STATE OF <u>LOUISIANA</u>

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING FACILITY SERVICES

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 ~~recipients~~ 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.

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Minimum Data Set (MDS): A core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care 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.

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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."