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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 17-0005

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

JUN 05 2017

Mrs. Jen Steele, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 17-0005

Dear Mrs. Steele:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 17-0005. Louisiana Department of Health and Hospitals proposes to revise the provisions governing the reimbursement methodology for nursing facilities in order to change the nursing facility rate setting method from a point-in- time methodology which determines rates by services utilized at a specific time, to a time-weighted methodology which determines rates by services over a longer period of time.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Based upon the information provided by the State, Medicaid State plan amendment 17-0005 is approved effective January 1, 2017. We are enclosing the CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **17-0005**

2. STATE: **Louisiana**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **January 1, 2017**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 **$0**
b. FFY 2018 **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Item 1, Page 3	**Same (TN 06-33)**
Attachment 4.19-D, Item 1, Pages 3a, 4, 5 and 6	**Same (TN 15-0023)**
Attachment 4.19-D, Item 1, Pages 6a, 6b and 6c	**None - New Pages**
Attachment 4.19-D, Item 1, Pages 7 and 7a	**Same (TN 15-0023)**
Attachment 4.19-D, Item 1, Page 9.a.(1)	**Same (TN 12-08)**
Attachment 4.19-D, Item 1, Page 9.a.(1)a	**None – New Page**
Attachment 4.19-D, Item 1, Page 9.b	**Same (TN 03-01)**
Attachment 4.19-D, Item 1, Page 9.h.2.b.	**Same (TN 07-12)**

10. SUBJECT OF AMENDMENT: **The SPA proposes to revise the provisions governing the reimbursement methodology for nursing facilities in order to change the nursing facility rate setting method from a point-in-time methodology which determines rates by services utilized at a specific time, to a time-weighted methodology which determines rates by services over a longer period of time.**

11. 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.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME:
Rebekah E. Gee MD, MPH

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 31, 2017

16. RETURN TO:
Jen Steele, Medicaid Director
State of Louisiana
Department of Health
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3-31-2017

18. DATE APPROVED: JUN 05 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1-1-2017

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

b. 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.

B. NEW FACILITIES AND CHANGES OF OWNERSHIP OF EXISTING FACILITIES

1. New facilities are those entities whose beds have not previously been certified to participate, or otherwise participated, in the Medicaid program. New facilities will be reimbursed using the statewide average case mix index to adjust the statewide direct care component of the statewide price and the statewide direct care component of the floor. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the statewide average of the facility-specific percentages determined in section C.2.c.i.(3). After the second full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with section C.2.c.i.(6)-(7) and section C.3. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the start of a calendar quarter two months or more after the facility has submitted sufficient age and square footage documentation to the Department. Following receipt of the age and square footage documentation, the new facility's capital rate will be calculated using the facility's actual age and square footage and the statewide occupancy from the most recent base year and will be effective at the start of the first calendar quarter two months or more after receipt. New facilities will receive the statewide average property tax and property insurance rate until the facility has a cost report included in a base year rate setting. New facilities will also receive a provider fee that has been determined by the Department.
2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity, costs, capital data, and pass-through of the prior owner. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures specified in section C.2.c.
3. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under section C.2.a. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the Secretary of the Department.
4. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with section A. These facilities will have their case-mix rates adjusted as follows:

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a. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using percentages that result in the lowest overall rate.

b. No property tax and insurance pass-through reimbursement shall be included in the case-mix rate.

c. The fair rental value rate calculated shall be based on 100 percent occupancy.

C. REIMBURSEMENT TO PRIVATE AND NON-STATE GOVERNMENT OWNED OR OPERATED NURSING FACILITIES

1. Definitions

Active Assessment: A resident minimum data set (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 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 (ARD): 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 section C.2., 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:

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

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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 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.

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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).

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).

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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."

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2. Rate Determination

   a. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price based reimbursement system. Rates shall be calculated from cost report and other statistical data. Effective January 1, 2003, the cost data used in rate setting will be from cost reporting periods ending July 1, 2000 through June 30, 2001. Effective July 1, 2004, and 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. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

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

      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.

      Effective with 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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b. Each facility's Medicaid daily rate is calculated as:
   i. the sum of the facility's direct care and care related price;
   ii. the statewide administrative and operating price;
   iii. each facility's capital rate component;
   iv. each facility's pass-through rate component
   v. adjustments to the rate; and
   vi. the statewide durable medical equipment price.

c. Determination of Rate Components
   i. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

      (1). The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's provider's direct care per diem cost by the facility cost report period case-mix index.
      (2). The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.
      (3). The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.
      (4). The statewide direct care and care related price is established at 110 percent of the direct care and care related resident-day-weighted median cost. For dates of service on or after July 1, 2011, the statewide direct care and care related price is established at 112.40 percent of the direct care and care related resident-day-weighted median cost.
      (5). The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. For periods prior to January 1, 2007, the statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the event that the nursing wage and staffing enhancement add-on is removed.

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Effective January 1, 2007, the statewide direct care and care related floor shall be reduced by one percentage point for each 30 cent reduction in the average Medicaid rate due to a budget reduction implemented by the Department. The floor cannot be reduced below 90 percent of the direct care and care related resident-day-weighted median cost.

Effective for rate periods January 1, 2017 through June 30, 2017, each nursing facility provider's direct care and care related floor will be calculated as follows:

For each nursing facility provider, 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. 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.

(6). For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in section C.2.c.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

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(7). 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 section C.2.c.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the 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.

(8). Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related per diem cost and the direct care and care related cost report period per diem floor. If the total direct care and care related per diem cost the facility incurred is less than the cost report period per diem floor, the facility shall remit to the Bureau the difference between these two amounts times the number of Medicaid days paid during the cost reporting period. The cost report period per diem floor shall be calculated using the calendar day-weighted average of the quarterly per diem floor calculations for the facility's cost reporting period.

(9). For dates of service on or after February 9, 2007, the facility-specific direct care rate will be increased by a $4.70 per diem wage enhancement for direct care staff prior to the case-mix adjustment. The $4.70 wage enhancement will be included in the direct care component of the floor calculations.

For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the $4.70 wage enhancement to a $1.30 wage enhancement prior to the case-mix adjustment for direct care staff. The $1.30 wage enhancement will be included in the direct care component of the floor calculations. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

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ii. The administrative and operating component of the rate shall be determined as follows.

(1) The per diem administrative and operating cost for each nursing facility is determined by dividing the facility's administrative and operating cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

(2) Each facility's per diem administrative and operating cost is arrayed from low to high and the resident day-weighted median cost is determined.

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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:

1. The nursing facility provider's rate period reimbursement rate will be calculated 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;
2. The nursing facility provider's rate period reimbursement rate will be 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;
3. 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;
4. 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 to the time-weighted method acuity measurement system.
5. 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;
6. 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.

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v. Adjustment to the Rate

Effective for dates of service on or after July 1, 2004, for state fiscal year 2005 and state fiscal year 2006, each private nursing facility's per diem case mix adjusted rate shall be reduced by $0.85.

Effective for dates of service on or after July 1, 2005, for state fiscal year 2006 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by $2.99.

Effective for dates of service on or after January 1, 2006, the previous reduction of $2.99 in each private nursing facility's per diem case mix adjusted rate is restored for the remainder of state fiscal year 2006.

In the event the Department is required to implement reductions in the nursing facility program as a result of a budget shortfall, a budget reduction category shall be created. This category shall reduce the statewide average Medicaid rate, without changing the established parameters, by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

(1) Effective for dates of service on or after January 22, 2010, the case-mix adjusted nursing facility rate of each non-State nursing facility shall be reduced by $1.95 per day (1.5 percent of the per diem rate on file as of January 21, 2010) until such time as the rate is rebased on July 1, 2010.

(2) Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 10.52 percent of the non-state owned nursing facilities statewide average daily rate in effect on June 30, 2010 until such time as the rate is rebased on July 1, 2010.

(3) Effective for dates of service on or after July 1, 2010, the per diem reimbursement for non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 (as described in Attachment 4.19-D, §I.C.2.v (2)) until such time as the rate is rebased on July 1, 2010.

(4) Effective for dates of service on or after July 1, 2011, the per diem reimbursement for non-state nursing facilities, excluding the provider fee, shall be reduced by $26.98 of the rate on file as of June 30, 2011 (as described in Attachment 4.19-D, §I.C.2.v.(3)) until such time as the rate is rebased on July 1, 2011.

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3. Case Mix Index Calculation

   a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.12b case-mix indices developed by the Centers for Medicare and Medicaid Services (CMS) shall be the basis for calculating average case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group will be excluded from the average case-mix index calculation.

   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:

      Effective with 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. Case-Mix Documentation Reviews and Case-Mix Index Reports

      i. The Department or shall provide each nursing facility provider with a Preliminary Case Mix Index Report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. This PCIR will serve as notice of the MDS assessments transmitted.

      ii. After giving the nursing facility provider a reasonable opportunity (approximately two weeks) 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.

      iii. 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, or its successor, "BC1-Delinquent". A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, classification system.

      iv. 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.

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	Cumulative Occupancy Increase for all Buyers Involved in the Purchase	Percentage of Base Capital Amount to be Paid	Total Annual Medicaid Incentive Payment (Per Closed Facility)		
			Under 115 Beds	115 Beds through 144 Beds	145 Beds & Up
Base Capital Amount			*$303,216*	*$424,473*	*$597,591*
	Less than 5.00%	67%	$203,155	$284,397	$400,386
	5.00% through 9.99%	78%	$236,508	$331,089	$466,121
	10.00% through 14.99%	89%	$269,862	$377,781	$531,856
	15.00% and up	100%	$303,216	$424,473	$597,591

i. Increased Occupancy
The cumulative increase in total nursing facility occupancy for all buyers involved in the transaction will be calculated based on the total occupancy reported for all buyers at the purchase date under section C.8.a.iv.(5) and the increase in total residents from the seller reported under section C.8.a.v.(1).

ii. Beds Surrendered
Beds surrendered will be based on the licensed beds surrendered for the closed facility.

iii. Annual Medicaid Incentive Payment Calculation
The payment amount that corresponds to the cumulative occupancy increase for all buyers and the number of beds surrendered will be multiplied by each buyer's percentage share in the transaction as reported in section C.8.a.iv.(4). The result will be each buyer's total annual Medicaid incentive payment for five years.

iv. Base Capital Amount
July 1 of each year, the base capital amount 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.

State: Louisiana
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