Resident-Weighted Median Costs and Prices—the resident-weighted median costs and prices calculated in accordance with §20005 of this rule during rebase years.

Calendar Quarter—a three-month period beginning January 1, April 1, July 1, or October 1.

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

a. attributable to depreciation;

b. capital related interest;

c. rent; and/or

d. lease and amortization expenses.

Care Related Cost Component—the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

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

Case-Mix 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.

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

Cost Neutralization—refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment—an MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS.

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

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

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

b. a proportionate allocation of allowable employee benefits; and

c. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

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.

a. 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.

i. 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.

Pass-Through Cost Component—includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department of Health.

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.

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.

Rate Year—a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates are in effect. It corresponds to a state fiscal year.

Resident-Day-Weighted Median Cost—a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

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.

Supervised Automatic Sprinkler System—a system that operates in accordance with the latest adopted edition of the National Fire Protection Association's *Life Safety Code*. It is referred to hereafter as a *fire sprinkler system*.

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.

Two-Hour Rated Wall—a wall that meets American Society for Testing and Materials International (ASTM) E119 standards for installation and uses two-hour rated sheetrock.

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supportive documentation requirements and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. Effective for the rate period of July 1, 2015 through June 30, 2016, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2014.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2014.

4. Base capital values for the Bed Buy-Back program (§20012) purposes will be set equal to the value of these items as of July 1, 2014.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2015.

6. As of the July 1, 2016 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2015 rating period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

C. Effective for the rate period of July 1, 2017 through June 30, 2018, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2016.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2017 state fiscal year (December 31, 2016).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2016.

4. Base capital values for the Bed Buy-Back Program (LAC 50:II.20012) purposes will be set equal to the value of these items as of July 1, 2016.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2017.

6. As of the July 1, 2018 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2017 rate period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020), LR 46:1684 (December 2020).

B. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and non-allowable cost contained in the CMS Publication 15-1, Provider Reimbursement Manuals, with the following exceptions.

1. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

2. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the 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.

3. Amended Cost Reports. The department will accept amended cost reports in electronic format for a period of 12 months following the end of the cost reporting period. Cost reports may not be amended after an audit or desk review has been initiated; however, the department maintains the right, at their discretion, to supersede this requirement and allow a cost report to be amended after the desk review or audit has been initiated. When an amended cost report is received by the department, it will notify the submitting facility if a desk review or audit covering the submitted cost report period has been initiated and that the amended cost report cannot be accepted. Amended cost reports should include a letter explaining the reason for the amendment, an amended certification statement with original signature, and the electronic format completed amended cost reports. Each amended cost report submitted should be clearly marked with “Amended” in the file name.