

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - NURSING FACILITY
SERVICES AND INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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I. METHOD FOR REIMBURSEMENT TO NURSING FACILITIES

The Department of Health and Hospitals, 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.

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 allowable 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 recipients.
 - 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.

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- 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 Medicaid Program 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.

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B. NEW FACILITIES AND CHANGES OF OWNERSHIP OF EXISTING FACILITIES

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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

- a. **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.
- b. **Assessment Reference Date (ARD)** – 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.
- c. **Base Resident-Weighted Median Costs and Prices** the resident-weighted median costs and prices calculated in accordance with section C.2., during rebase years.
- d. **Calendar Quarter** — a three-month period beginning January 1, April 1, July 1, or October 1.
- e. **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.
- f. **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.
- g. **Case Mix** — a measure of the intensity of care and services used by similar residents in a facility.
- h. **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

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assessment. Two average CMIs will be determined for each facility on a quarterly basis, one using all residents (the facility average CMI) and one using only Medicaid residents (the Medicaid average CMI).

- i. **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.
- j. **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.
- k. **Delinquent MDS Resident Assessment** — an MDS assessment that is more than 121 days old, as measured by the ARDfield on the MDS.
- l. **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.
- m. **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 review.
- n. **Facility-Wide Average Case-Mix Index** — the simple average, carried to four decimal places, of all resident case-mix indices based on the first 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.
- o. **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**.

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- p. **Index Factor** — will be based on the Skilled Nursing Home without Capital Market Basket Index published by Data Resources Incorporated (DRI-WEFA).
- q. **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 certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the current MDS assessment required and approved by the Centers for Medicare and Medicaid Services (CMS).
- r. **MDS Supportive Documentation Guidelines** — the Department’s publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III classification system. These guidelines shall be maintained by the Department and updated and published as necessary.
- s. **Pass-Through Cost Component** — includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department.
- t. **Preliminary Case Mix Index (PCIR)** – the preliminary report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter.
- u. **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).
- v. **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.
- w. **RUG-III Resident Classification System** — the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III group, the RUG-III with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.
- x. **Summary Review Results Letter** – a letter sent to the nursing facility that reports the final results of the CMDR and concludes the review.
- y. **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.

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- z. **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.
- aa. **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 documentation guidelines and a different RUG-III classification would result; therefore, the MDS assessment would be considered "unsupported."

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. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.
- 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 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

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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. 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.
- (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.

- 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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(3). The statewide administrative and operating price is established at 107.5 percent of the administrative and operating resident-day-weighted median cost.

iii. The capital component of the rate for each facility shall be determined as follows.

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(1). The capital cost component rate shall be based on a fair rental value (FRV) reimbursement system. Under a FRV system, a facility is reimbursed on the basis of the estimated current value, also referred to as the current construction costs, of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility and its total square footage.

(2). Effective January 1, 2003, the new value per square foot shall be \$97.47. This value per square foot shall be increased by \$9.75 for land plus an additional \$4,000 per licensed bed for equipment. This amount shall be trended forward annually to the midpoint of the rate year using the change in the unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication or a comparable publication if this publication ceases to be published, 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. A nursing facility's fair rental value per diem is calculated as follows.

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(a). Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus \$9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. To this value add the product of total licensed beds times \$4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent * 30)] of the new bed value. There shall be no recapture of depreciation.

(b). A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's current value times a rental factor. The rental factor shall be the 20-year Treasury Bond Rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk factor of 2.5 percent with an imposed floor of 9.25 percent and a ceiling of 10.75 percent.

- (c). The nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 70 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 70 percent of the annualized licensed capacity of the facility.

As of July 1, 2011, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 85 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 85 percent of the annualized licensed capacity of the facility.

- (d). The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years. Beginning January 1, 2007 and the first day of every calendar quarter thereafter, the age of each facility will be reduced for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. Changes in licensed beds are only recognized, for rate purposes, at July 1 of a rebase year unless the change in licensed beds is related to a change in square footage. The occupancy rate applied to a facility's licensed beds will be based on the base year occupancy.
- (e). If a facility performed a major renovation/improvement project (defined as a project with capitalized cost equal to or greater than \$500 per bed), the cost of the renovation project will be used to determine the equivalent number of new beds that project represents. The equivalent-number of new beds from a renovation/improvement

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project will be determined by dividing the cost of the renovation/improvement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation/improvement project. The equivalent number of new beds will be used to determine the weighted average age of all beds for this facility.

Major renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts or other auditable records. Costs must be capitalized in compliance with the Medicare provider reimbursement manual in order to be considered in a major renovation/improvement project. The cost of the project shall only include the cost of items placed into service during a time period not to exceed the previous 24 months prior to a re-aging. Entities that also provide non-nursing facility services or conduct other non-nursing facility business activities must allocate their renovation cost between the nursing facility and non-nursing facility business activities. Documentation must be provided to the Department or its designee to substantiate the accuracy of the allocation of cost. If sufficient documentation is not provided, the renovation/improvement project will not be used to re-age the nursing facility.

Weighted average age changes as a result of replacements/ improvements and/or new bed additions must be requested by written notification to the Department prior to the rate effective date of the change and separate from the annual cost report. The written notification must include sufficient documentation as determined the Department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

iv. Pass-Through Component of the Rate.

STATE <u>Louisiana</u>	
DATE REC'D	<u>3-13-2013</u>
DATE APP'VD	<u>OCT 24 2013</u>
DATE EFF	<u>3-1-2013</u>
ISS. 179	<u>1315</u>

The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. 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 pass through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

Effective July 1, 2007, an add-on amount of \$8.02 shall be added to each facility's per diem rate in order to reimburse providers for Medicaid's share of the costs associated with payment of provider fees.

Effective March 1, 2013, an add-on amount of \$10.00 shall be added to each facility's per diem rate in order to reimburse providers for Medicaid's share of the costs associated with payment of provider fees.

TN# 1315 Approval Date OCT 24 2013 Effective Date 3-1-2013
Supersedes
TN# 1119

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.

TN# 12-08
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TN# 11-24

Approval Date JUN 18 2012

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- (5) Effective for dates of service on or after July 1, 2012, the per diem reimbursement for non-state (includes private) nursing facilities, excluding the provider fee, shall be reduced by \$32.37 of the rate on file as of June 30, 2012 (as described in Attachment 4.19-D, §I.C.2.v.(4)) until such time as the rate is rebased on July 1, 2012.
- (6) Effective for dates of service on or after July 1, 2012, the average daily rates for non-state (includes private) nursing facilities shall be reduced by \$4.11 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and before the state fiscal year 2013 rebase.
- (7) Effective for the dates of service on or after July 1, 2012, the average daily rates for non-state (includes private) nursing facilities shall be reduced by \$1.15 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and after the fiscal year 2013 rebase.
- (8) Effective for the dates of service on or after July 20, 2012, the average daily rates for non-state (includes private) nursing facilities shall be reduced by 1.15 percent per day of the average daily rate on file as of July 19, 2012 after the sunset of the state fiscal year 2012 rebase and after the fiscal year 2013 rebase.
- (9) Effective for dates of service on or after September 1, 2012, the average daily rates for non-state (includes private) nursing facilities shall be reduced by \$13.69 per day of the average daily rate on file as of August 31, 2012 before the state fiscal year 2013 rebase which will occur on September 1, 2012.
- (10) Effective for the dates of service on or after September 1, 2012, the average daily rates for non-state (includes private) nursing facilities shall be reduced by \$1.91 per day of the average daily rate on file as of August 31, 2012 after the state fiscal year 2013 rebase which will occur on September 1, 2012.
- (11) Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state (includes private) nursing facilities, excluding the provider fee, shall be reduced by \$53.05 of the rate in effect on June 30, 2013 until such time that the rate is rebased.
- (12) Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state (includes private) nursing facilities, excluding the provider fee, shall be reduced by \$18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.
- (13) Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state (includes private) nursing facilities, shall be adjusted and rebased which results in an increase of \$3.58 in the average daily rate.
- (14) Effective for the rate period of July 1, 2015 through June 30, 2016, the Department shall suspend the provisions currently governing the reimbursement methodology for nursing facilities and imposes the following provisions governing reimbursements for nursing facility services.
 - i. 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.

State: Louisiana
Date Received: September 16, 2015
Date Approved: **MAR 07 2016**
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Transmittal Number: 15-0023

TN 15-0023

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- ii. All costs and cost components that are required to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).
 - iii. 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.
 - iv. Base capital values for the Bed Buy-Back program purposes will be set equal to the value of these items as of July 1, 2014.
 - v. 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.
 - vi. 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.
 - vii. No other provisions of the current nursing facility reimbursement methodology shall be suspended for this time period.
 - viii. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- d. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour rated walls placed in service on or after July 1, 2006 will be excluded from the renovation/improvement costs used to calculate the FRV to the extent the nursing home is reimbursed for said costs in accordance with section 6.

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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 facility, with a completed and submitted assessment, shall be assigned a RUG-III 34 group on the first day of each calendar quarter. The RUG-III group is calculated based on the resident's most current assessment, available on the first 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 first day of each calendar quarter.
- c. 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 payer source on the first day of the calendar quarter.
- d. Verification of Minimum Data Set (MDS) Assessment
 - i. The department or its contractor shall provide each nursing facility with a point-in-time preliminary case mix index (CMI) report by approximately the fifteenth day of the second month following the beginning of a calendar quarter. This preliminary report will serve as notice of the MDS assessments transmitted.
 - ii. After allowing the facilities a reasonable amount of time (approximately two weeks) to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction policy where applicable, the department or its contractor shall provide each nursing facility with a final CMI report utilizing MDS assessments
 - iii. If the department or its contractor determines that a nursing facility has delinquent MDS (minimum data sets) 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". A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III classification system.
 - iv. The department or its contractor shall periodically review the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department.

SUPERSEDES: TN- 99-04

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4. Enhanced Reimbursement

Payment for SN/ID and SN/TDC services shall be made using a prospective reimbursement methodology. This methodology utilizes the SN rate inflated to the applicable rate year plus an average allowable cost per day. The average allowable cost per day is determined by dividing total allowable ID/TDC costs by total ID/TDC days. Costs are categorized into four rate components (Direct Nursing Costs, Other Direct Care Services, Plant and Maintenance Costs, and Allocated Costs). The Direct Nursing Costs are inflated using the DPI-Medical Care-Consumer Index for All Urban Consumers-South Region. Other Direct Care Services, Plan and Maintenance Costs, and Allocated Costs are inflated using the CPI-All Items-Consumer Index for All Urban Consumers-South Region. The adjustment factor for each rate component is computed by dividing the value of the corresponding index for December of the year preceding the rate year by the value of the index one year earlier. An additional \$23.49 pass-through payment for durable medical equipment (DME) will be made for SN/ID and SN/TDC Medicaid days.

a. SN/ID (Skilled Nursing/Infectious Diseases)

Reimbursement for SN/ID services shall be limited to the same rates paid for care of SN recipients plus a prospective statewide enhancement to ensure reasonable access to appropriate services. The enhanced amount shall be based on average allowable incremental costs of all acceptable cost reports (submitted on the Department's cost report form and completed according to the Department's instructions) for the year on which rates are based and in accordance with guidelines for allowable incremental costs and inflated forward to reflect current costs. In addition, the following requirements must be met:

- (1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;
- (2) The facility must be licensed to provide nursing services; and
- (3) The facility must have entered into a separate contractual agreement with the Bureau to provide SN/ID services in accordance with standards for the care of individuals with infectious diseases and meet all staffing and service requirements applicable to this recipient population.

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99-19

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Allowable incremental costs for SN/ID include the following:

- (1) Direct Nursing Costs are based on the demonstrated salary and related benefits cost of nursing personnel directly related to providing SN/ID services. Nursing services personnel include head/charge nurse, registered nurses (RNs), licensed practical nurses (LPNs), nurse assistants, and orderlies. These costs exclude administrative nursing costs not directly related to patient care.

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HCFA 179	<u>99-19</u>
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- (a) A minimum of 4.0 nursing hours per patient day for infectious disease residents is required. Costs for direct patient care in excess of 9.6 hours per patient day are not allowable on the SN/ID supplemental cost report.

- (b) The marginal portion of the demonstrated salary and related benefits cost of nursing service personnel directly related to providing SN/ID services in excess of nursing requirements for routine skilled nursing services will be allowed as SN/ID cost.

- (2) Other Direct Care Services are based on demonstrated appropriate services including the following:

- (a) Respiratory therapy, social services or any other specialized services that are directly attributable to SN/ID status and not covered in the SN rate.

- (b) Specialized nursing supplies related to SN/ID status must be supported by detailed justification that substantiates the cost of any specialized nursing supplies.

- (c) Specialized dietary needs related to SN/ID status must be supported by detailed justification that substantiates the cost of any specialized dietary needs.

- (3) Plant and Maintenance costs are based on demonstrated dependency on SN/ID special equipment. Costs associated with demonstrated enhanced infection control measures are included. Capitalized purchases are not included.

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(4) Allocated costs are based on the ration of direct nursing hours required for SN/ID services that are not covered in the regular skilled rate (1.4 hours per resident day) related to total facility direct nursing hours. The following costs are allocated: administrative and general, nursing administration (Director of Nursing), housekeeping, medical supplies, and dietary.

(5) Incentive Factor is equal to 5% of the average incremental costs added to the enhanced rate in order to assure reasonable access to SN/ID services.

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Facilities shall submit cost reports at the end of each 12 month period. Providers shall be required to segregate SN/ID costs from other long term care costs and to submit a supplemental cost report which shall be subject to audit. No duplication of costs shall be allowed and allowable costs shall be in accordance with Medicare cost principles.

The Department will review Medicaid costs and payments annually to insure the reimbursement rates remain reasonably related to costs by comparing total Medicaid allowable costs from the latest available audited and/or desk reviewed cost reports to total Medicaid payments for that year.

Rates will be rebased in subsequent years by determining average costs (total allowable ID costs divided by total ID days) using the latest available audited and/or desk reviewed specialized services cost reports. Costs will be inflated as described above and a five percent (5%) incentive factor added. The rate will be finalized by adding the skilled reimbursement rate effective for the same rate period. Base rate adjustments will result in a new base rate component which will be used to calculate the rate for subsequent years. A base rate adjustment may be made when the event, or events, causing the adjustment is not one that would be reflected in inflationary indices.

Application of an inflationary adjustment to reimbursement rates for non-fixed costs in non-rebasing years shall apply only in years when the legislature allocates funds for this purpose. The adjustment shall be limited to the amount appropriated by the State Legislature.

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b. SN/TDC (Skilled Nursing/Technology Dependent Care)

Reimbursement for SN/TDC services shall be limited to the same rates paid for care of SN recipients plus a prospective statewide enhancement to ensure reasonable access to appropriate services. The enhanced amount shall be based on average allowable incremental costs of all acceptable cost reports (submitted on the Department's cost report form and completed according to the Department's instructions) for the year on which rates are based and in accordance with guidelines for allowable incremental costs and inflated forward to reflect current costs. In addition, the following requirements must be met:

- (1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;
- (2) The facility must be licensed to provide nursing services; and
- (3) The facility must have entered into a separate contractual agreement with the Bureau to provide SN/TDC services in accordance with standards for the care of technology dependent recipients and meet all applicable staffing and service requirements applicable to this recipient population.

Allowable incremental costs for TN/TDC include the following:

- (1) Direct Nursing Costs are based on the demonstrated salary and related benefits cost of nursing service personnel directly related to providing SN/TDC services. Nursing service personnel include head/charge nurse, registered nurses (RNs), licensed practical nurses (LPNs), nurse assistants and orderlies. These costs exclude administrative nursing costs not directly related to patient care.
 - (a) A minimum of 4.5 nursing hours per patient day for technology dependent care residents is required. Costs for direct patient care in excess of 9.6 hours per patient day are not allowed.
 - (b) The marginal portion of the demonstrated salary and related

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benefits cost of nursing service personnel directly related to providing SN/TDC services in excess of nursing requirements for routine skilled nursing services will be allowed as SN/TDC costs.

(2) Other Direct Care Services are based on demonstrated appropriate services including the following:

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- (a) Respiratory therapy, social services or any other specialized services that are directly attributable to SN/TDC status and not covered in the SN rate.
- (b) Specialized nursing supplies related to SN/TDC status must be supported by detailed justification that substantiates the cost of any specialized nursing supplies.
- (c) Specialized dietary needs related to SN/TDC status must be supported by detailed justification that substantiates the cost of any specialized dietary needs.

(3) Plant and Maintenance costs are based on demonstrated dependency on SN/TDC special equipment. Capitalized purchases are not included.

(4) Allocated Costs are based on the ration of direct nursing hours required for SN/TDC services that are not covered in the regular skilled rate (1.9 hours per resident day) related to total facility direct nursing hours. The following costs are allocated: administrative and general, nursing administration (Director of Nursing), housekeeping, medical supplies, and dietary.

(5) Incentive Factor is equal to 5% of the average allowable incremental costs added to the enhanced rate, in order to assure reasonable access to TN/TDC services.

Facilities shall submit cost reports at the end of each 12 month period. Providers shall be required to segregate SN/TDC costs from other long term care costs and to submit a supplemental cost report which shall be subject to audit. No duplication of costs shall be allowed and allowable costs shall be in accordance with Medicare cost principles.

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The Department will review Medicaid costs and payments annually to insure that the reimbursement rates remain reasonably related to costs by comparing total Medicaid allowable costs from the latest available audited and/or desk reviewed cost reports to total Medicaid payments for that year.

Rates will be rebased in subsequent years by determining average costs (total allowable TDC costs divided by total TDC days) using the latest available audited and/or desk reviewed specialized services cost reports. Costs will be inflated as described above and a five percent (5%) incentive factor added. The rate will be finalized by adding the skilled reimbursement rate effective for the same rate period. Base rate adjustments will result in a new base rate component which will be used to calculate the rate for subsequent years. A base rate adjustment may be made when the event, or events, causing the adjustment is not one that would be reflected in inflationary indices.

Application of an inflationary adjustment to reimbursement rates for non-fixed costs in non-rebasing years shall apply only in years when the legislature allocates funds for this purpose. The adjustment shall be limited to the amount appropriated by the State Legislature.

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5. Neurological Rehabilitation Treatment (NRT) Program

The NRT Program services were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living which occurred within six months prior to admission.

The NRT Program has two levels of care services. The Rehabilitation level service is for an injury or condition of recent onset and the Complex Care level service is for an injury or condition requiring transitional or long term care in a specialized setting capable of addressing cognitive, medical technological and family needs.

The health conditions of these patients in both levels of care must be determined to be too medically complex or demanding for a typical skilled nursing setting, but these conditions no longer warrant in-patient hospital care. The facility shall provide care to patients as outlined in the medical criteria established by the Department for both levels of care. NRT Program services should be rendered throughout the recovery process not to exceed ninety days, with a maximum of three thirty-day extensions. The NRT Level of Care certification cannot exceed a total of six months for either or a combination of both. Admissions and continued stay are determined by the Health Standards Section.

Reimbursement for NRT Program services is through prospective flat rates that were developed on budgeted cost data. The rates established are all inclusive and are not in addition to the NF rates. The Department will audit cost reports annually. The rates will be rebased when there is a minimum 5% difference in the actual rate and the audited rate.

Rehabilitation level services are designed to reduce the patient's rehabilitation and medical needs while restoring the person to an optimal level of physical, cognitive and behavioral function within the content of the person, family and community. Rehabilitation level services base rate is \$489.11.

Complex Care level services are designed to provide care for patients who have a variety of medical/surgical concerns requiring a high skill level of nursing, medical and/or rehabilitation interventions to maintain medical/functional stability. Complex Care level services base rate is \$359.90.

The NRT Program shall utilize the Consumer Price Index for All Urban Consumers - Southern Region, All Items Economic Adjustment Factors, as published by the United States Department of Labor to give yearly inflation adjustments. This economic adjustment factor is computed by dividing the value of the All Items index for December of the year preceding the rate year (July

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1 through June 30) by the value of the All Items index one year earlier (December of the second preceding year).

This factor, All Items, will be applied to the total base which includes fixed cost. Interim adjustments to rates shall conform to Attachment 4.19-D, Page 9., Interim Adjustment to Rates for regular nursing facilities. Rebasing shall conform to Attachment 4.19-D, Page 7.

Annual financial and compliance audits are required from the NRT Program provider as well as the submittal of additional cost reporting documents as requested by the Department.

Providers are required to segregate NRT Program costs from all other long term care costs in a separate annual cost report and submit a separate annual cost report for each level of care (rehabilitation and complex care services). Medicare cost principles found in the Provider Reimbursement Manual (HIM-15) shall be used to determine allowable costs. The facility must adhere to the following:

- 1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;
- 2) The facility must be licensed to provide nursing services and shall admit and maintain residents requiring any nursing facility level of care designation;
- 3) The facility must have entered into a contractual agreement with the Bureau to provide NRT Program services in accordance with standards for the care of persons with neurological rehabilitation treatment needs and meet all staffing and service requirements applicable to this client population; and
- 4) The facility must be accredited by the Joint Commission of accreditation of Healthcare Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF).

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6. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations – These costs are to be calculated separately from the case mix calculation and are added to the per diem reimbursement.
- a. All nursing facilities are required to be protected throughout by a fire sprinkler system by January 1, 2008. Where means of egress passes through building areas outside of a nursing facility, those areas shall be separated from the nursing facility by a two-hour rated wall or shall be protected by a fire sprinkler system.
 - b. Nursing Facility Procedure and Documentation Requirements:
 - i. A completed fire sprinkler system plan or two-hour rated wall plan, or both, must be submitted to the Department for review and approval by December 31, 2006.
 - ii. Upon approval of the plans and after installation is completed, nursing facilities must submit auditable depreciation schedules and invoices to support the installation cost of all fire sprinkler systems and two-hour rated walls. The documentation must be submitted to the Department or its designee. All supporting documentation, including depreciation schedules and invoices, must indicate if the cost was previously included in a fair rental value re-age request.
 - c. Medicaid participating nursing facilities that install or extend fire sprinkler systems or two-hour rated walls, or both, after August 1, 2001, and in accordance with this section, may receive Medicaid reimbursement for the cost of installation over a five year period beginning the later of July 1, 2007 or the date of installation.
 - i. The annual total reimbursable cost is equal to a nursing facility's total installation cost of all qualified fire sprinkler systems and two-hour rated walls divided by five.
 - ii. The per diem cost is calculated as the annual total reimbursable cost divided by total nursing facility resident days as determined by the nursing facility's most recently audited or desk reviewed Medicaid cost report as of April 30, 2007. If a cost report is not available, current nursing facility resident day census records may be used at the Department's approval.
 - iii. The per diem cost is reduced by any fair rental value per diem increase previously recognized as a result of the costs being reimbursed under this section. This adjusted per diem cost shall be paid to each qualifying nursing facility as an additional component of their Medicaid daily rate for five years.

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7. Reimbursement for Nursing Facility Evacuation and Temporary Sheltering Expenses

Nursing facilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to additional reimbursement of specific evacuation and temporary sheltering expenses incurred in addition to expenses included in their case-mix per diem rate.

a. Eligibility for Reimbursement

- i. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the Department apply for the Federal Emergency Management Agency assistance on their behalf.
- ii. Nursing facilities must submit expense and reimbursement documentation related to the evacuation or temporary sheltering of Medicaid nursing facility residents to the Department.

b. Eligible Expenses (Reimbursed in addition to the customary per diem rate)

Expenses eligible for reimbursement must occur as a direct result of an evacuation and be reasonable, necessary, and proper. All eligible expenses must be in addition to normal daily operating expenses already included in the nursing facility's case-mix per diem rate. Eligible expenses are subject to audit at the Department's discretion. Eligible expenses may include the following:

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- i. Evacuation expenses – includes expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. The following expenses will be reimbursed to the evacuating nursing facility in addition to their customary per diem rate.
 - (1) Resident transportation and lodging expense during travel.
 - (2) Additional nursing staff transportation, lodging, wage, and contract labor expense when accompanying residents.
 - (3) Any other additional allowable expenses as defined in the CMS Publication 15-1 that are directly related to the evacuation, and that would normally be allowed under the Louisiana nursing facility case-mix rate.
- ii. Host nursing facility temporary sheltering expenses - Host nursing facilities are defined as Medicaid-certified nursing facilities that admit residents discharged from evacuated nursing facilities. Evacuating nursing facilities will not receive any payment for residents that have been admitted to a host nursing facility. The following expenses will be paid to the host nursing facility in addition to their customary per diem rate for a period not to exceed six months.

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Additional direct care expenses, when a direct care expense increase of 10% or more is documented. Direct care expenses are defined under the Louisiana case-mix rule and the increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined by the Department.

- c. Payment of Eligible Expenses (In addition to the customary per diem rate)
 - i. For payment purposes, total eligible Medicaid expenses will be the sum of non resident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid-resident specific expenses. All expenses will be reduced for Medicaid's share of all reimbursement from other sources including FEMA or its successor. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.
 - ii. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the Department by the end of each calendar quarter.
 - iii. All eligible expenses documented and allowed under this section will be removed from allowable expense when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.
 - (1) Equipment purchases that are reimbursed on a rental rate may have their remaining basis included as allowable cost on future cost reports provided that the equipment is in the nursing facility and is being used. If the remaining basis requires capitalization under CMS Publication 15-1 guidelines, then depreciation will be recognized.
 - iv. All payments will remain under the UPL cap.
- d. Evacuated nursing facilities may also be entitled to reimbursement in accordance with the Medicaid leave day provisions contained in Attachment 4.19-C, section II.C.

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8. Fair Rental Value, Property Tax, and Property Insurance Incentive Payments to Buyers of Nursing Facilities after Closure

On or after July 20, 2007, a Louisiana Medicaid participating nursing facility (buyer(s)) that purchases and closes an existing Louisiana Medicaid participating nursing facility (seller) will be eligible to receive fair rental value, property tax, and property insurance incentive payments for five years after the legal transfer of ownership and closure of the seller's nursing facility.

a. Qualifying Buyer(s) - In order for the buying facility to qualify for the incentive payments in section C.8.b., the following conditions must be met:

- i. The buyer(s) must close the purchased nursing facility (seller) within 90 days after the legal transfer of ownership from seller to buyer(s).
- ii. After closing the facility, all buyers must permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state.
- iii. The buyer(s) must be Medicaid-certified nursing facility operator(s) at the time of purchase and continue their Medicaid participation throughout the entire five year payment period.

A change in ownership of a buyer facility will not be considered a break in Medicaid participation, provided that the new owner of the nursing facility continues to participate in the Medicaid Program as a certified nursing facility.

- iv. The buyer(s) must provide the following information in writing to the Department within 30 days after the legal transfer of ownership:
 - (1) a list of all buyers;
 - (2) a list of all sellers;
 - (3) the date of the legal transfer of ownership;
 - (4) each buyer's percentage share of the purchased facility; and
 - (5) each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.
- v. The buyer(s) must provide the following information in writing to the Department within 110 days after the legal transfer of ownership:
 - (1) a list of the nursing facility residents that transferred from the seller facility and were residents of the buyer facility as of 90 days after the legal transfer of ownership date. The nursing facility resident list must include the payer source for each resident.
 - (2) the date that the seller's facility was officially closed and no longer operating as a nursing facility.

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- b. Incentive Calculation - The total annual Medicaid incentive payment for each transaction will be based on the following table and the subparagraphs that follow:

	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
<i>Base Capital Amount</i>			\$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, 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.

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c. Re-base of Buyers' Fair Rental Value, Property Tax, and Property Insurance Per Diems

All buyers will have their fair rental value, property tax, and property insurance per diems re-based using the number of residents reported by each buyer under section C.8.a.v.(1). The re-base will be retroactive to the date of closure of the purchased facility. The calculation will be as follows:

- (1) The number of total resident days used in the calculation of each buyer's current fair rental value per diem under section C.2.c.iii.(2) will be increased by the number of residents the buyer reported under section C.8.a.v.(1) multiplied by the total number of current rate year days.
- (2) The number of total resident days used in the calculation of each buyer's current pass through property tax and insurance per diem under section C.2.c.iv. will be increased by the number of residents the buyer reported under section C.8.a.v.(1) multiplied by the number of calendar days included in the buyer's most recent base-year cost report.
- (3) The resident day adjustment to each buyer's fair rental value, property tax, and property insurance per diem will continue until the buyer's base-year cost report, as defined under section C.2.a., includes a full twelve months of resident day data following the closure of the acquired facility (seller). If a buyer's base year cost report overlaps the closure date of the acquired facility, a proportional adjustment to that buyer's resident days will be made for use in the fair rental value, property tax, and property insurance per diem calculations.

d. Payments

- i. The fair rental value, property tax, and property insurance incentive payment will be paid to the buyer(s) as part of their Medicaid per diem for current services billed over five years (twenty quarters) effective the beginning of the calendar quarter following the closure of the seller's facility and the surrender of the seller's licensed beds to the Department. The per diem will be calculated as the buyer's annual Medicaid incentive payment under section C.8.b.iii divided by annual Medicaid days. Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility, as determined under section C.8.a.v.(1), multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report.
- ii. The revised fair rental value per diem and revised property tax and insurance per diem for the buyer(s) will be effective the first day of the month following the closure of the acquired facility (seller).
- iii. The incentive payments when combined with all other Medicaid nursing facility payments shall not exceed the Medicare upper payment limit.

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9. Additional Payments and Square Footage Adjustments for Private Room Conversion

Effective for dates of service on or after September 1, 2007, Medicaid participating nursing facilities that convert a semi-private room to a Medicaid-occupied private room are eligible to receive an additional \$5 per diem payment. Facilities that participate will have their fair rental value per diem revised based on the change in licensed beds.

- a. Qualifying Facilities - In order for a nursing facility's beds to qualify for an additional \$5 per diem payment, a revised fair rental value (FRV), a revised property tax pass-through, and a revised property insurance pass-through, all of the following conditions must be met.
 - i. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.
 - ii. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the \$5 per diem payment.
 - iii. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.
 - iv. The nursing facility must submit the following information to the Department within 30 days of the private room conversion:
 - (1) the number of rooms converted from semi-private to private;
 - (2) the revised bed license;
 - (3) a resident listing by payer type for the converted private rooms; and
 - (4) the date of the conversions.
- b. The additional \$5 per diem payment determination will be as follows:
 - i. An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.
 - ii. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in C.9.a.
 - iii. A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of this section have been met.
- c. The revised fair rental value per diem will be calculated as follows:
 - i. After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.
 - ii. After a qualifying private room conversion, the allowable square footage per bed used in C.2.c.iii.(2) will be determined as follows:

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- (1) No Change in Total Square Footage. The total allowable square footage after a qualifying private room conversion will be equal to the total allowable square footage immediately prior to the conversion, provided no other facility renovations or alterations changing total square footage occur concurrently or subsequently to the private room conversion.
 - (2) Square Footage Changes to Existing Buildings. If a change in total nursing square footage occurs in a building existing on September 1, 2007, and that change is concurrent with or subsequent to a private room conversion, the allowable square footage will be determined in accordance with C.2.c.iii.(2)(a) as if the private room conversion did not occur.
 - (3) Square Footage Changes Due to New Buildings. Replacement buildings constructed or first occupied after September 1, 2007 will have their allowable square footage calculated in accordance with C.2.c.iii.(2)(a).
- iii. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 85 % of the revised annual bed days available after the change in licensed beds.
 - iv. A revised fair rental value per diem will be calculated under C.2.c.iii.(2) using the allowable square footage according to C.9.c.i., remaining licensed beds, and the revised minimum occupancy calculation.
 - v. The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria in paragraph C.9.a.
- d. Reporting. To remain eligible for the conversion payments and the allowable square footage calculations, facilities must report Medicaid-occupied private rooms with every annual cost report. The Department may also require an alternate billing procedure for providers to receive the additional \$5 private room rate.

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10. Transition of a State-Owned or Operated Nursing Facility to a Private Nursing Facility through a Change of Ownership

A state owned or operated nursing facility that changes ownership (CHOW) in order to transition to a private nursing facility will be exempt from the case-mix direct care and care-related spending floor for a period of 12 months following the effective date of the CHOW under the following conditions. The state-owned or operated facility is located in the DHH administrative region 1; and the change of ownership is the result of a leasing arrangement.

- a. **Cost Reports** – The previous owner of the nursing facility must file a closing cost report within 60 days of the CHOW for the time period that spans from the beginning of the facility's cost report period to the date of the CHOW. The closing and initial cost reports must be filed in accordance with cost report provisions in section I.A. , including the filing of all Medicaid supplemental schedules.
- b. **Capital Data Survey** – A capital data survey must be filed with the Department within 60 days of the effective date of the CHOW. The initial cost report period following the CHOW will be determined based on the elected fiscal year end of the new facility. The capital data survey must include the nursing facility's date of construction, current square footage, and all renovations made since the facility's opening.
- c. **Rate Determination** – During the transition period (12 months following the effective date of the change of ownership), the Medicaid reimbursement rate for the transitioned nursing facility shall be reimbursed as follows:
 - i. The per diem rate shall be the per diem rate on file as of March 19, 2010 for the state-owned or operated facility.
 - ii. The transitioned nursing facility will be transferred to the case-mix reimbursement system at the end of the 12 month transition period.
 - iii. The Medicaid reimbursement rate and direct care/care-related floor shall be calculated in accordance with the rate determination provisions of section I.C.2
 - (1) The direct care/care-related floor will be effective on the date of transition to the case mix reimbursement system.
 - (2) For purposes of this initial floor calculation, direct care and care-related spending will be determined by apportioning cost report period costs based on calendar days.

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- iv. Under the case mix reimbursement methodology, the facility will file cost reports in accordance with the cost report provisions in section I.A., including all Medicaid supplemental schedules. If the nursing facility's cost report period overlaps the date of transition to the case mix reimbursement methodology, the case mix direct care and care-related floor will only be applied to the portion of the cost report period that occurs after the date of transition to case mix.
- v. Until the nursing facility has an audited or desk reviewed cost report that is available for use in a case mix rebase in accordance with the rate determination provisions of section I.C.2.a., the case mix reimbursement rate components will be based on the following criteria except as noted in section vi. below.
- (1) The facility's acuity as determined from its specific case mix index report for the quarter prior to the effective date of the rate.
 - (2) The direct care and care-related statewide median prices in effect for that period. 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 nursing facility's most recent non-disclaimed audited or desk reviewed cost report. The facility-specific percentages will be determined using the methodology described in I.C.2.c.i.(3).
 - (3) The administrative and operating statewide median prices in effect for that period.
 - (4) The capital data for the fair rental value rate component will be calculated from the facility-submitted capital data survey and the occupancy percentage from the most recent non-disclaimed audited or desk reviewed cost report as of the effective date of the rate.
 - (5) The facility's property insurance cost will be calculated from the most recent non-disclaimed audited or desk reviewed cost report as of the rate effective date.
 - (6) The property tax cost will be collected in the form of an interim property tax report specified by the Department. The interim property tax report must be filed within 30 days after the beginning of the nursing facility's cost reporting period. Failure to provide the interim property tax report within the specified time frame will result in a zero dollar reimbursement rate for the property tax rate component. The facility must continue to file an interim property tax report until the facility is able to produce a non-disclaimed audited or desk reviewed cost report that contains property tax cost.
 - (7) Provider fee and budget adjustments in effect for all other case mix facilities will be applicable.
- vi. A disclaimed cost report that would otherwise be used in a rebase will result in a rate calculated in accordance with the New facilities and change of ownership provisions

of section I.B. and the provisions contained in above sections iii. and iv. will no longer be applicable.

- vii. If additional data is needed, the Department may request that the facility submit Medicaid supplemental cost report schedules for those cost report period year ends for which the facility has not previously submitted Medicaid supplemental schedules.
- d. **Subsequent CHOW** – If there is a subsequent CHOW which results in the nursing facility reverting to a state-owned or operated facility, then the reimbursement methodology for a state-owned or operated nursing facility will be reinstated following the effective date of the CHOW and all other provisions of this section will no longer be applicable.

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D. REIMBURSEMENT TO PUBLIC NURSING FACILITIES

Effective August 1, 2005, the prospective reimbursement rate will include the cost of durable medical equipment and supplies required to comply with the plan of care for Medicaid recipients residing in nursing facilities. The payment rate for each of these facilities will be the nursing facility's allowable cost from the most recent filed Medicaid cost report trended forward to the midpoint of the rate year.

State-owned or operated nursing facilities will be paid a prospective per diem reimbursement rate. The per diem payment rate for each of these facilities will be calculated using the nursing facility's allowable cost from the most recently filed Medicaid cost report trended forward from the midpoint of the cost report year to the midpoint of the rate year using the index factor as defined in section C.1.m.

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E. Enhancement Pool Funded by Transfer From Parish Owned Nursing Facilities

1. Enhancement Pool Creation

An enhancement pool is created to increase reimbursement to parish owned facilities in proportion to their share of Medicaid days provided during the reporting period used to set rates. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

2. Calculation of Nursing Facility Payment Differential

The nursing facility payment differential for any year shall be the difference between the upper limit of aggregate payments to nursing facilities as defined in 42 CFR §447.272 and the aggregate Medicaid per diem reimbursement paid to nursing facilities for the year, determined for all nursing facilities participating in the state's Medicaid Program, or for a subset of these facilities that embraces parish-owned nursing facilities for which a separate upper payment limit calculation is required by 42 CFR §447.272 as in effect in that year.

3. Calculation of Enhancement Pool Amount

Total payments from the pool in any year shall not exceed a percentage of the nursing facility payment differential that will be determined by the Department for each payment year.

4. Enhancement Pool Distribution

The entire enhancement pool amount shall be distributed on a quarterly basis to qualifying parish-owned nursing facilities based on their pro-rata share

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of the total annual Medicaid days of care of all qualifying parish-owned nursing facilities. Determination of annual Medicaid occupancy level and Medicaid days of care shall be based on the most recently filed cost reports on file with the Department.

5. Definition of Qualifying Facilities

- a. Qualifying facilities are parish-owned nursing facilities that:
 - (i) have an annual Medicaid occupancy level at or above sixty percent (60%);
 - (ii) provide 12,000 or more Medicaid days of care annually; and
 - (iii) have entered into (or be part of a parish government that has entered into) a transfer agreement with the Department providing for an intergovernmental transfer of funds.

Determination of Upper Limit

For purposes of the Enhancement Pool payments covered by this section E., the upper limit of aggregate payments to nursing facilities pursuant to 42 CFR §447.272 shall be determined using the RUGS III classification system utilized in determining nursing home reimbursement in the Medicare program. MDS data will be utilized to determine the classification of Medicaid-eligible residents of nursing homes participating in the State's Medicaid program. Payment rates for each classification will be those published by HCFA for Medicare, as adjusted by the HCFA published wage indexes. The Medicare payment rates will be further adjusted to reflect add-ons enacted by statute, and additional adjustments will be made to achieve comparability of Medicare and Medicaid rates (including adjustments to offset disparities in the various components of the Medicare and Medicaid rates).

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7. Special Condition to Assure Use of Funds for Health Care Purposes

This section E. shall remain in effect until one of the following events occurs:

- a. The effective date of a HCFA approval of an amendment to the plan withdrawing this section E;
- b. The effective date of a HCFA approval of an amendment effectively superseding this section;
- c. The State, without HCFA approval, dissolves, in whole or in substantial part, the Medicaid Trust Fund for the Elderly established by Act 143 of the First Extraordinary Session, 2000, of the state legislature, or enacts a law or takes any other action which allows the principal of or the income from the Medicaid Trust Fund for the Elderly to be used for purposes other than for which they can be used under the terms of Act 143 as in place on January 1, 2001, other than for expansion of Medicaid eligibility. The State agrees to notify HCFA if either of these events occurs. The State will also certify on each Quarterly Expenditure Report, Form HCFA-64, that it submits to HCFA that neither of the above events has occurred.

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ADDITIONAL REQUIREMENT: In the event any of the conditions specified in paragraph c. of this sub-section 7 occurs, or if the State fails to make the certification referred to in paragraph c. after reasonable (30 days) notice of its failure to do so, the State agrees to return an amount equal to the entire corpus of the Medicaid Trust Fund for the Elderly (at the time just preceding the event) to HCFA in the same manner, and subject to the same terms and conditions, including but not limited to the provisions of 42 CFR §430.48, as if that amount had been disallowed by HCFA pursuant to §1903(d) of the Social Security Act. Should the State

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fail to reflect the return of such amount on its first Expenditure Report, HCFA Form HCFA-64, submitted following the events described in paragraph c, the State agrees that HCFA shall disallow that amount, pursuant to §1903(d) and subject to 42 CFR 430.48, on the grant award that is based on the Expenditure Report where the return of such funds should have been reflected.

8. Enhancement pool payments to qualifying facilities shall sunset on June 30, 2005. All payments made under this state plan amendment while in effect are valid. The state may submit a state plan amendment after June 30, 2005 that re-implements the above enhancement pool payment methodology or a different methodology.



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F. Non-State Governmental Organization Nursing Facilities

Supplemental Payments

1. Effective for dates of service on or after January 20, 2016, the following five nursing facilities, which are owned or operated by a non-state government organization (NSGO) and have entered into an agreement with the Department to participate, shall qualify for a Medicaid supplemental payment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities effective for January 20, 2016 are as follows:
 - a. Gueydan Memorial Guest Home;
 - b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);
 - c. LaSalle Nursing Home;
 - d. Natchitoches Parish Hospital LTC Unit; and
 - e. St. Helena Parish Nursing Home.
2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.
3. **Payment Calculations.** The Medicaid supplemental payment for each state fiscal year (SFY) will be calculated 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 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;

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- (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. 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.

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- 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.

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- (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
- (i) 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
- (i) 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.

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4. Frequency of Payments and Calculations
 - a. 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.

 5. 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.

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