John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

October 12, 2023

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
601 East 12th Street, Room 0300
Kansas City, Missouri 64106-2898

RE: Louisiana Title XIX State Plan
Transmittal No. 23-0041

Dear Mr. Scott:

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan. Should you have any questions or concerns regarding this matter, please contact Karen Barnes at (225) 342-3881 or via email at Karen.Barnes@la.gov.

Sincerely,

_____for
Stephen R. Russo, JD
Secretary

Attachments (2)

SRR:KS:UN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **23-0041**

2. STATE: **LA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2024** **$0**
b. FFY **2025** **$0**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Page 2
Attachment 4.19-D, Page 4
Attachment 4.19-D, Pages 5-6

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same (TN 06-33)
Same (TN 22-0005)
Same (TN 17-0005)

9. SUBJECT OF AMENDMENT

The purpose of this SPA is to amend the standards for payment and reimbursement for nursing facilities in order to implement the patient driven payment model for case-mix classification and mandate use of the optional state assessment item set.

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED:

The Governor does not review State Plan material.

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Pam Diez, designee for Stephen R. Russo, JD

13. TITLE
Secretary

14. DATE SUBMITTED
October 12, 2023

15. RETURN TO

Kimberly Sullivan, J.D.
Interim Medicaid Executive Director
Louisiana Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

I. REIMBURSEMENT METHODOLOGY

The Department of Health, Office of the Secretary, Bureau of Health Services Financing, establishes a system of prospective payment for nursing facilities based on recipient care needs that incorporates acuity measurements as determined under the Resource Utilization Group III (RUG-III) resident classification methodology. This system establishes a facility specific price for the Medicaid nursing facility residents served. It also provides for enhanced reimbursement for Medicaid residents who require skilled nursing services for an infectious disease and technology dependent care. Facilities may furnish any or all of these levels of care to residents. Every nursing facility must meet the requirements for participation in the Medicaid program.

Effective for assessments with assessment reference dates of October 1, 2023 and after, the Department mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the assessment it was performed in conjunction with.

A. COST REPORTS

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

    a. Providers of nursing facility level of care are required to report all reasonable and allow-able cost on a regular nursing facility cost report. Effective for periods ending on or after June 30, 2002, the regular nursing facility cost report will be the skilled nursing facility cost report adopted by the Medicare Program. This cost report is frequently referred to as the Health Care Financing Administration (HCFA) 2540. The cost reporting period begin date shall be the later of the first day of the facility's fiscal period or the facility's certification date. The cost reporting end date shall be the earlier of the last day of the facility's fiscal period or the final day of operation as a nursing facility.

    b. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the Bureau. Facilities shall submit their Medicare cost report and their state Medicaid supplemental cost report in accordance with procedures established by the Department.

    c. Providers of skilled nursing-infectious disease (SN-ID), skilled nursing-technology dependent care (SN-TDC), and skilled nursing neurological rehabilitation treatment (SN-NRT) program services must file additional supplemental schedules designated by the Bureau documenting the incremental cost of providing SN-ID, SN-TDC, and SN-NRT services to Medicaid beneficiaries.

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

2. 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 Manual, with the following exceptions.

    a. 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.

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

i. attributable to depreciation;
ii. capital related interest;
iii. rent; and/or
iv. 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 beneficiaries.

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

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.

Cost Neutralization: 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 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:

i. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
ii. a proportionate allocation of allowable employee benefits; and
iii. 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.

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.

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), or as mandated by the Department through the use of the optional state assessment (OSA).

Optional State Assessment (OSA) - assessment required by Medicaid to report on Medicaid-covered stays that allows nursing facility providers to use resource utilization group (RUG) RUG-III or RUG-IV models as the basis for Medicaid payment until the Louisiana legacy payment model (RUG-III) ends.

Patient Driven Payment Model (PDPM) - the proposed new Medicare payment rule for skilled nursing facilities. The PDPM identifies and adjusts different case-mix components for the varied needs and characteristics of a resident's care and then combines case-mix components with a non-case-mix component to determine the full skilled nursing facilities (SNF) prospective payment system (PPS) per diem rate for that resident.

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 classification system. These requirements shall be maintained by the Department and updated and published as necessary.

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.

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

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

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 (PCIR): The preliminary report that reflects the acuity of the residents in the nursing facility.

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 (SFY).

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

RUG-III Resident Classification System: The resource utilization group used to classify residents. When a resident classifies into more than one RUG-III group, or its successor, the RUG-III 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.

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."